

VETERANS' MILLENNIUM HEALTH CARE ACT

JULY 16, 1999.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STUMP, from the Committee on Veterans' Affairs,
submitted the following

R E P O R T

[To accompany H.R. 2116]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 2116) to amend title 38, United States Code, to establish a program of extended care services for veterans and to make other improvements in health care programs of the Department of Veterans Affairs, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; REFERENCES TO TITLE 38, UNITED STATES CODE.

(a) SHORT TITLE.—This Act may be cited as the “Veterans’ Millennium Health Care Act”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents; references to title 38, United States Code.

TITLE I—ACCESS TO CARE

- Sec. 101. Extended care services.
- Sec. 102. Reimbursement for emergency treatment.
- Sec. 103. Eligibility for care of combat-injured veterans.
- Sec. 104. Access to care for military retirees.
- Sec. 105. Benefits for persons disabled by participation in compensated work therapy program.
- Sec. 106. Pilot program of medical care for certain dependents of enrolled veterans.
- Sec. 107. Enhanced services program at designated medical centers.
- Sec. 108. Counseling and treatment for veterans who have experienced sexual trauma.

TITLE II—PROGRAM ADMINISTRATION

Sec. 201. Medical care collections.
 Sec. 202. Health Services Improvement Fund.
 Sec. 203. Veterans Tobacco Trust Fund.
 Sec. 204. Authority to accept funds for education and training.
 Sec. 205. Extension and revision of certain authorities.
 Sec. 206. State Home grant program.
 Sec. 207. Expansion of enhanced-use lease authority.
 Sec. 208. Ineligibility for employment by Veterans Health Administration of health care professionals who have lost license to practice in one jurisdiction while still licensed in another jurisdiction.

TITLE III—MISCELLANEOUS

Sec. 301. Review of proposed changes to operation of medical facilities.
 Sec. 302. Patient services at Department facilities.
 Sec. 303. Report on assisted living services.
 Sec. 304. Chiropractic treatment.
 Sec. 305. Designation of hospital bed replacement building at Ioannis A. Lougaris Department of Veterans Affairs Medical Center, Reno, Nevada.

TITLE IV—CONSTRUCTION AND FACILITIES MATTERS

Sec. 401. Authorization of major medical facility projects.
 Sec. 402. Authorization of major medical facility leases.
 Sec. 403. Authorization of appropriations.

(c) REFERENCES TO TITLE 38, UNITED STATES CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—ACCESS TO CARE

SEC. 101. EXTENDED CARE SERVICES.

(a) REQUIREMENT TO PROVIDE EXTENDED CARE SERVICES.—(1) Chapter 17 is amended by inserting after section 1710 the following new section:

“§ 1710A. Extended care services

“(a) The Secretary (subject to section 1710(a)(4) of this title and subsection (c) of this section) shall operate and maintain a program to provide extended care services to eligible veterans in accordance with this section. Such services shall include the following:

“(1) Geriatric evaluation.

“(2) Nursing home care (A) in facilities operated by the Secretary, and (B) in community-based facilities through contracts under section 1720 of this title.

“(3) Domiciliary services under section 1710(b) of this title.

“(4) Adult day health care under section 1720(f) of this title.

“(5) Such other noninstitutional alternatives to nursing home care, including those described in section 1720C of this title, as the Secretary considers reasonable and appropriate.

“(6) Respite care under section 1720B of this title.

“(b)(1) In carrying out subsection (a), the Secretary shall provide extended care services which the Secretary determines are needed (A) to any veteran in need of such care for a service-connected disability, and (B) to any veteran who is in need of such care and who has a service-connected disability rated at 50 percent or more.

“(2) The Secretary, in making placements for nursing home care in Department facilities, shall give highest priority to veterans (A) who are in need of such care for a service-connected disability, or (B) who have a service-connected disability rated at 50 percent or more. The Secretary shall ensure that a veteran described in this subsection who continues to need nursing home care shall not after placement in a Department nursing home be transferred from the facility without the consent of the veteran, or, in the event the veteran cannot provide informed consent, the representative of the veteran.

“(c)(1) The Secretary, in carrying out subsection (a), shall prescribe regulations governing the priorities for the provision of nursing home care in Department facilities so as to ensure that priority for such care is given (A) for patient rehabilitation, (B) for clinically complex patient populations, and (C) for patients for whom there are not other suitable placement options.

“(2) The Secretary may not furnish extended care services for a non-service-connected disability other than in the case of a veteran who has a service-connected disability rated at 50 percent or more unless the veteran agrees to pay to the United States a copayment for extended care services of more than 21 days in any year.

“(d)(1) A veteran who is furnished extended care services under this chapter and who is required under subsection (c)(2) to pay an amount to the United States in order to be furnished such services shall be liable to the United States for that amount.

“(2) In implementing subsection (c)(2), the Secretary shall develop a methodology for establishing the amount of the copayment for which a veteran described in subsection (c) is liable. That methodology shall provide for—

“(A) establishing a maximum monthly copayment (based on all income and assets of the veteran and the spouse of such veteran);

“(B) protecting the spouse of a veteran from financial hardship by not counting all of the income and assets of the veteran and spouse (in the case of a spouse who resides in the community) as available for determining the copayment obligation; and

“(C) allowing the veteran to retain a monthly personal allowance.

“(e)(1) There is established in the Treasury of the United States a revolving fund known as the Department of Veterans Affairs Extended Care Fund (hereinafter in this section referred to as the “fund”). Amounts in the fund shall be available, without fiscal year limitation and without further appropriation, exclusively for the purpose of providing extended care services under subsection (a).

“(2) All amounts received by the Department under this section shall be deposited in or credited to the fund.”

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1710 the following new item:

“1710A. Requirement to provide extended care.”.

(b) REQUIREMENT TO INCREASE EXTENDED CARE SERVICES.—(1) Not later than January 1, 2000, the Secretary of Veterans Affairs shall develop and begin to implement a plan for carrying out the recommendation of the Federal Advisory Committee on the Future of Long-Term Care to increase, above the level of extended care services which were provided as of September 30, 1998—

(A) the options and services for home and community-based care for eligible veterans; and

(B) the percentage of the Department of Veterans Affairs medical care budget dedicated to such care.

(2) The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities operated by the Secretary during any fiscal year is not less than the level of such services provided nationally in facilities operated by the Secretary during fiscal year 1998.

(c) ADULT DAY HEALTH CARE.—Section 1720(f)(1)(A) is amended to read as follows:

“(f)(1)(A) The Secretary may furnish adult day health care services to a veteran enrolled under section 1705(a) of this title who would otherwise require nursing home care.”

(d) RESPITE CARE PROGRAM.—Section 1720B is amended—

(1) in subsection (a), by striking “eligible” and inserting “enrolled”;

(2) in subsection (b)—

(A) by striking “the term ‘respite care’ means hospital or nursing home care” and inserting “the term ‘respite care services’ means care and services”;

(B) by striking “is” at the beginning of each of paragraphs (1), (2), and (3) and inserting “are”; and

(C) by striking “in a Department facility” in paragraph (2); and

(3) by adding at the end the following new subsection:

“(c) In furnishing respite care services, the Secretary may enter into contract arrangements.”.

(e) CONFORMING AMENDMENTS.—Section 1710 is amended—

(1) in subsection (a)(1), by striking “may furnish nursing home care,”; and

(2) in subsection (a)(4), by inserting “, and the requirement in section 1710A of this title that the Secretary provide a program of extended care services,” after “medical services”.

(f) STATE HOMES.—Section 1741(a)(2) is amended by striking “adult day health care in a State home” and inserting “extended care services described in any of paragraphs (4) through (6) of section 1710A(a) of this title under a program administered by a State home”.

(g) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) Subsection (c)(2) of section 1710A(a) of title 38, United States Code (as added by subsection (a)), shall take effect on the effective date of regulations prescribed

by the Secretary of Veterans Affairs under subsections (c)(2) and (d) of such section. The Secretary shall publish the effective date of such regulations in the Federal Register.

(3) The provisions of section 1710(f) of title 38, United States Code, shall not apply to any day of nursing home care on or after the effective date of regulations under paragraph (2).

SEC. 102. REIMBURSEMENT FOR EMERGENCY TREATMENT.

(a) **AUTHORITY TO PROVIDE REIMBURSEMENT.**—Chapter 17 is amended by inserting after section 1724 the following new section:

“§ 1725. Reimbursement for emergency treatment

“(a) **GENERAL AUTHORITY.**—(1) Subject to subsections (c) and (d), the Secretary may reimburse a veteran described in subsection (b) for the reasonable value of emergency treatment furnished the veteran in a non-Department facility.

“(2) In any case in which reimbursement is authorized under subsection (a)(1), the Secretary, in the Secretary’s discretion, may, in lieu of reimbursing the veteran, make payment of the reasonable value of the furnished emergency treatment directly—

“(A) to a hospital or other health care provider that furnished the treatment;

or

“(B) to the person or organization that paid for such treatment on behalf of such veteran.

“(b) **ELIGIBILITY.**—(1) A veteran referred to in subsection (a)(1) is an individual who is an active Department health-care participant who is personally liable for emergency treatment furnished the veteran in a non-Department facility.

“(2) A veteran is an active Department health-care participant if the veteran—

“(A) is described in any of paragraphs (1) through (6) of section 1705(a) of this title;

“(B) is enrolled in the health care system established under such section; and

“(C) received care under this chapter within the 12-month period preceding the furnishing of such emergency treatment.

“(3) A veteran is personally liable for emergency treatment furnished the veteran in a non-Department facility if the veteran—

“(A) is financially liable to the provider of emergency treatment for that treatment;

“(B) has no entitlement to care or services under a health-plan contract;

“(C) has no other contractual or legal recourse against a third party that would, in whole or in part, extinguish such liability to the provider; and

“(D) is not eligible for reimbursement for medical care or services under section 1728 of this title.

“(c) **LIMITATIONS ON REIMBURSEMENT.**—(1) The Secretary, in accordance with regulations prescribed by the Secretary, shall—

“(A) establish the maximum amount payable under subsection (a);

“(B) delineate the circumstances under which such payments may be made, to include such requirements on requesting reimbursement as the Secretary shall establish; and

“(C) provide that in no event may a payment under that subsection include any amount for which the veteran is not personally liable.

“(2) Subject to paragraph (1), the Secretary may provide reimbursement under this section only after the veteran or the provider of emergency treatment has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such treatment.

“(3) Payment by the Secretary under this section, on behalf of a veteran described in subsection (b), to a provider of emergency treatment, shall, unless rejected and refunded by the provider within 30 days of receipt, extinguish any liability on the part of the veteran for that treatment. Neither the absence of a contract or agreement between the Secretary and the provider nor any provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate the requirement in the preceding sentence.

“(d) **INDEPENDENT RIGHT OF RECOVERY.**—(1) In accordance with regulations prescribed by the Secretary, the United States shall have the independent right to recover any amount paid under this section when, and to the extent that, a third party subsequently makes a payment for the same emergency treatment.

“(2) Any amount paid by the United States to the veteran (or the veteran’s personal representative, successor, dependents, or survivors) or to any other person or organization paying for such treatment shall constitute a lien in favor of the United

States against any recovery the payee subsequently receives from a third party for the same treatment.

“(3) Any amount paid by the United States to the provider that furnished the veteran’s emergency treatment shall constitute a lien against any subsequent amount the provider receives from a third party for the same emergency treatment for which the United States made payment.

“(4) The veteran (or the veteran’s personal representative, successor, dependents, or survivors) shall ensure that the Secretary is promptly notified of any payment received from any third party for emergency treatment furnished to the veteran. The veteran (or the veteran’s personal representative, successor, dependents, or survivors) shall immediately forward all documents relating to such payment, cooperate with the Secretary in the investigation of such payment, and assist the Secretary in enforcing the United States right to recover any payment made under subsection (c)(3).

“(e) WAIVER.—The Secretary, in the Secretary’s discretion, may waive recovery of a payment made to a veteran under this section that is otherwise required by subsection (d)(1) when the Secretary determines that such waiver would be in the best interest of the United States, as defined by regulations prescribed by the Secretary.

“(f) DEFINITIONS.—For purposes of this section:

“(1) The term ‘emergency treatment’ means medical care or services furnished, in the judgment of the Secretary—

“(A) when Department or other Federal facilities are not feasibly available and an attempt to use them beforehand would not be reasonable;

“(B) when such care or services are rendered in a medical emergency of such nature that delay would be hazardous to life or health; and

“(C) until such time as the veteran can be transferred safely to a Department facility or other Federal facility.

“(2) The term ‘health-plan contract’ includes any of the following:

“(A) An insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement under which health services for individuals are provided or the expenses of such services are paid.

“(B) An insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of such Act (42 U.S.C. 1395j).

“(C) A State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.).

“(D) A workers’ compensation law or plan described in section 1729(a)(2)(A) of this title.

“(E) A law of a State or political subdivision described in section 1729(a)(2)(B) of this title.

“(3) The term ‘third party’ means any of the following:

“(A) A Federal entity.

“(B) A State or political subdivision of a State.

“(C) An employer or an employer’s insurance carrier.

“(D) An automobile accident reparations insurance carrier.

“(E) A person or entity obligated to provide, or to pay the expenses of, health services under a health-plan contract.”.

(b) CONFORMING AMENDMENTS.—(1) Section 1729A(b) is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following new paragraph:

“(6) Section 1725 of this title.”.

(2) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1724 the following new item:

“1725. Reimbursement for emergency treatment.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 180 days after the date of the enactment of this Act.

(d) IMPLEMENTATION REPORTS.—The Secretary of Veterans Affairs shall include with the budget justification materials submitted to Congress in support of the Department of Veterans Affairs budget for fiscal year 2002 and for fiscal year 2003 a report on the implementation of section 1725 of title 38, United States Code, as added by subsection (a). Each such report shall include information on the experience of the Department under that section and the costs incurred, and expected to be incurred, under that section.

SEC. 103. ELIGIBILITY FOR CARE OF COMBAT-INJURED VETERANS.

(a) PRIORITY OF CARE.—Chapter 17 is amended —

(1) in section 1710(a)(2)(D), by inserting “or who was injured in combat” after “former prisoner of war”; and

(2) in section 1705(a)(3), by inserting “or who were injured in combat” after “former prisoners of war”.

(b) **DEFINITION OF INJURED IN COMBAT.**—Section 1701 is amended by adding at the end the following new paragraph:

“(10) The term ‘injured in combat’ means wounded in action as the result of an act of an enemy of the United States or otherwise wounded in action by weapon fire while directly engaged in armed conflict (other than as the result of willful misconduct by the wounded individual).”.

SEC. 104. ACCESS TO CARE FOR MILITARY RETIREES.

(a) **IMPROVED ACCESS.**—(1) Section 1710(a)(2) is amended—

(A) by striking “or” at the end of subparagraph (F);

(B) by striking the period at the end of subparagraph (G) and inserting “; or”; and

(C) by adding at the end the following new subparagraph:

“(H) who has retired from active military, naval, or air service in the Army, Navy, Air Force, or Marine Corps, is eligible for care under the TRICARE program established by the Secretary of Defense, and is not otherwise described in paragraph (1) or in this paragraph.”.

(2) Section 1705(a) is amended—

(A) by redesignating paragraph (7) as paragraph (8);

(B) by inserting after paragraph (6) the following new paragraph (7):

“(7) Veterans who are eligible for hospital care, medical services, and nursing home care under section 1710(a)(2)(H) of this title.”; and

(C) in paragraph (6), by inserting “(other than subparagraph (H) of such section)” before the period at the end.

(b) **INTERAGENCY AGREEMENT.**—(1) The Secretary of Defense shall enter into an agreement (characterized as a memorandum of understanding or otherwise) with the Secretary of Veterans Affairs with respect to the provision of medical care by the Secretary of Veterans Affairs to eligible military retirees in accordance with the amendments made by subsection (a). That agreement shall include provisions for reimbursement of the Secretary of Veterans Affairs by the Secretary of Defense for medical care provided by the Secretary of Veterans Affairs to an eligible military retiree and may include such other provisions with respect to the terms and conditions of such care as may be agreed upon by the two Secretaries.

(2) Reimbursement under that agreement shall be in accordance with rates agreed upon by the Secretary of Defense and the Secretary of Veterans Affairs. Such reimbursement may be made by the Secretary of Defense or by the appropriate TRICARE Managed Care Support contractor, as determined in accordance with that agreement.

(3) In entering into the agreement under paragraph (1), particularly with respect to determination of the rates of reimbursement under paragraph (2), the Secretary of Defense shall consult with TRICARE Managed Care Support contractors.

(4) The Secretary of Veterans Affairs may not enter into an agreement under paragraph (1) for the provision of care in accordance with the amendments made by subsection (a) with respect to any geographic service area, or a part of any such area, of the Veterans Health Administration unless—

(A) in the judgment of that Secretary, the Department of Veterans Affairs will recover the costs of providing such care to eligible military retirees; and

(B) that Secretary has certified and documented, with respect to any geographic service area in which the Secretary proposes to provide care in accordance with the amendments made by subsection (a), that such geographic service area, or designated part of any such area, has adequate capacity (consistent with the requirements in section 1705(b)(1) of title 38, United States Code, that care to enrollees shall be timely and acceptable in quality) to provide such care.

(5) The agreement under paragraph (1) shall be entered into by the Secretaries not later than nine months after the date of the enactment of this Act. If the Secretaries are unable to reach agreement, they shall jointly report, by that date or within 30 days thereafter, to the Committees on Armed Services and the Committees on Veterans' Affairs of the Senate and House of Representatives on the reasons for their inability to reach an agreement and their mutually agreed plan for removing any impediments to final agreement.

(c) **DEPOSITING OF REIMBURSEMENTS.**—Amounts received by the Secretary of Veterans Affairs under the agreement under subsection (b) shall be deposited in the Department of Veterans Affairs Health Services Improvement Fund established under section 1729B of title 38, United States Code, as added by section 202.

(d) PHASED IMPLEMENTATION.—(1) The Secretary of Defense shall include in each TRICARE contract entered into after the date of the enactment of this Act provisions to implement the agreement under subsection (b).

(2) The amendments made by subsection (a) and the provisions of the agreement under subsection (b)(2) shall apply to the furnishing of medical care by the Secretary of Veterans Affairs in any area of the United States only if that area is covered by a TRICARE contract that was entered into after the date of the enactment of this Act.

(e) ELIGIBLE MILITARY RETIREES.—For purposes of subsection (b), an eligible military retiree is a member of the Army, Navy, Air Force, or Marine Corps who—

- (1) has retired from active military, naval, or air service;
- (2) is eligible for care under the TRICARE program established by the Secretary of Defense;
- (3) has enrolled for care under section 1705 of title 38, United States Code; and
- (4) is not described in paragraph (1) or (2) of section 1710(a) of such title (other than subparagraph (H) of such paragraph (2)), as amended by subsection (a).

SEC. 105. BENEFITS FOR PERSONS DISABLED BY PARTICIPATION IN COMPENSATED WORK THERAPY PROGRAM.

Section 1151(a)(2) is amended—

- (1) by inserting “(A)” after “proximately caused”; and
- (2) by inserting before the period at the end the following: “, or (B) by participation in a program (known as a ‘compensated work therapy program’) under section 1718 of this title”.

SEC. 106. PILOT PROGRAM OF MEDICAL CARE FOR CERTAIN DEPENDENTS OF ENROLLED VETERANS.

(a) IN GENERAL.—(1) Chapter 17 is amended by inserting after section 1713 the following new section:

“§ 1713A. Medical care for certain dependents of enrolled veterans: pilot program

“(a) The Secretary may, during the program period, carry out a pilot program to provide primary health care services for eligible dependents of veterans in accordance with this section.

“(b) For purposes of this section:

“(1) The term ‘program period’ means the period beginning on the first day of the first month beginning more than 180 days after the date of the enactment of this section and ending three years after that day.

“(2) The term ‘eligible dependent’ means an individual who—

“(A) is the spouse or child of a veteran who is enrolled in the system of patient enrollment established by the Secretary under section 1705 of this title; and

“(B) is determined by the Secretary to have the ability to pay for such care or services either directly or through reimbursement or indemnification from a third party.

“(c) The Secretary may furnish health care services to an eligible dependent under this section only if the dependent (or, in the case of a minor, the parent or guardian of the dependent) agrees—

“(1) to pay to the United States an amount representing the reasonable charges for the care or services furnished (as determined by the Secretary); and

“(2) to cooperate with and provide the Secretary an appropriate assignment of benefits, authorization to release medical records, and any other executed documents, information, or evidence reasonably needed by the Secretary to recover the Department’s charges for the care or services furnished by the Secretary.

“(d)(1) The health care services provided under the pilot program under this section may consist of such primary hospital care services and such primary medical services as may be authorized by the Secretary. The Secretary may furnish those services directly through a Department medical facility or, subject to paragraphs (2) and (3), pursuant to a contract or other agreement with a non-Department facility (including a health-care provider, as defined in section 8152(2) of this title).

“(2) The Secretary may enter into a contract or agreement to furnish primary health care services under this section in a non-Department facility on the same basis as provided under subsections (a) and (b) of section 1703 of this title or may include such care in an existing or new agreement under section 8153 of this title

when the Secretary determines it to be in the best interest of the prevailing standards of the Department medical care program.

“(3) Primary health care services may not be authorized to be furnished under this section at any medical facility if the furnishing of those services would result in the denial of, or a delay in providing, access to care for any enrolled veteran at that facility.

“(e)(1) In the case of an eligible dependent who is furnished primary health care services under this section and who has coverage under a health-plan contract, as defined in section 1729(i)(1) of this title, the United States shall have the right to recover or collect the reasonable charges for such care or services from such health-plan contract to the extent that the individual or the provider of the care or services would be eligible to receive payment for such care or services from such health-plan contract if the care or services had not been furnished by a department or agency of the United States.

“(2) The right of the United States to recover under paragraph (1) shall be enforceable with respect to an eligible dependent in the same manner as applies under subsections (a)(3), (b), (c)(1), (c)(2), (d), (f), (h), and (i) of section 1729 of this title with respect to a veteran.

“(f)(1) Subject to paragraphs (2) and (3), the pilot program under this section shall be carried out during the program period in not more than four veterans integrated service networks, as designated by the Secretary. In designating networks under the preceding sentence, the Secretary shall favor designation of networks that are suited to serve dependents of veterans because of—

“(A) the capability of one or more medical facilities within the network to furnish primary health care services to eligible dependents while assuring that veterans continue to receive priority for care and services;

“(B) the demonstrated success of such medical facilities in billings and collections;

“(C) support for initiating such a pilot program among veterans in the network; and

“(D) such other criteria as the Secretary considers appropriate.

“(2) In implementing the pilot program, the Secretary may not provide health care services for dependents who are children—

“(A) in more than one of the participating networks during the first year of the program period; and

“(B) in more than two of the participating networks during the second year of the program period.

“(3) In implementing the pilot program, the Secretary shall give priority to facilities which operate women veterans’ clinics.”.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1713 the following new item:

“1713A. Medical care for certain dependents and enrolled veterans: pilot program.”.

(b) GAO REVIEW AND RECOMMENDATIONS.—(1) Beginning six months after the commencement of the pilot program, the Comptroller General, in consultation with the Under Secretary for Health of the Department of Veterans Affairs, shall monitor the conduct of the pilot program.

(2) Not later than 14 months after the commencement of the pilot program, the Comptroller General shall submit to the Secretary of Veterans Affairs a report setting forth the Comptroller General’s findings and recommendations with respect to the first 12 months of operation of the pilot program.

(3)(A) The report under paragraph (2) shall include the findings of the Comptroller General regarding—

(i) whether the collection of reasonable charges for the care or services provided reasonably covers the costs of providing such care and services; and

(ii) whether the Secretary, in carrying out the program, is in compliance with the limitation in subsection (d)(3) of section 1713A of title 38, United States Code, as added by subsection (a).

(B) The report shall include the recommendations of the Comptroller General regarding any remedial steps that the Secretary should take in the conduct of the program or in the billing and collection of charges under the program.

(4) The Secretary, in consultation with, and following receipt of the report of, the Comptroller General, shall take such steps as may be needed to ensure that any recommendations of the Comptroller General in the report under paragraph (2) with respect to billings and collections, and with respect to compliance with the limitation in subsection (d)(3) of such section, are carried out.

(5) For purposes of this subsection, the term “commencement of the pilot program” means the date on which the Secretary of Veterans Affairs begins to furnish services

to eligible dependents under the pilot program under section 1713A of title 38, United States Code, as added by subsection (a).

SEC. 107. ENHANCED SERVICES PROGRAM AT DESIGNATED MEDICAL CENTERS.

(a) **FINDINGS.**—Congress makes the following findings:

(1) Historically, health care facilities under the jurisdiction of the Department of Veterans Affairs have not consistently been located in proximity to veteran population concentrations.

(2) Hospital occupancy rates at numbers of Department medical centers are at levels substantially below a level needed for efficient operation and optimal quality of care.

(3) The costs of maintaining highly inefficient medical centers, which were designed and constructed decades ago to standards no longer considered acceptable, substantially diminish the availability of resources which could be devoted to the provision of needed direct care services.

(4) Freeing resources currently devoted to highly inefficient provision of hospital care could, through contracting for acute hospital care and establishing new facilities for provision of outpatient care, yield improved access and service to veterans.

(b) **ENHANCED SERVICES PROGRAM AT DESIGNATED MEDICAL CENTERS.**—The Secretary of Veterans Affairs, in carrying out the responsibilities of the Secretary to furnish hospital care and medical services through network-based planning, shall establish an enhanced service program at Department medical centers (hereinafter in this section referred to as “designated centers”) that are designated by the Secretary for the purposes of this section. Medical centers shall be designated to improve access, and quality of service provided, to veterans served by those medical centers. The Secretary may designate a medical center for the program only if the Secretary determines, on the basis of a market and data analysis (which shall include a study of the cost-effectiveness of the care provided at such center), that the medical center—

(1) can, in whole or in part, no longer be operated in a manner that provides hospital or other care efficiently and at optimal quality because of such factors as—

(A) the current and projected need for hospital or other care capacity at such center;

(B) the extent to which the facility is functionally obsolete; and

(C) the cost of operation and maintenance of the physical plant; and

(2) is located in proximity (A) to one or more community hospitals which have the capacity to provide primary and secondary hospital care of appropriate quality to veterans under contract arrangements with the Secretary which the Secretary determines are advantageous to the Department, or (B) to another Department medical center which is capable of absorbing some or all of the patient workload of such medical center.

(c) **MEDICAL CENTER PLAN.**—The Secretary shall, with respect to each designated center, develop a plan aimed at improving the accessibility and quality of service provided to veterans. Each plan shall be developed in accordance with the requirements for strategic network-based planning described in section 8107 of title 38, United States Code. In the plan for a designated center, the Secretary shall describe a program which, if implemented, would allow the Secretary to do any of the following:

(1) Provide for a Department facility described in subsection (b)(2)(B) to absorb some or all of the patient workload of the designated center.

(2) Contract, under such arrangements as the Secretary determines appropriate, for needed primary and secondary hospital care for veterans—

(A) who reside in the catchment area of each designated center;

(B) who are described in paragraphs (1) through (6) of section 1705(a) of title 38, United States Code; and

(C) whom the Secretary has enrolled for care pursuant to section 1705 of title 38, United States Code.

(3) Cease to provide hospital care, or hospital care and other medical services, at such center.

(4) If practicable, lease, under subchapter V of chapter 81 of title 38, United States Code, land and improvements which had been dedicated to providing care described in paragraph (3).

(5) Establish, through reallocation of operational funds and through appropriate lease arrangements or renovations, facilities for—

(A) delivery of outpatient care; and

(B) services which would obviate a need for nursing home care or other long-term institutional care.

(d) **EMPLOYEE PROTECTIONS.**—(1) In entering into any contract or lease under subsection (c), the Secretary shall attempt to ensure that employees of the Secretary who would be displaced under this section be given priority in hiring by such contractor, lessee, or other entity.

(2) In carrying out subsection (c)(5), the Secretary shall give preference to providing services through employee-based delivery models.

(e) **REQUIRED CONSULTATION.**—In developing a plan under subsection (c), the Secretary shall obtain the views of veterans organizations, exclusive employee representatives, and other interested parties and provide for such organizations and parties to participate in the development of the plan.

(f) **SUBMISSION OF PLAN TO CONGRESS.**—The Secretary may not implement a plan described in subsection (c) with respect to a medical center unless the Secretary has first submitted a report containing a detailed plan and justification to the appropriate committees of Congress. No action to carry out such plan may be taken after the submission of such report until the end of a 45-day period following the date of the submission of the report, not less than 30 days of which shall be days during which Congress shall have been in continuous session. For purposes of the preceding sentence, continuity of a session of Congress is broken only by adjournment sine die, and there shall be excluded from the computation of any period of continuity of session any day during which either House of Congress is not in session during an adjournment of more than three days to a day certain.

(g) **IMPLEMENTATION OF PLAN.**—In carrying out the plan described in subsection (c), or a modification to that plan following the submission of such plan to the appropriate committees of Congress, the Secretary—

(1) may, without regard to any limitation under section 1703 of title 38, United States Code, contract for hospital care for veterans who are—

(A) described in paragraphs (1) through (6) of section 1705(a) of title 38, United States Code; and

(B) enrolled under subsection (a) of such section 1705;

(2) may enter into any contract under section 8153 of title 38, United States Code;

(3) shall, in exercising the authority of the Secretary under this section to contract for hospital care, provide for ongoing oversight and management, by employees of the Department, of the hospital care furnished such veterans; and

(4) shall, in the case of a designated center which ceases to provide services under the program—

(A) ensure a reallocation of funds as provided in subsection (h); and

(B) provide reemployment assistance to employees.

(h) **FUNDS ALLOCATION.**—In carrying out subsection (g)(4), the Secretary shall ensure that not less than 90 percent of the funds that would have been made available to a designated center to support the provision of services, but for such mission change, shall be made available to the appropriate health care region of the Veterans Health Administration to ensure that the implementation of the plan under subsection (g) will result in demonstrable improvement in the accessibility, and quality of service provided, to veterans in the catchment area of such center.

(i) **SPECIALIZED SERVICES.**—The provisions of this section do not diminish the obligations of the Secretary under section 1706(b) of title 38, United States Code.

(j) **REPORT.**—Not later than 12 months after implementation of any plan under subsection (b), the Secretary shall submit to Congress a report on the implementation of the enhanced service program.

(k) **RESIDUAL AUTHORITY.**—Nothing in this section may be construed to diminish the authority of the Secretary to—

(1) consolidate, eliminate, abolish, or redistribute the functions or missions of facilities in the Department;

(2) revise the functions or missions of any such facility or activity; or

(3) create new facilities or activities in the Department.

SEC. 108. COUNSELING AND TREATMENT FOR VETERANS WHO HAVE EXPERIENCED SEXUAL TRAUMA.

(a) **EXTENSION OF PERIOD OF PROGRAM.**—Subsection (a) of section 1720D is amended—

(1) in paragraph (1), by striking “December 31, 2001” and inserting “December 31, 2002”; and

(2) in paragraph (3), by striking “December 31, 2001” and inserting “December 31, 2002”.

(b) MANDATORY NATURE OF PROGRAM.—(1) Subsection (a)(1) of such section is further amended by striking “may provide counseling to a veteran who the Secretary determines requires such counseling” and inserting “shall operate a program under which the Secretary provides counseling and appropriate care and services to veterans who the Secretary determines require such counseling and care and services”.

(2) Subsection (a) of such section is further amended—

(A) by striking paragraph (2); and

(B) by redesignating paragraph (3) (as amended by subsection (a)(2)) as paragraph (2).

(c) OUTREACH EFFORTS.—Subsection (c) of such section is amended—

(1) by inserting “and treatment” in the first sentence and in paragraph (2) after “counseling”;

(2) by striking “and” at the end of paragraph (1);

(3) by redesignating paragraph (2) as paragraph (3); and

(4) by inserting after paragraph (1) the following new paragraph (2):

“(2) shall ensure that information about the counseling and treatment available to veterans under this section—

“(A) is revised and updated as appropriate;

“(B) is made available and visibly posted at appropriate facilities of the Department; and

“(C) is made available through appropriate public information services; and”.

(d) REPORT ON IMPLEMENTATION OF OUTREACH ACTIVITIES.—Not later than six months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committees on Veterans’ Affairs of the Senate and House of Representatives a report on the Secretary’s implementation of paragraph (2) of section 1720D(c) of title 38, United States Code, as added by subsection (c). Such report shall include examples of the documents and other means of communication developed for compliance with that paragraph.

(e) STUDY OF EXPANDING ELIGIBILITY FOR COUNSELING AND TREATMENT.—(1) The Secretary of Veterans Affairs, in consultation with the Secretary of Defense, shall conduct a study to determine—

(A) the extent to which former members of the reserve components of the Armed Forces experienced physical assault of a sexual nature or battery of a sexual nature while serving on active duty for training;

(B) the extent to which such former members have sought counseling from the Department of Veterans Affairs relating to those incidents; and

(C) the additional resources that, in the judgment of the Secretary, would be required to meet the projected need of those former members for such counseling.

(2) Not later than 16 months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committees on Veterans’ Affairs of the Senate and House of Representatives a report on the results of the study conducted under paragraph (1).

(f) OVERSIGHT OF OUTREACH ACTIVITIES.—Not later than 14 months after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall submit to the appropriate congressional committees a joint report describing in detail the collaborative efforts of the Department of Veterans Affairs and the Department of Defense to ensure that members of the Armed Forces, upon separation from active military, naval, or air service, are provided appropriate and current information about programs of the Department of Veterans Affairs to provide counseling and treatment for sexual trauma that may have been experienced by those members while in the active military, naval, or air service, including information about eligibility requirements for, and procedures for applying for, such counseling and treatment. The report shall include proposed recommendations from both the Secretary of Veterans Affairs and the Secretary of Defense for the improvement of their collaborative efforts to provide such information.

(g) REPORT ON IMPLEMENTATION OF SEXUAL TRAUMA TREATMENT PROGRAM.—Not later than 14 months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committees on Veterans’ Affairs of the Senate and House of Representatives a report on the use made of the authority provided under section 1720D of title 38, United States Code, as amended by this section. The report shall include the following with respect to activities under that section since the enactment of this Act:

(1) The number of veterans who have received counseling under that section.

(2) The number of veterans who have been referred to non-Department mental health facilities and providers in connection with sexual trauma counseling and treatment.

TITLE II—PROGRAM ADMINISTRATION

SEC. 201. MEDICAL CARE COLLECTIONS.

- (a) LIMITED AUTHORITY TO SET COPAYMENTS.—(1) Section 1722A is amended—
- (A) by redesignating subsections (b) and (c) as subsections (c) and (d), respectively;
- (B) by inserting after subsection (a) the following new subsection (b):
- “(b) The Secretary, pursuant to regulations which the Secretary shall prescribe, may—
- “(1) increase the copayment amount in effect under subsection (a);
- “(2) establish a maximum annual pharmaceutical copayment amount under subsection (a) for veterans who have multiple outpatient prescriptions; and
- “(3) require a veteran, other than a veteran described in subsection (a)(3), to pay to the United States a reasonable copayment for sensori-neural aids, electronic equipment, and any other costly item or equipment furnished the veteran for a nonservice-connected condition, other than a wheelchair or artificial limb.”;
- and
- (C) in subsection (c), as redesignated by subparagraph (A)—
- (i) by striking “this section” and inserting “subsection (a)”; and
- (ii) by adding at the end the following new sentence: “Amounts collected through use of the authority under subsection (b) shall be deposited in Department of Veterans Affairs Health Services Improvement Fund.”.
- (2)(A) The heading of such section is amended to read as follows:

“§ 1722A. Copayments for medications and certain costly items and equipment”.

(B) The item relating to such section in the table of sections at the beginning of chapter 17 is amended to read as follows:

“1722A. Copayments for medications and certain costly items and equipment.”.

(b) OUTPATIENT TREATMENT OF CATEGORY C VETERANS.—(1) Section 1710(g) is amended—

(A) in paragraph (1), by striking “the amount under paragraph (2) of this subsection” and inserting “in the case of each outpatient visit the applicable amount or amounts established by the Secretary by regulation”; and

(B) in paragraph (2), by striking all after “for an amount” and inserting “which the Secretary shall establish by regulation.”.

SEC. 202. HEALTH SERVICES IMPROVEMENT FUND.

(a) ESTABLISHMENT OF FUND.—Chapter 17 is amended by inserting after section 1729A the following new section:

“§ 1729B. Health Services Improvement Fund

“(a) There is established in the Treasury of the United States a fund to be known as the ‘Department of Veterans Affairs Health Services Improvement Fund’.

“(b) Amounts received or collected after the date of the enactment of this section under any of the following provisions of law shall be deposited in the fund:

“(1) Section 1713A of this title.

“(2) Section 1722A(b) of this title.

“(3) Section 8165(a) of this title.

“(4) Section 104(c) of the Veterans’ Millennium Health Care Act.

“(c) Amounts in the fund are hereby available, without fiscal year limitation, to the Secretary for the purposes stated in subparagraphs (A) and (B) of section 1729A(c)(1) of this title.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1729A the following new item:

“1729B. Health Services Improvement Fund.”.

SEC. 203. VETERANS TOBACCO TRUST FUND.

(a) FINDINGS.—Congress finds the following:

(1) Smoking related illnesses, including cancer, heart disease, and emphysema, are highly prevalent among the more than 3,000,000 veterans who use the Department of Veterans Affairs health care system annually.

(2) The Department of Veterans Affairs estimates that it spent \$3,600,000,000 in 1997 to treat smoking-related illnesses and that over the next five years it will spend \$20,000,000,000 on such care.

(3) Congress established the Department of Veterans Affairs in furtherance of its constitutional power to provide for the national defense in order to provide benefits and services to veterans of the uniformed services.

(4) There is in the Department of Veterans Affairs a health care system which has as its primary function to provide a complete medical and hospital service for the medical care and treatment of such veterans as can be served through available appropriations.

(5) The Federal Government, including the Department of Veterans Affairs, has lacked the means to prevent the onset of smoking-related illnesses among veterans and has had no authority to deny needed treatment to any veteran on the basis that an illness is or might be smoking-related.

(6) With some 20 percent of its health care budget absorbed in treating smoking-related illnesses, the Department of Veterans Affairs health care system has lacked resources to provide needed nursing home care, home care, community-based ambulatory care, and other services to tens of thousands of other veterans.

(7) The network of academically affiliated medical centers of the Department of Veterans Affairs provides a unique system within which outstanding medical research is conducted and which has the potential to expand significantly ongoing research on tobacco-related illnesses.

(8) It is in the public interest for Congress to enact legislation requiring that a portion of any amounts received from manufacturers of tobacco products be used to meet the costs of (A) treatment for diseases and adverse health effects associated with the use of tobacco products by those who served their country in uniform, and (B) medical and health services research relating to prevention and treatment of, and rehabilitation from, tobacco addiction and diseases associated with tobacco use.

(b) ESTABLISHMENT OF TRUST FUND.—(1) Chapter 17 is amended by inserting after section 1729B, as added by section 202(a), the following new section:

“§ 1729C. Veterans Tobacco Trust Fund

“(a) There is established in the Treasury of the United States a trust fund to be known as the ‘Veterans Tobacco Trust Fund’, consisting of such amounts as may be appropriated, credited, or donated to the trust fund.

“(b) If a lawsuit is brought by the United States against the tobacco manufacturers seeking recovery of costs incurred or to be incurred by the United States that are attributable to tobacco-related illnesses, there shall be credited to the trust fund from any amount recovered by the United States pursuant to that lawsuit, without further appropriation, the amount that bears the same ratio to the amount recovered as the amount of the Department’s costs for health care attributable to tobacco-related illnesses for which recovery is sought in the suit bears to the total amount sought by the United States in the suit.

“(c) After September 30, 2004, amounts in the trust fund shall be available, without fiscal year limitation, to the Secretary of Veterans Affairs for the following purposes:

“(1) Furnishing medical care and services under this chapter, to be available during any fiscal year for the same purposes and subject to the same limitations (other than with respect to the period of availability for obligation) as apply to amounts appropriated from the general fund of the Treasury for that fiscal year for medical care.

“(2) Conducting medical research, rehabilitation research, and health systems research, with particular emphasis on research relating to prevention and treatment of, and rehabilitation from, tobacco addiction and diseases associated with tobacco use.”.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1729B, as added by section 202(b), the following new item:

“1729C. Veterans Tobacco Trust Fund.”.

SEC. 204. AUTHORITY TO ACCEPT FUNDS FOR EDUCATION AND TRAINING.

(a) ESTABLISHMENT OF NONPROFIT CORPORATIONS AT MEDICAL CENTERS.—Section 7361(a) is amended—

(1) by inserting “and education” after “research”;

(2) by adding at the end the following: “Such a corporation may be established to facilitate either research or education or both research and education.”.

(b) PURPOSE OF CORPORATIONS.—Section 7362 is amended—

(1) in the first sentence, by inserting “and education and training as described in sections 7302, 7471, 8154, and 1701(6)(B) of this title” after “of this title”; and

(2) in the second sentence—

(A) by inserting “or education” after “research”; and

(B) by striking “that purpose” and inserting “these purposes”.

(c) BOARD OF DIRECTORS.—Section 7363(a) is amended—

(1) in subsection (a)(1), by striking all after “medical center, and” and inserting “as appropriate, the assistant chief of staff for research for the medical center and the associate chief of staff for education for the medical center, or, in the case of a facility at which such positions do not exist, those officials who are responsible for carrying out the responsibilities of the medical center director, chief of staff, and, as appropriate, the assistant chief of staff for research and the assistant chief for education; and”;

(2) in subsection (a)(2), by inserting “or education, as appropriate” after “research”; and

(3) in subsection (c), by inserting “or education” after “research”.

(d) APPROVAL OF EXPENDITURES.—Section 7364 is amended by adding at the end the following new subsection:

“(c)(1) A corporation established under this subchapter may not spend funds for an education activity unless the activity is approved in accordance with procedures prescribed by the Under Secretary for Health.

“(2) The Under Secretary for Health shall prescribe policies and procedures to guide the expenditure of funds by corporations under paragraph (1) consistent with the purpose of such corporations as flexible funding mechanisms.”.

SEC. 205. EXTENSION AND REVISION OF CERTAIN AUTHORITIES.

(a) READJUSTMENT COUNSELING PROGRAM.—Section 1712A(a)(1)(B)(ii) is amended by striking “2000” and inserting “2003”.

(b) COMMITTEE ON MENTALLY ILL VETERANS.—Section 7321(d)(2) is amended by striking “three” and inserting “five”.

(c) COMMITTEE ON POST-TRAUMATIC STRESS DISORDER.—Section 110 of Public Law 98–528 (38 U.S.C. 1712A note) is amended—

(1) in subsection (e)(1), by striking “March 1, 1985” and inserting “March 1, 2000”; and

(2) in subsection (e)(2), by striking “February 1, 1986” and inserting “February 1, 2001”.

(d) EXTENSION OF AUTHORITY TO MAKE GRANTS.—Section 3(a)(2) of the Homeless Veterans Comprehensive Service Programs Act of 1992 (38 U.S.C. 7721 note) is amended by striking “September 30, 1999” and inserting “September 30, 2002”.

(e) AUTHORITY TO MAKE GRANTS FOR HOMELESS VETERANS.—Section 3(b)(2) of the Homeless Veterans Comprehensive Service Programs Act of 1992 (38 U.S.C. 7721 note) is amended by striking “and no more than 20 programs which incorporate the procurement of vans as described in paragraph (1)”.

SEC. 206. STATE HOME GRANT PROGRAM.

(a) GENERAL REGULATIONS.—Section 8134 is amended—

(1) by redesignating subsection (b) as subsection (c);

(2) by striking the matter in subsection (a) preceding paragraph (2) and inserting the following:

“(a)(1) The Secretary shall prescribe regulations for the purposes of this subchapter.

“(2) In those regulations, the Secretary shall prescribe for each State the number of nursing home and domiciliary beds for which assistance under this subchapter may be furnished. Such regulations shall be based on projected demand for such care 10 years after the date of the enactment of the Veterans Millennium Health Care Act by veterans who at such time are 65 years of age or older and who reside in that State. In determining such projected demand, the Secretary shall take into account travel distances for veterans and their families.

“(3)(A) In those regulations, the Secretary shall establish criteria under which the Secretary shall determine, with respect to an application for assistance under this subchapter for a project described in subparagraph (B) which is from a State that has a need for additional beds as determined under subsections (a)(2) and (d)(1), whether the need for such beds is most aptly characterized as great, significant, or limited. Such criteria shall take into account the availability of beds already operated by the Secretary and other providers which appropriately serve the needs which the State proposes to meet with its application.

“(B) This paragraph applies to a project for the construction or acquisition of a new State home facility, to a project to increase the number of beds available at a State home facility, and a project to replace beds at a State home facility.

“(4) The Secretary shall review and, as necessary, revise regulations prescribed under paragraphs (2) and (3) not less often than every four years.

“(b) The Secretary shall prescribe the following by regulation:”;

(3) by redesignating paragraphs (2) and (3) of subsection (b), as designated by paragraph (2), as paragraphs (1) and (2);

(4) in subsection (c), as redesignated by paragraph (1), by striking “subsection (a)(3)” and inserting “subsection (b)(2)”; and

(5) by adding at the end the following new subsection:

“(d)(1) In prescribing regulations to carry out this subchapter, the Secretary shall provide that in the case of a State that seeks assistance under this subchapter for a project described in subsection (a)(3)(B), the determination of the unmet need for beds for State homes in that State shall be reduced by the number of beds in all previous applications submitted by that State under this subchapter, including beds which have not been recognized by the Secretary under section 1741 of this title.

“(2)(A) Financial assistance under this subchapter for a renovation project may only be provided for a project for which the total cost of construction is in excess of \$400,000 (as adjusted from time to time in such regulations to reflect changes in costs of construction).

“(B) For purposes of this paragraph, a renovation project is a project to remodel or alter existing buildings for which financial assistance under this subchapter may be provided and does not include maintenance and repair work which is the responsibility of the State.”.

(b) APPLICATIONS WITH RESPECT TO PROJECTS.—Section 8135 is amended—

(1) in subsection (a)—

(A) by striking “set forth—” in the matter preceding paragraph (1) and inserting “set forth the following:”;

(B) by capitalizing the first letter of the first word in each of paragraphs (1) through (9);

(C) by striking the comma at the end of each of paragraphs (1) through (7) and inserting a period; and

(D) by striking “, and” at the end of paragraph (8) and inserting a period;

(2) by redesignating subsections (b), (c), (d), and (e) as subsections (c), (d), (e), and (f), respectively;

(3) by inserting after subsection (a) the following new subsection (b):

“(b)(1) Any State seeking to receive assistance under this subchapter for a project that would involve construction or acquisition of either nursing home or domiciliary facilities shall include with its application under subsection (a) the following:

“(A) Documentation (i) that the site for the project is in reasonable proximity to a sufficient concentration and population of veterans who are 65 years of age and older, and (ii) that there is a reasonable basis to conclude that the facilities when complete will be fully occupied.

“(B) A financial plan for the first three years of operation of such facilities.

“(C) A five-year capital plan for the State home program for that State.

“(2) Failure to provide adequate documentation under paragraph (1)(A) or to provide an adequate financial plan under paragraph (1)(B) shall be a basis for disapproving the application.”;

(4) in subsection (c), as redesignated by paragraph (2)—

(A) in paragraph (1), by striking “for a grant under subsection (a) of this section” in the matter preceding subparagraph (A) and inserting “under subsection (a) for financial assistance under this subchapter”;

(B) in paragraph (2)—

(i) by striking “the construction or acquisition of” in subparagraph (A); and

(ii) by striking subparagraphs (B), (C), and (D) and inserting the following:

“(B) An application from a State for a project at an existing facility to remedy a condition or conditions that have been cited by an accrediting institution, by the Secretary, or by a local licensing or approving body of the State as being threatening to the lives or safety of the patients in the facility.

“(C) An application from a State that has not previously applied for award of a grant under this subchapter for construction or acquisition of a State nursing home.

“(D) An application for construction or acquisition of a nursing home or domiciliary from a State that the Secretary determines, in accordance with regula-

tions under this subchapter, has a great need for the beds to be established at such home or facility.

“(E) An application from a State for renovations to a State home facility other than renovations described in subparagraph (B).

“(F) An application for construction or acquisition of a nursing home or domiciliary from a State that the Secretary determines, in accordance with regulations under this subchapter, has a significant need for the beds to be established at such home or facility.

“(G) An application that meets other criteria as the Secretary determines appropriate and has established in regulations.

“(H) An application for construction or acquisition of a nursing home or domiciliary from a State that the Secretary determines, in accordance with regulations under this subchapter, has a limited need for the beds to be established at such home or facility.”; and

(C) in paragraph (3), by striking subparagraph (A) and inserting the following:

“(A) may not accord any priority to a project for the construction or acquisition of a hospital; and”.

(c) **TRANSITION.**—The provisions of sections 8134 and 8135 of title 38, United States Code, as in effect on June 1, 1999, shall continue in effect after such date with respect to applications described in section 8135(b)(2)(A) of such title, as in effect on that date, that are identified on the list that (1) is described in section 8135(b)(4) of such title, as in effect on that date, and (2) was established by the Secretary of Veterans Affairs on October 29, 1998.

(d) **EFFECTIVE DATE FOR INITIAL REGULATIONS.**—The Secretary of Veterans Affairs shall prescribe the initial regulations under subsection (a) of section 8134 of title 38, United States Code, as added by subsection (a), not later than April 30, 2000.

SEC. 207. EXPANSION OF ENHANCED-USE LEASE AUTHORITY.

(a) **AUTHORITY.**—Section 8162(a)(2) is amended—

(1) by striking “only if the Secretary” and inserting “only if—

“(A) the Secretary”;

(2) by redesignating subparagraphs (A), (B), and (C) as clauses (i), (ii), and (iii), respectively, and realigning those clauses so as to be four ems from the left margin;

(3) by striking the period at the end of clause (iii), as so redesignated, and inserting “; or”; and

(4) by adding at the end the following:

“(B) the Secretary determines that the implementation of a business plan proposed by the Under Secretary for Health for applying the consideration under such a lease to the provision of medical care and services would result in a demonstrable improvement of services to eligible veterans in the geographic service-delivery area within which the property is located.”.

(b) **TERM OF ENHANCED-USE LEASE.**—Section 8162(b) is amended—

(1) in paragraph (2), by striking “may not exceed—” and all that follows and inserting “may not exceed 75 years.”; and

(2) by striking paragraph (4) and inserting the following:

“(4) The terms of an enhanced-use lease may provide for the Secretary to—

“(A) obtain facilities, space, or services on the leased property; and

“(B) use minor construction funds for capital contribution payments.”.

(c) **DESIGNATION OF PROPERTY PROPOSED TO BE LEASED.**—(1) Subsection (b) of section 8163 is amended—

(A) by striking “include—” and inserting “include the following.”;

(B) by capitalizing the first letter of the first word of each of paragraphs (1), (2), (3), (4), and (5);

(C) by striking the semicolon at the end of paragraphs (1), (2), and (3) and inserting a period; and

(D) by striking subparagraphs (A), (B), and (C) of paragraph (4) and inserting the following:

“(A) would—

“(i) contribute in a cost-effective manner to the mission of the Department;

“(ii) not be inconsistent with the mission of the Department;

“(iii) not adversely affect the mission of the Department; and

“(iv) affect services to veterans; or

“(B) would result in a demonstrable improvement of services to eligible veterans in the geographic service-delivery area within which the property is located.”.

(2) Subparagraph (E) of subsection (c)(1) of that section is amended by striking clauses (i), (ii), and (iii) and inserting the following:

“(i) would—

“(I) contribute in a cost-effective manner to the mission of the Department;

“(II) not be inconsistent with the mission of the Department;

“(III) not adversely affect the mission of the Department; and

“(IV) affect services to veterans; or

“(ii) would result in a demonstrable improvement of services to eligible veterans in the geographic service-delivery area within which the property is located.”.

(d) USE OF PROCEEDS.—Section 8165(a) is amended—

(1) by striking paragraph (1) and inserting the following:

“(a)(1) Funds received by the Department under an enhanced-use lease and remaining after any deduction from those funds under subsection (b) shall be deposited in the Department of Veterans Affairs Health Services Improvement Fund established under section 1729B of this title. The Secretary shall make available to the designated health care region of the Veterans Health Administration within which the leased property is located not less than 75 percent of the amount deposited in the fund attributable to that lease.”; and

(2) by adding at the end the following new paragraph:

“(3) For the purposes of paragraph (1), the term ‘designated health care region of the Veterans Health Administration’ means a geographic area designated by the Secretary for the purposes of the management of, and allocation of resources for, health care services provided by the Veterans Health Administration.”.

(e) REPEAL OF TERMINATION PROVISION.—(1) Section 8169 is repealed.

(2) The table of sections at the beginning of chapter 81 is amended by striking the item relating to section 8169.

(f) REPEAL OF OBSOLETE PROVISIONS.—Section 8162 is amended—

(1) by striking the last sentence of subsection (a)(1); and

(2) by striking subsection (c).

SEC. 208. INELIGIBILITY FOR EMPLOYMENT BY VETERANS HEALTH ADMINISTRATION OF HEALTH CARE PROFESSIONALS WHO HAVE LOST LICENSE TO PRACTICE IN ONE JURISDICTION WHILE STILL LICENSED IN ANOTHER JURISDICTION.

Section 7402 is amended by adding at the end the following new subsection:

“(f) A person may not be employed in a position under subsection (b) (other than under paragraph (4) of that subsection) if—

“(1) the person is or has been licensed, registered, or certified (as applicable to such position) in more than one State; and

“(2) either—

“(A) any of those States has terminated such license, registration, or certification for cause; or

“(B) the person has voluntarily relinquished such license, registration, or certification in any of those States after being notified in writing by that State of potential termination for cause.”.

TITLE III—MISCELLANEOUS

SEC. 301. REVIEW OF PROPOSED CHANGES TO OPERATION OF MEDICAL FACILITIES.

Section 8110 of title 38, United States Code, is amended by adding at the end the following new subsections:

“(d) The Secretary may not in any fiscal year close more than 50 percent of the beds within a bed section (of 20 or more beds) of a Department medical center unless the Secretary first submits to the Committees on Veterans’ Affairs of the Senate and the House of Representatives a report providing a justification for the closure. No action to carry out such closure may be taken after the submission of such report until the end of the 21-day period beginning on the date of the submission of the report.

“(e) The Secretary shall submit to the Committees on Veterans’ Affairs of the Senate and the House of Representatives, not later than January 20 of each year, a report documenting by network for the preceding fiscal year the following:

“(1) The number of medical service and surgical service beds, respectively, that were closed during that fiscal year and, for each such closure, a description of the changes in delivery of services that allowed such closure to occur.

“(2) The number of nursing home beds that were the subject of a mission change during that fiscal year and the nature of each such mission change.

“(f) For purposes of this section:

“(1) The term ‘closure’, with respect to beds in a medical center, means ceasing to provide staffing for, and to operate, those beds. Such term includes converting the provision of such bed care from care in a Department facility to care under contract arrangements.

“(2) The term ‘bed section’, with respect to a medical center, means psychiatric beds (including beds for treatment of substance abuse and post-traumatic stress disorder), intermediate, neurology, and rehabilitation medicine beds, extended care (other than nursing home) beds, and domiciliary beds.

“(3) The term ‘justification’, with respect to closure of beds, means a written report that includes the following:

“(A) An explanation of the reasons for the determination that the closure is appropriate and advisable.

“(B) A description of the changes in the functions to be carried out and the means by which such care and services would continue to be provided to eligible veterans.

“(C) A description of the anticipated effects of the closure on veterans and on their access to care.”.

SEC. 302. PATIENT SERVICES AT DEPARTMENT FACILITIES.

(a) SCOPE OF SERVICES.—Section 7803 is amended—

(1) in subsection (a)—

(A) by striking “(a)” before “The canteens”; and

B) by striking “in this subsection;” and all that follows through “the premises” and inserting “in this section”; and

(2) by striking subsection (b).

(b) TECHNICAL AMENDMENTS.—(1) Paragraphs (1) and (11) of section 7802 are each amended by striking “hospitals and homes” and inserting “medical facilities”.

(2) Section 7803, as amended by subsection (a), is amended—

(A) by striking “hospitals and homes” each place it appears and inserting “medical facilities”; and

(B) by striking “hospital or home” and inserting “medical facility”.

SEC. 303. REPORT ON ASSISTED LIVING SERVICES.

Not later than April 1, 2000, the Secretary of Veterans Affairs shall submit to the Committees on Veterans Affairs of the Senate and House of Representatives a report on the feasibility of establishing a pilot program to assist veterans in receiving needed assisted living services. The Secretary shall include in such report recommendations on—

(1) the services and staffing that should be provided to a veteran receiving assisted living services under such a pilot program;

(2) the appropriate design of such a pilot program; and

(3) the issues that such a pilot program should be designed to address.

SEC. 304. CHIROPRACTIC TREATMENT.

(a) ESTABLISHMENT OF PROGRAM.—(1) Within 120 days after the date of the enactment of this Act, the Under Secretary for Health of the Department of Veterans Affairs, after consultation with chiropractors, shall establish a policy for the Veterans Health Administration regarding the role of chiropractic treatment in the care of veterans under chapter 17 of title 38, United States Code.

(b) DEFINITIONS.—For purposes of this section:

(1) The term “chiropractic treatment” means the manual manipulation of the spine performed by a chiropractor for the treatment of such musculo-skeletal conditions as the Secretary considers appropriate.

(2) The term “chiropractor” means an individual who—

(A) is licensed to practice chiropractic in the State in which the individual performs chiropractic services; and

(B) holds the degree of doctor of chiropractic from a chiropractic college accredited by the Council on Chiropractic Education.

SEC. 305. DESIGNATION OF HOSPITAL BED REPLACEMENT BUILDING AT IOANNIS A. LOUGARIS DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, RENO, NEVADA.

The hospital bed replacement building under construction at the Ioannis A. Lougaris Department of Veterans Affairs Medical Center in Reno, Nevada, is hereby designated as the “Jack Streeter Building”. Any reference to that building in any law, regulation, map, document, record, or other paper of the United States shall be considered to be a reference to the Jack Streeter Building.

TITLE IV—CONSTRUCTION AND FACILITIES MATTERS

SEC. 401. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS.

The Secretary of Veterans Affairs may carry out the following major medical facility projects, with each project to be carried out in the amount specified for that project:

- (1) Renovation to provide a domiciliary at Orlando, Florida in a total amount not to exceed \$2,400,000, to be derived only from funds appropriated for Construction, Major Projects, for a fiscal year before fiscal year 2000 that remain available for obligation.
- (2) Surgical addition at the Kansas City, Missouri, Department of Veterans Affairs medical center, in an amount not to exceed \$13,000,000.

SEC. 402. AUTHORIZATION OF MAJOR MEDICAL FACILITY LEASES.

The Secretary of Veterans Affairs may enter into leases for medical facilities as follows:

- (1) Lease of an outpatient clinic, Lubbock, Texas, in an amount not to exceed \$1,112,000.
- (2) Lease of a research building, San Diego, California, in an amount not to exceed \$1,066,500.

SEC. 403. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to the Secretary of Veterans Affairs for fiscal year 2000 and for fiscal year 2001—

- (1) for the Construction, Major Projects, account \$13,000,000 for the project authorized in section 401(2); and
- (2) for the Medical Care account, \$2,178,500 for the leases authorized in section 402.

(b) LIMITATION.—The project authorized in section 401(2) may only be carried out using—

- (1) funds appropriated for fiscal year 2000 or fiscal year 2001 pursuant to the authorization of appropriations in subsection (a);
- (2) funds appropriated for Construction, Major Projects, for a fiscal year before fiscal year 2000 that remain available for obligation; and
- (3) funds appropriated for Construction, Major Projects, for fiscal year 2000 for a category of activity not specific to a project.

INTRODUCTION

H.R. 2116 addresses a spectrum of issues reviewed by the Committee in hearings and through other oversight mechanisms over the course of this year.

The Committee's hearing on February 11, on the Department's budget for fiscal year 2000 set an important framework for its oversight and legislative agenda this year.

On February 24, 1999, the Committee's Subcommittee on Health held a hearing to develop in greater depth an understanding of the VA Medical Care budget for fiscal year 2000 and the fiscal state of the VA health care system. Those testifying at the hearing included: Dr. Thomas Garthwaite, the VA's Deputy Under Secretary for Health; William (Ted) Galey, M.D., Director VISN 20; Mr. James Farsetta, Director VISN 3; Ms. Laura Miller, Director VISN 10; Mr. Thomas Trujillo, former Director of VISN 18; Mr. Nick Bacon, Director of the Arkansas Department of Veterans Affairs; Mr. Dennis Cullinan, Director, National Legislative Service, Veterans of Foreign Wars; Ms. Jacqueline Garrick, Deputy Director, National Veterans Affairs and Rehabilitation Commission, The American Legion; Mr. Richard A. Wannemacher, Jr., Associate National Legislative Director, Disabled American Veterans; Mr. Harley L. Thomas, Associate Legislative Director, Paralyzed Veterans of

America; Ms. Veronica A'zera, Legislative Director, AMVETS; and Mr. George C. Duggins, National President, Vietnam Veterans of America.

Thereafter, the Subcommittee on Health held oversight hearings on issues central to future planning for VA health care. On March 10, 1999, the Subcommittee took testimony on the Veterans Health Administration's management of its capital assets. Among those testifying at that hearing were Mr. Stephen P. Backhus, Director, Veterans' Affairs and Military Health Care Issues, Health, Education, and Human Services Division, General Accounting Office; Dr. Daniel H. Winship, Dean, Loyola University, Chicago Stritch School of Medicine; Dr. Thomas Garthwaite, the VA's Deputy Under Secretary for Health.

On April 22, 1999, the Subcommittee on Health received testimony on the future of VA's long-term care program. Those testifying at this hearing included: Dr. Kenneth W. Kizer, the VA's Under Secretary for Health; Dr. Judith A. Salerno, Chief Consultant of VA's Geriatrics and Extended Care Strategic Healthcare Group; Dr. John Rowe, Chairman, Federal Advisory Committee on the Future of VA Long-Term Care; Mr. Robert Shaw, President, National Association of State Veterans Homes; Pamela Zingeser of Birch and Davis; Kathleen Greve, VA's Chief of State Home Construction; Mr. Steve Watson, Administrator of the Ocala Harborside Healthcare Nursing Home, and Mr. Rick Jelinek, Senior Vice President, Managed Care Solutions.

Following up on its prior hearings and oversight work, the Subcommittee developed, and on May 19, 1999, received testimony on a draft bill entitled the Veterans' Millennium Health Care Act and on a second draft bill to establish a pilot program for the care of certain veterans' dependents. Among those testifying at this hearing were: Dr. Kenneth W. Kizer, the VA's Under Secretary for Health; Mr. John R. Vitikacs, Assistant Director, Veterans Affairs and Rehabilitation Commission, The American Legion; Mr. Dennis M. Cullinan, National Legislative Director, Veterans of Foreign Wars; Mr. Richard A. Wannemacher, Jr., Associate National Legislative Director, Disabled American Veterans; Mr. Larry D. Rhea, Deputy Director of Legislative Affairs, Non Commissioned Officers Association; Mr. Harley L. Thomas, Associate National Legislative Director, Paralyzed Veterans of America; Colonel Robert F. Norton, USA (Ret.), Deputy Director of Government Relations, The Retired Officers Association; Mr. John J. Daly, Legislative Assistant, The Retired Enlisted Association; and Mr. Rick Weidman, Legislative Director, Vietnam Veterans of America.

In light of the testimony on May 19, substantial changes were made to the draft legislation. On June 9, the Subcommittee on Health held a meeting to consider the revised draft, captioned the Chairman's mark of the Veterans' Millennium Health Care Act. This draft bill was approved by the Subcommittee with an amendment offered by the Ranking Member of the Health Subcommittee, Rep. Luis Gutierrez. The amendment would provide for a one-year extension of VA's sexual trauma counseling program (through 2002) and for mandating that VA operate that program. The Subcommittee recommended that the legislation, subsequently intro-

duced as H.R. 2116, be referred for consideration by the Full Committee.

SUMMARY OF THE REPORTED BILL

I. Long-term care reform

These provisions would:

- (1) mandate that VA operate and maintain a national program of extended care services and would specify that that program must include geriatric evaluations, nursing home care (in-house and contract), adult day health care, domiciliary care and respite;
- (2) require VA to maintain nationally the level of "in-house" extended care services provided as of September 30, 1998;
- (3) require VA, in addition to maintaining such capacity, to develop and begin to implement by January 1, 2000 a plan for carrying out the recommendation of the Federal Advisory Committee on the Future of Long-Term Care that VA should increase both home and community-based care options as well as the percentage of the medical care budget dedicated to such care;
- (4) mandate VA to provide needed extended care services in the case of veterans who are 50 percent service-connected or in need of such care for a service-connected condition; and provide such veterans highest priority for placement in VA nursing homes;
- (5) provide, in the case of a veteran in need of extended care services for a nonservice-connected condition (other than a veteran described in paragraph (4) above), that VA shall—
 - (a) in providing nursing home care in VA facilities, give priority to placements (i) to rehabilitate patients, (ii) for unique patient populations (such as Alzheimers' disease), and (iii) for patients with no other good placement options;
 - (b) establish a copayment policy (applicable to extended care of more than 21 days in a year) which would be based on the following principles applied in State veterans' homes:
 - (i) the establishment of a maximum monthly copayment;
 - (ii) the payment requirement would be based on an ability-to-pay formula tied to income and assets of a veteran and spouse;
 - (iii) provision would be made to protect the veteran's spouse (if she/he lives in the community) from financial hardship by exempting at least part of the couple's income and assets from consideration in determining the copayment obligation; and
 - (iv) providing for the veteran to retain a monthly personal allowance.
- (6) establish a revolving fund in the Treasury in which to deposit copayments under paragraph (5)(b) to be used to expand extended care services, as described in paragraph (3) above;
- (7) Lift the six-month limit on VA providing adult day health care;

- (8) Authorize VA to furnish respite care services under contract in the veteran's home or in any other setting;
- (9) Authorize VA to expand the scope of the State home program to encompass all extended care services;
- (10) Revise the priority system for the award of grants under the State home construction program (A) to provide a higher priority for renovation projects than accorded under current law (with highest priority for projects to remedy life-safety problems), (B) for applications for bed-producing projects, prioritize based on the relative need for adding new beds (with higher priority to states with great need vs. those with moderate or limited need, and taking into account existing VA and community nursing home beds), and (C) to "grandfather" those VA-approved projects for which states have provided funding in advance; and
- (11) Require VA to report to Congress on the feasibility of a pilot program to provide veterans assisted living services.

II. Improved access through facility realignment

These provisions would:

- (1) Require VA to establish enhanced-service programs to improve access and quality of service provided at medical centers which (A) are no longer providing high quality, efficient hospital care based on such factors as (i) current and projected need for the service, (ii) functional obsolescence, and (iii) aging physical plant, and (B) could obtain needed hospital care services from a nearby VA facility or under reasonable contract arrangements;
- (2) provide for the development of an enhanced service plan at a designated center (to be based on strategic network planning) that would allow for—
 - (a) ceasing to provide hospital (or other) care at the medical center;
 - (b) contracting or otherwise arranging for the provision of needed hospital or other care;
 - (c) long-term leasing of buildings or grounds which are no longer needed;
 - (d) retaining *locally* operational savings as well as the proceeds of long-term leases to be used to establish and operate modern clinics and/or extended care services;
 - (e) providing re-employment assistance to those displaced;
- (3) require VA to provide for veterans organizations, employee unions, and other interested parties to participate in developing an enhanced service plan;
- (4) provide that such a plan may in no way diminish the VA's obligation to maintain specialized medical programs;
- (5) provide that VA cannot implement an enhanced service plan without first submitting the proposed plan and justification to Congress, and waiting for a period of 45 days;
- (6) expand VA's authority to enter into enhanced-use leases by
 - (a) authorizing VA to enter into a long-term lease of property when that would enable it (as demonstrated in a business plan) to apply the proceeds of the lease to demonstrably improve services in that geographic area (such as by

- using such monies to lease and operate a new outpatient clinic);
- (b) extending the duration of such a lease term for up to 75 years (to encourage maximum return);
- (c) providing that funds from enhanced use or other long-term leases shall be deposited in a new Health Services Improvement Fund (with not less than 75 percent of the proceeds to be made available to the network where the property is located); and
- (d) authorizing VA to use minor construction funds (rather than medical care funds alone) to meet costs involved in such leasing.

III. Eligibility reform

These provisions would:

- (1) provide specific authority for VA care and treatment for veterans who have sustained an injury in combat recognized by the award of the Purple Heart, and would provide them the same priority as former POW's and veterans who are 10 or 20 percent service-connected;
- (2)(a) provide specific authority for VA care and treatment for those TRICARE-eligible military retirees who are not otherwise eligible for VA care as "category A" veterans (this legislation would make them category A veterans with priority immediately below "group 6");
- (b) require VA and DoD to enter into an implementing agreement under which DoD would reimburse VA at rates to be agreed upon by the Secretaries, but which must be sufficient for VA to recover the costs of treating such retirees;
- (c) limit VA from entering into an agreement to provide care to these veterans in any area unless VA would recover its costs and has certified and documented that it has the capacity to provide such care; and
- (d) provide for phased implementation.

IV. Enhanced revenues

These provisions would:

- (1) direct VA to establish a copayment policy applicable to extended care services, as described in section I(5)(b), above, with revenues to be used to expand home and community-based extended care;
- (2) *subject to the current statutory exemptions*, authorize VA, through regulations which VA may promulgate, to (a) increase the copayment amount on prescription drugs; and (b) establish reasonable copayments on hearing aids, eyeglasses, electronic equipment, and other costly items or equipment furnished a veteran for a nonservice-connected condition (but specifically exempt wheelchairs and artificial limbs from any copayment requirement);
- (3) establish that new revenues under the bill (other than those for extended care services and in paragraph (5) below) would be for deposit into a new Health Services Improvement Fund, which would be free of any requirement that such amounts

must be made available for expenditure in appropriations acts;

- (4) direct the Secretary to establish a more appropriate copayment, or schedule of copayments, applicable to outpatient care provided to category C veterans (in lieu of the current requirement that the copayment is 20 percent of the average cost of an outpatient visit); and
- (5) require (if the United States prevails in a suit against tobacco companies to recover costs incurred to the Government attributable to tobacco-related illnesses) that (a) VA shall retain the proportionate amount of the recovery attributable to VA's costs of providing care for tobacco-related illnesses, and (b) such funds are to be deposited in a trust fund in the Treasury to be available after fiscal year 2004 for furnishing medical care and conducting research.

V. Other Program Improvements

- (1) Provide compensation under title 38, United States Code, section 1151 and, health care coverage to a veteran who suffers disability or death as a result of participation in a VA compensated work therapy program;
- (2) Extend, through December 31, 2002, eligibility for Vet Center counseling to Vietnam-era veterans;
- (3) Extend, until September 30, 2002, VA's authority to make grants to assist homeless veterans, and strike limits on the number of vans which such grants may support;
- (4) Extend the requirement that VA maintain special committees relating to post-traumatic stress disorder and to the care of the seriously chronically mentally ill;
- (5) Authorize VA nonprofit corporations to accept donations to support VA continuing education needs;
- (6) Clarify the authority of VA's canteen service to sell items to outpatients and for use off the premises.
- (7) Authorize VA to establish and make reasonable emergency care payments for "category A" (priority 1–6) veterans who (a) have no health insurance or other medical care coverage, and (b) are enrolled in the VA health care system and have received VA care within the twelve months before the emergency treatment.
- (8) Authorize VA to establish a three-year pilot program in up to four networks to provide primary care services (subject to reimbursement) to dependents of veterans.
- (9) Require VA to report to Congress on proposed closures within a fiscal year of 50 percent or more of the beds in certain bed sections at any VA medical center, and to notify Congress annually by network of closures and mission changes in other bed sections.
- (10) Require VA to establish a policy on the role of chiropractic treatment in the Department's care of veterans.
- (11) Provide that VA may not employ a health care professional if a state has terminated for cause the individual's license to practice.

- (12) Extend by one year VA's authority to provide sexual trauma counseling, and direct that the VA operate the program during that period.
- (13) Authorize two major construction projects and two major medical facility leases.
- (14) Name a new replacement hospital building at the Reno, Nevada VA medical center for a veteran who is the most decorated combat veteran in that State.

BACKGROUND AND DISCUSSION

Three years ago, this Committee developed and held hearings on legislation to reform VA rules governing eligibility for care. That "eligibility reform" legislation, Public Law 104-262, paved the way for a major shift—from primary reliance on VA hospital care to less costly outpatient care. It also resulted in vastly improved access for many veterans.

That legislation was described as a first step on a path to reform of the VA health care system. With H.R. 2116, the Committee takes another very significant step in tackling some of the major challenges facing VA. In addressing in this legislation many of the key issues discussed in hearings over the course of this year, the Committee offers a blueprint to help position VA to meet pressing veterans' needs in the new millennium.

Overall, the bill has four central themes: (1) to provide new direction to address veterans' long-term care needs; (2) to expand veterans' access to care; (3) to close gaps in current eligibility law; and (4) to establish needed reforms to improve the VA health care system.

LONG-TERM CARE

The Department of Veterans Affairs has long recognized the aging of America's World War II and Korean War veterans as a major challenge for its health care system. Aging veterans' access to acute-care services has expanded significantly since the publication in 1984 of a VA needs assessment entitled "Caring for the Older Veteran". In contrast, VA extended care and long-term care programs have not experienced comparable growth. Thus, veterans who have enjoyed markedly improved access to ambulatory or hospital care have been at greater risk with respect to needed nursing home care or alternatives to institutional care.

The VA's fiscal year 2000 budget cited the need to increase spending for community-based long-term care. However, rather than presenting a realistic plan for expanding the delivery of such services, that budget effectively proposed a dramatic reduction in VA's real spending power. As documented in the Committee's budget hearings earlier this year, the Administration's "plan" for VA health care for the coming fiscal year is for reductions in services; its budget provides no plausible strategy or mechanism to expand long-term care.

While VA may be faulted for years of skirting its responsibility to plan and budget for veterans' long-term care needs, its policy of decentralizing decisionmaking authority has compounded the problem.

Since its decentralization in 1995, the Veterans Health Administration (VHA) has undergone enormous change. Long-term care programs have been affected by changes in workload and policy. Twenty-two network directors nationwide now make decisions about policy and funding that were once made at VA Headquarters. National service chiefs who once made decisions about various programs became “consultants”. In their new roles, consultants could offer only advice about program management.

Coinciding with the implications of these organizational changes, tighter budgets created additional challenges for VHA. Many viewed the payment methodology under VA’s new funding allocation mechanism as a disincentive to operating long-term nursing home care programs. Nursing home care, which VA officials came to see as a “discretionary” program, became vulnerable to cost-cutting, and Headquarters, by design, had little ability to affect network decisions.

A survey of VA chiefs of staff initiated by the Committee’s Ranking Member last year documented these and other changes which have affected VA long-term care programs. Among its findings, the survey documented that many medical centers have changed the mission of their nursing home units, offering post-acute restorative, rehabilitative, and palliative care, rather than ongoing care for age-associated problems. The survey also found that the number of beds VA funds or operates devoted to providing long-term care had dropped.

The Committee believes that, while VA has demonstrated some improvements in quality and increased the number of new veterans it treats, decentralization has also led to troubling shifts in long-term care delivery patterns. The result has been marked variability—from network to network—in veterans’ access to VA nursing home care and nursing home care alternatives.

It is untenable that VA network or facility directors should dismantle critically needed care programs on the basis that nursing home care is costly or that Congress has somehow invited VA officials to exercise the discretion to provide or not provide such care.

Veterans’ advocates have rightly called for a legislative response to this disturbing situation. But formulating such legislation requires a measured, balanced hand. That effort must acknowledge budget constraints as well as other areas of unmet or only partially-met need. It must also recognize that the formidable costs associated with long-term care create access barriers for Americans at large.

This Committee has for some time pressed the Department to formulate a plan to provide for veterans’ long-term care needs. In response, the Under Secretary for Health established a Federal Advisory Committee on the Future of VA Long-Term Care early in 1997. Among its charges, the Advisory Committee was asked to evaluate access to long-term care for veterans, appropriate models for service delivery, and the VA’s appropriate investment in long-term care. The Committee’s findings and recommendations were published in June 1998 in “VA Long-Term Care At The Crossroads: Report of the Federal Advisory Committee on the Future of VA Long-Term Care.” Unlike VA’s 1984 report, “Caring for Older Veterans,” which assessed veterans’ needs but failed to provide a strat-

egy for meeting them, the advisory committee's report frankly acknowledged that its charge was to take account of budget constraints in formulating a plan for the future of VA long-term care.

Among its recommendations, the Advisory Committee called on VA to establish performance measures, financial incentives and broad national guidance for VA long-term care. VA now operates or funds three nursing home programs; the Committee recommended that VA maintain a core of VA-delivered services, but meet additional service goals through contracting and use of the State home program.

The Advisory Committee also recommended VA triple the percentage of the VA health care budget devoted to home and community based long-term care services and double the proportion of long-term care spending invested in home care, community-based services, and "enriched housing" programs. It recommended establishing a "grandfather" clause for patients who have resided in VA facilities for more than 1000 days. Notwithstanding its receipt of this report last year from an Advisory Committee, the Department has been slow to adopt or otherwise act on those recommendations.

The reported bill builds on the Advisory Committee's findings and recommendations, but goes considerably further. The bill squarely addresses the notion that VA long-term care programs are simply "discretionary". This notion holds that—because the Secretary "may" provide such care to veterans (rather than "shall" provide, subject to the availability of resources)—the Secretary (or his subordinates) may also opt not to provide such services. If the Secretary has the authority not to provide such services to all veterans in need, some officials apparently reason, he must also be free not to operate such programs. While such reasoning is spurious, it has clearly taken hold among those whose decisions are apparently colored by the high cost of operating these programs. It is most disturbing that this misconception is held at the highest levels of the Department, as reflected in the recent testimony of VA's chief physician:

Dr. KIZER. . . . [U]nder the law we are mandated to provide acute care services. Long-term care is a discretionary item.

* * * * *

[T]oday under the law, long-term care is considered a discretionary program, not on the same footing as acute care service. And in an era of severe budget limitations and constraints, some of the changes that have been seen with regard to the service of long-term care should really come as no surprise given the inequity between how those are treated under the law. And we hope that as a result of this and continuing dialogue, we will achieve parity for long-term care and acute care, and the statutory recognition that these are merely different points along a continuum of care that should be provided for, not only veterans, but by all health plans." (Subcommittee on Health, Hearing on Long-Term Care, April 22, 1999)

It is important that Congress set to rest the notion that its actions have created a legal chasm requiring VA to provide acute

care, on the one hand, while permitting it *not* to provide long-term care, on the other. The reported bill, accordingly, would bury the myth that VA medical centers may cease to provide nursing home care, for example, as a matter of budgetary or programmatic discretion. To the contrary, the bill makes clear that extended care (as defined in new section 1710A) is as much an element of VA's medical care mission as is ambulatory or other acute care. However, given the implications of a Congressional Budget Office cost estimate of any legislation which employs the phrase "the Secretary shall provide . . ." specified services, this measure does not state that VA shall provide extended care services to all veterans whom it enrolls for VA care. At the same time, that omission is not intended to signal that VA has a greater obligation to provide acute care services than long-term care, or that VA must deploy its resources so as to maximize the number who receive acute care services, while limiting the number to whom it provides long-term care. With respect to the April 22 testimony quoted above, nothing in this bill (or chapter 17 of title 38, United States Code, as so amended) would bar the Secretary from limiting the number of veterans enrolled (under section 1705 of title 38) to a population which could receive a complete continuum of care.

The reported bill would, however, make several significant changes to lift limits that may now impede VA from providing a needed continuum of care or that limit VA from providing care in the most appropriate mode. The measure directs VA to develop a plan for, and begin to carry out, the Advisory Committee's recommendation to expand home and community-based care options for veterans needing long-term care through an increase in spending on such services. The measure would also adopt the Advisory Committee's recommendation regarding the assignment of priorities for nursing home placements. But it would go further to direct that highest priority for such placements should go to veterans in need of such care for a service-connected disability and to those in need of such care who have a service-connected disability rated 50 percent or greater. H.R. 2116 also directs VA to provide extended care services, as needed, to these service-connected veterans. Such direction should not effect a substantial change from current practice, which has long recognized the debt owed both the service-connected veteran needing care for a service-connected disability as well as the veteran with profound service-incurred health problems. By way of increasing VA's flexibility to meet veterans' long-term care needs, the measure would lift a six-month limitation in current law on provision of adult day health care. It would also authorize VA to provide respite care (now limited to care in VA facilities) through contract arrangements. VA could, accordingly, provide respite care in the veteran's home (which in the view of the Advisory Committee represents the preferred location), in community nursing homes, or in other residential care facilities.

With these provisions, the reported bill makes it clear that VA has broad authority to provide extended care services, through VA facilities and staff and under contract arrangements, as appropriate. (As VA medical care appropriations are in the nature of "discretionary spending", however, it should be noted that these provisions do not establish an entitlement to care as such.)

With respect to VA's authority, however, the Subcommittee heard testimony at its April 22 hearing which suggests that it may be cost-effective for VA to explore contracting for "care coordination and management" of non-institutionalized veterans in need of long-term care services. The Committee learned that there are entities experienced in long-term care management under Medicaid or similar long-term care programs which may be able to provide VA such services. The Committee would encourage the Department to consider the development of a pilot program, giving first priority for participation to service-connected veterans needing such care for service-connected conditions or with service-connected conditions rated 50 percent or more. The Committee envisions a contractor managing the delivery of services under such a pilot. This would include "leveraging" available VA services (such as outpatient treatment, a home improvement/structural alteration grant, and respite care, for example) while contracting for or providing directly other services which VA is authorized to provide but may not have the capacity to do so (to include such noninstitutional alternatives to nursing home care as VA has determined appropriate under section 101).

Cost-sharing

The Committee is cognizant that there are budget implications associated with its long-term care provisions. It is important to note that other provisions of the reported bill provide means of offsetting those costs. (See, for example, section 107(c)(5)(B).) Section 101 specifically directs the Secretary to establish copayments applicable to provision of extended care services (as defined in section 101) of 21 days or more in any year for a nonservice-connected disability. The measure would specifically exempt only veterans who have a service-connected disability rated 50 percent or greater from responsibility for such cost-sharing.

The Committee believes that the adoption of such a policy is not only a reasonable component of its effort to address veterans' long-term care needs, but a step that should be taken as a matter of equity. Under current law, largely arbitrary circumstances often dictate whether similarly-situated veterans will receive entirely cost-free VA nursing home care or bear very substantial costs of care—either in a State veterans' home or through a required spend-down of assets to qualify for Medicaid. All but three states participate in the State home program, and in all but one State veterans are required to make payments toward the cost of their care, up to a prescribed maximum and subject to ability to pay.

In 1986, Congress established co-payments for VA and contract community nursing home care applicable to veterans who do not qualify for priority care as so-called "category A" beneficiaries. Amendments enacted in 1990 subjected such veterans to an additional \$5-a-day copayment for nursing home care. In 1992, the General Accounting Office published a report exploring whether VA could more extensively offset some of the costs of long-term care. GAO noted that in fiscal year 1990, when VA spent some \$1.3 billion to provide nursing home and domiciliary care, VA offset less than one-tenth of one percent of its costs through copayments, which totalled \$260,389. GAO, in studying the experience in State

veterans' homes, found that seven of the eight State homes it visited required veterans to contribute to their care by means of a copayment, and that co-payments were collected from *90 percent of their veteran residents*. GAO also found that 39 of the (then) 40 states with veterans homes required veterans to contribute to the cost of their care. Of the 39, 16 set variable copayments based on incomes and assets, 15 set variable copayments based only on incomes, and 8 charged a fixed copayment regardless of incomes or assets.

In its study, GAO found that states used only financial criteria for exempting some veterans from cost-sharing, but that states used stricter criteria in determining a veteran's ability to make copayments than the "means test" threshold (then set at \$18,171 for a single veteran) in VA. GAO noted that none of the homes they visited automatically classifies a veteran as unable to pay if he or she received a VA pension or was eligible for Medicaid. Two of the eight states, for example, required single veterans to make at least minimal copayments if their annual incomes exceeded \$2400 and \$1080, respectively. Among the eight, GAO reported that the maximum daily copayments were, respectively, \$92.56, \$90.60, \$79.40, \$77.56, \$66.14, \$29.59, \$18.74, and \$5. In setting the applicable copayment for any particular veteran, each state surveyed had provisions to protect the veteran's spouse by excluding the principal residence and a portion of the veteran's income from computation towards co-payment. And all eight excluded a specified amount of the veteran's monthly income from the copayment computation as a personal needs allowance.

GAO concluded that in the face of rising health care costs, Congress "may wish to consider changing the current policy for charging veterans for care in VA and community facilities to help offset increased operating costs, fund care for more veterans, or both." The Committee concurs with this recommendation, and the reported bill, accordingly, makes provision that such copayments are to be deposited into a new revolving fund to be used exclusively to provide extended care services. In so providing, the Committee intends that such copayments would help offset the costs of expanding home and community-based long-term care as required under section 101(b) of the reported bill and any other new costs under section 101.

While section 101 vests some discretion in the Secretary to develop a methodology for establishing copayment amounts, it directs that such a methodology provide for variable copayments (based on all family income and assets). The measure also requires that the copayment policy provide (in the case where the veteran has a spouse who resides in the community) for protecting the spouse from financial hardship by not counting all of the income and assets as available for determining the copayment obligation, and allow the veteran to retain a monthly personal allowance. The Committee does not intend that the copayment be simply a symbolic or token payment. It is intended to help offset the significant costs of VA long-term care programs, and to address the inequity in current law, described above. Thus, it is the Committee's intention that VA implement a copayment methodology under which the maximum copayment amount would not be less than the median

figure among the maximum amounts employed by the various states which require a copayment.

State homes

Perhaps the most important partners in VA's efforts to provide for the long-term care needs of eligible veterans are the states, which provide care through 95 State veterans homes. The State home program is a longstanding Federal-state partnership under which the VA provides both grant support (of up to 65 percent of cost) for the construction and renovation of homes and per diem payments to cover up to 50 percent of the cost of caring for eligible veterans in these homes. Forty-three states are operating homes under the program, up from 35 in 1988; four states which do not have State homes have recently been awarded grants or filed applications. Over the last decade the State homes have expanded from some 18,400 beds to 24,000.

The increased participation of states in the program owes much to provisions of Public Law 99-576, enacted in 1986. Public Law 99-576 revised provisions of law under which VA had previously administered the program. Under then-existing law, VA maintained that it had no basis to differentiate among and establish priorities by which to rank or weight applications. Accordingly, the Department awarded grants in the order in which applications (which met the statutory criteria) were received. This "first-come/first served" system, however, was seen as a disincentive to states which had not participated in the program. Notwithstanding the benefits of constructing and operating State-operated extended-care beds in previously non-participating states, such states' applications might be years away from receipt of grant support, in a queue behind earlier-filed (but not necessarily more worthy) applications. Public Law 99-576, accordingly, revised the enabling law for the State home construction program. Among its changes, the law established a framework for VA to assign priorities to State home applications. The law directed VA to accord highest priority to applications for which the state has made available its share of funds for the project. Second priority was to go to applications from states that do not have any State home facilities, third to states that have the greatest need for nursing home or domiciliary beds, and fourth to applications meeting any other criteria determined by VA.

The changes established by Public Law 99-576 were successful in realizing that law's goals, with both many more states participating in the program and a substantial increase in the number of new State home beds. The law had unintended consequences, however. With the high priority given in the law (and its implementing regulations) to bed-producing projects, state applications for renovation of existing homes have necessarily been given a lower priority. Thus, even renovations needed to remedy conditions which may threaten patient safety have consistently fallen below bed-producing projects. With the requirement in existing law that the Secretary publish a list of approved applications in the order of their priority on the basis of which to grant awards, these renovation projects have consistently been "outranked" and gone unfunded. Thus, even states which have appropriated their share of funds for such projects have seen them languish.

Both the states and the Department of Veterans Affairs have recognized the need to revise existing law. While the National Association of State Veterans Homes (NASVH) has proposed a legislative remedy, the VA has been more cautious in embracing any specific legislative solution. Last year the Department contracted with a consultant to conduct a study of the program and to develop recommendations for changes in the prioritization methodology. The Subcommittee heard testimony on April 22 on these issues from the contractor, Birch & Davis Associates, Inc.; Department officials; an NASVH representative; and a representative of the nursing home industry.

The reported bill addresses many concerns raised by these parties. In its review of the program, the consultant, for example, identified a number of issues inherent in the current prioritization methodology reflected in VA's regulations governing the grant program. The consultant reported that:

[several] issues emanate from the fact that bed need is measured in terms of the maximum bed capacity or bed supply the VA would help finance if Congress appropriated the money. Veterans are assumed to need these beds, and their need is assumed to be uniform nationally. Unmet need is said to exist whenever a state does not have the maximum bed capacity that the VA would fund, regardless of the availability of suitable beds in VA facilities, community nursing and domiciliary homes, or existing State homes. The maximum bed capacity that the VA will fund is 4 nursing home beds per 1,000 veterans and 2 domiciliary beds per 1,000 veterans. We found no empirical justification for these bed standards. Second, bed need is measured in terms of the entire veteran population rather than veterans who are likely to utilize beds in State homes . . . Third, unmet bed need is predicated on the number of veterans residing in a state at the time a grant request is submitted rather than the number of veterans who are likely to seek care during a home's useful life . . . Fourth, unmet bed need plays a role in the assignment of priorities to grant requests submitted by states with an unmet bed need at or above 91 per cent of the maximum allowable or "fundable" capacity. Unmet bed need has no bearing on the priority assigned to other grant requests, however.

The reported bill directs the Secretary to prescribe new regulations (and thus revise its current regulation at 38 Code of Federal Regulations, section 17.211) to set the number of beds for each state for which grant assistance may be provided. The Committee expects that VA will consult with the NASVH in developing such regulations. The bill specifies that such regulations are to be based on projected demand for such care (ten years from date of enactment) on the part of veterans who at such time are 65 or older, and that in projecting such demand, VA is to take account of travel distance for veterans and their families. (In so specifying, the Committee intends that such regulations take account of situations where, for example, a state may already have a substantial number of State nursing home beds, but such facility or facilities are remote from

a major population center. In such a case, the existence of nursing home bed capacity at a great distance from such population center should not preclude the state from establishing additional State home beds if needed to serve that population center.)

The reported bill also calls for the Secretary to establish the criteria (based on each state's relative need for additional beds) by which VA would determine whether, with respect to applications for bed-producing projects, the state's need for additional beds is most aptly characterized as "great", "significant", or only "limited". This characterization would determine the relative priority of any bed-producing project under the revised prioritization methodology established under the bill. In establishing these criteria, VA is to take into account the availability of VA-operated beds and community nursing home beds which would appropriately serve the needs for nursing home care or domiciliary care, as pertinent. (The reference to "appropriately" serving such needs reflects the Committee's view that levels and quality of care may differ substantially from institution to institution. Accordingly, excess capacity in one domain (involving a lower level or substantially lower quality of care) should not necessarily be construed to "appropriately" serve veterans' need for a particular level of care.

The Committee is also aware that there is variability in VA's long-term care resources from network to network. The Committee anticipates, accordingly, that in a state where, for example, VA provides little or no long-term care in VA nursing homes (and relies to a greater extent than in other networks and other states on the State home program to meet that need), there should be recognition of a greater relative need for State-operated nursing home beds in that state than in other states in which VA meets a greater "market share" of such long-term nursing home care needs.

Rather than adopting the proposal that a first-come/first served principle be reestablished, the Committee seeks to retain priorities, but to reorder those priorities to achieve a better balance between bed-producing projects and renovations, and to prioritize within those categories as well. In addition, the measure would require clearer direction to the states on a number of issues. Among these, the bill would require clearer distinctions be drawn between the states' obligations to keep a home in good maintenance and repair, on the one hand, and a renovation project which may be the subject of grant support, on the other. The measure would also place stricter control on the states in siting new State home facilities to ensure that future State home projects are located in reasonable proximity to veteran population centers.

In the Committee's view, section 206 should help strengthen the State home program and thereby maintain a valuable Federal/state partnership in support of veterans.

IMPROVED ACCESS TO CARE

Enhanced Services Program

Paralleling the experience of medical care in the private sector, the VA health care system has undergone a major transformation in recent years. Until recently, VA has been primarily a hospital-based system. Now, however, most VA care is delivered on an out-

patient basis, with more and more VA care delivered closer to where veterans live. Many factors have enabled VA to make these changes. Among them, a reduction of over 25,000 acute care beds since September 1994 has permitted VA to shift much of its workload from the hospital ward to the ambulatory care arena. Along with other changes, it has also freed up resources to permit VA to establish more than 200 community-based outpatient clinics since October 1996. With these changes, VA over the last four years has seen an increase of 9 million ambulatory care visits and a 31.7 percent decline in hospital admissions.

While the pace of VA's transformation has not been without problems, the changes have renewed focus, within VA and without, on the infrastructure of VA's health care system. Seen from the perspective of veterans' health care needs on the brink of a new millennium, VA's health care "real estate" represents at once both a national expression of the country's commitment to veterans and at the same time something of an anachronism. VA delivers care at 181 major delivery locations, but over 40 percent of its 4,700 buildings have been in operation for more than 50 years; almost 200 of them were built before 1900. (As the General Accounting Office has noted, many organizations in the private sector consider 40–50 years to represent the useful life of a building.)

Many of VA's facilities were designed to provide care in a very different manner than the way care is provided today. As the VA health care system was being developed, hospitals were designed to provide most of the care patients needed, care which typically required long lengths of stay. Such buildings, however, lacked physician examination rooms where ambulatory care is delivered; they were designed without sensitivity to patient privacy. While VA has maintained these old structures and made renovations to keep them operational and safe, many are functionally obsolete. Historically, VA hospitals were not consistently sited near veteran population centers. To the contrary, facilities to care for an illness like tuberculosis or mental illness, which at the time was thought to require a tranquil, rural location, are situated in relatively remote locations. The rural location once thought beneficial to treating these illnesses is now a liability, complicating the recruitment of scarce medical specialists, nurses, and technicians. Today, occupancy rates at numbers of those hospitals are substantially below levels needed for efficient operation and optimal quality of care. Maintaining highly inefficient hospitals, which were designed and constructed decades ago to standards no longer deemed acceptable, substantially diminishes the availability of funds needed to strengthen care-delivery in facilities which should be retained.

Despite its aging infrastructure and a backlog of major construction proposals initiated by VA medical centers estimated to be in the billions, VA budget plans have for several years clearly given major construction work a very low priority. (In contrast to major construction budgets of more than \$500 million earlier in this decade, VA sought major medical construction funding of \$121 million in fiscal year 1998, \$84 million in fiscal year 1999, and \$73 million in fiscal year 2000. Merely maintaining this infrastructure has huge costs. In testimony presented to the Subcommittee on Health, the General Accounting Office projected that one of every four VA

medical care dollars is spent on maintaining and operating VA's thousands of buildings. GAO warned that VA is likely to spend billions of dollars over the next five years to operate hundreds of unneeded buildings.

Congress cannot simply ignore VA's management of its capital assets. Until recently, however, it appeared that VA itself was ignoring that responsibility. As GAO reported to the Subcommittee on Health in a March 10, 1999 hearing, "VHA's planning focuses on individual needs of assets at its 181 [major] delivery locations, even though most locations operate in markets that also include other VA locations." GAO recommended that VA should instead be focusing its capital asset planning not on individual facilities as such but on "markets". GAO urged VA to focus particularly on those 40 areas (or "markets") in which VA has multiple delivery sites (from 2 to 9) and on those 66 markets in which there is a single VHA facility. GAO expressed the view that VA's 40 multiple-facility markets offer great opportunity for "asset restructuring and benefit enhancements for veterans" because they have 115 major delivery sites in which utilization is significantly below inpatient capacity and these sites "compete with other VA locations to serve rapidly declining veteran populations."

Of VHA's 40 multiple-location markets, GAO estimated that VHA spends about \$2.7 billion annually to operate and maintain 3,000 buildings and 10,000 acres in these markets, and plans to invest over \$1.2 billion to improve these assets over the next five years. GAO testified that this "represents a drain on VHA's health care resources because most locations in these markets have delivery capacity that VHA considers functionally obsolete", including substandard inpatient and outpatient capacity, and safety concerns.

Illustrating the situation of multiple sites in a single market, the Subcommittee on Health heard testimony from the dean of a medical school affiliated with one of VA's four medical centers in Chicago. Dr. Daniel Winship, a former senior official in the Veterans Health Administration, and Dean of Loyola University Stritch Medical School, stated that "by any objective measure . . . [the area] does not need four VA medical centers. I am confident it could do acceptably well with two, probably more optimally with three . . . The VA can take a lesson from other health care systems . . . , i.e., savings gained by real elimination of duplications and redundancies . . . and, yes, even closure of unneeded facilities can be applied to more rapidly and completely creating ambulatory sites for care. This strategy is NOT one of closing the system. Rather, it will replace an archaic, decrepit, inefficient delivery system with a new, better, cost effective one. Quality will improve, access will improve . . . [VA managers] must be allowed to let go of practices which will lead to the demise of the system." This view generally mirrors the findings of the GAO, which in an April 1998 report concluded that closing a VA hospital in Chicago would save millions and enhance access to services. (GAO/HEHS-98-64, April 16, 1998).

VA medical center mission changes and even hospital closures have been under discussion for at least a decade, but the subject is no longer simply hypothetical. As recently as last summer, the

Paralyzed Veterans of America for the first time called on VA in a resolution “to develop a plan within one year to close down VAMCs which are no longer needed”. The resolution’s clear goal is that the savings achieved by such closures be redirected to improve delivery of needed care.

For years, VA evaded serious consideration of closing inefficient hospitals, despite widespread hospital closures in the private sector. Ironically, the first VA hospital closure in decades came about not through the persuasiveness of health planners, but as a result of an earthquake. The lessons of that experience are telling, however. The closure of the Martinez, California VA Medical Center and the decision not to build a replacement hospital—but instead to establish a full-service ambulatory clinic—are widely recognized as having resulted in improving care-delivery. The subsequent decision, rejecting proposed construction of a replacement hospital in northern California, and relying instead on multi-site contracts for hospital care, provide an important case study. This experience and subsequent mission-changes at other facilities across the country suggest a model, provided for in the reported bill, for improving VA care-delivery.

Some have proposed adoption of a “Base Realignment and Closure Commission” (BRAC) model. But the nature of the BRAC process—from enacting such legislation, to establishing a commission, conducting exhaustive system and facility review and analysis, and carrying out required community hearings—would take years to reach and carry out final decisions. It is also a process which takes authority away from officials responsible to Congress for meeting veterans’ health care needs and vests it in a commission dedicated simply to closing facilities.

The distinction between a BRAC model and this legislation was aptly summarized by Dr. Kenneth Kizer, testifying on May 19, 1999 before the Subcommittee on Health on the draft legislation subsequently introduced as H.R. 2116:

Dr. KIZER: The analogy to the BRAC is a fatally flawed analogy. It is one that contaminates the thinking in the whole process here. BRAC is about taking something away. And despite what the words of BRAC may mean, what it has meant is taking something away from a community. When we talk about realignment of VA facilities, what we are talking about is how can we get the best health care return on investment for the limited dollars that we have. It is not about taking health care away.

The reported bill gives real meaning to that concept, in requiring specifically that any hospital or medical center closure must enhance patient care in that area through reinvestment of operating funds and capital in new facilities or services, such as a new, full-service outpatient clinic or community-based clinics, for example.

In the context of discussions about a “closure commission”, the reported bill very clearly identifies the Department charged with responsibility to meet veterans’ health care needs as the appropriate entity to identify VHA’ core infrastructure needs. VA clearly has authority under current law to take such actions, but it has not done so in a broad-based manner. The reported bill provides a

framework for the requisite analysis, planning, participation, and review so central to this difficult subject.

As GAO has testified, VA must begin by asking the right questions. It must look methodically and in-depth at geographic areas or “markets” in which it operates facilities—not narrowly and arbitrarily at individual facilities. VA contracted for such a market analysis in considering veterans’ needs for hospital care in northern California, and ultimately concluded, prudently in the Committee’s view, that construction of a \$211 million hospital at Travis Air Force Base was not its best option. As GAO noted, VA initiated a market-based assessment in Chicago in response to GAO’s recommendation.

The intent underlying section 107 is to provide a framework—not now provided for under law or published policy—for VA to realign its health care infrastructure. This provision aims to substitute a statutory structure for ad hoc decisionmaking, and to provide stakeholders and VA administrators confidence that there is a credible path to make needed system changes and safeguards against error.

Section 107 underscores that capital asset management and facility realignment—where it can improve access and quality of service to the veteran—are responsibilities of the Secretary. The measure outlines a two-pronged framework for exercising that responsibility. Consistent with GAO’s recommendations, it envisions a data-driven analysis of pertinent VA “markets” (as described in GAO’s testimony). Such an analysis would answer at least two basic questions with respect to any such market. First, are one or more VA medical centers—in whole or in part—unable to be operated efficiently (and to provide care of high quality) because of such factors as the cost of operating and maintaining an aging physical plant, its functional obsolescence, and limited need for such care capacity? A second question follows only if the preceding is answered affirmatively. If so, then the bill asks whether that inefficiency is so great that it would be demonstrably beneficial in terms of patient care, in VA’s judgment, to cease operating that facility (or cease providing a particular level or levels of care there), and either provide for one or more other VA facilities in proximity to it to absorb some or all of the patient workload, or contract with one or more community hospitals which have the capacity and capability to provide care of appropriate quality. (Thus, even assuming that a particular VA facility is demonstrably “inefficient”, this measure effectively rules out consideration of closure if alternative options provide no net benefit. For example, the bill would not seek the closure of an “inefficient” rural facility if such closure meant VA would provide care through contract arrangements with a community facility where care is clearly of markedly inferior quality.)

Where such a market analysis leads VA officials to conclude that a mission change or facility closure is warranted and can result in improved access to and quality of care, section 107 provides VA tools to achieve the best possible outcome for veterans and protections for affected VA employees. Consistent with the discussion above—that this bill is not aimed at closing facilities, but at enhancing services—its focus is on the establishment of “enhanced services programs” and the development of a plan in each instance

to achieve it. To that end, the bill requires in the case of a medical center or centers designated as a site for an enhanced service program, that VA is to provide for the participation of veterans organizations and employee unions in the development of such plans. Central to the development of such plan and to materially improving access and care quality is the requirement that operating funds (as well as funds under an “enhanced use lease” of VA property under section 207) be reinvested. In that manner, the closure of an obsolete hospital can “fund” the establishment of a full service VA outpatient clinic or series of smaller clinics, for example. Importantly, the measure also provides not only contracting authority to ensure that a service capability is not lost, but the requirement that in such contracting VA maintain ongoing oversight and care-management of patients placed in community hospitals.

Rather than a hospital closure provision, section 107 provides new protections for veterans, employees, and other stakeholders, and greater confidence that vital decisions regarding VA health care will result not only in a more efficient health care system, but a better one.

Reimbursement for emergency treatment

Section 102 of the reported bill would authorize VA to make reasonable payments for emergency treatment which non-VA facilities have provided certain enrolled veterans who have no medical insurance and no other recourse for payment. VA advises that, under current law, it lacks authority (other than through the mechanism of a contract) to pay for emergency care of a nonservice-connected condition. In the Committee’s view, uninsured veterans who have a high priority for VA care (“category A” veterans), have relied on VA as their primary health-care provider, and have no other recourse for payment should not incur extraordinary costs in medical emergencies where a VA facility is not reasonably accessible.

The Committee is aware that many uninsured individuals often use emergency rooms as a source of primary care. The reported bill is clearly not intended to cover such care. To that end, section 102 defines emergency care narrowly to cover only situations in which to delay treatment would be hazardous to life or health (and does not cover care rendered after the patient’s condition has been stabilized). The measure also provides ample authority for VA to effectively and efficiently administer this authority to ensure that scarce resources are not inappropriately paid out on claims not contemplated under this section. VA should make provision in its implementing regulations for an appropriate screening requirement. For example, VA could require providers of care to contact the Department within a specified period to obtain “clearance” or confirmation that it is providing true emergency treatment to a veteran. (Since such a communication could not reasonably address the other elements inherent in establishing eligibility under this provision, it could not provide a basis for a VA commitment to reimburse for the treatment. Thus any such “clinical clearance” would remain subject to an appropriate VA determination that the other conditions specified in the bill had been met.) It would serve, however, to provide the necessary clinical determination that treatment is being rendered in a true medical emergency. At the same

time, it would also serve to put the provider on notice of the importance—in light of the limits on VA coverage for emergency care under the measure and the VA's interest that the veteran not be billed for services—of transferring the veteran to a VA treatment facility at such time as a transfer can be safely accomplished.

The Committee also strongly believes that to ensure even-handed and efficient administration of this clinical review and clearance process, VA should consider establishing a central processing office or function that could carry out that process, rather than having the function performed at a medical center or VISN level. Indeed, the Committee believes it would be reasonable and prudent for VA to use a single centralized office to administer the entire emergency care reimbursement process.

In adopting the emergency care provision in the bill, the Committee recognized the significant potential cost of such a measure if limitations were not imposed. To contain costs, the Committee has taken steps to ensure that VA will pay for this non-VA care only when a veteran has no other recourse for payment for the care. The Committee intends that VA truly be a payer of last resort.

The Committee recognizes that for VA to be a payer of last resort, it must ascertain before authorizing any payment under this section that a veteran has no medical insurance whatsoever or any other medical coverage. It must also ascertain that the veteran or provider (as pertinent) has exhausted all other possible claims and remedies reasonably available against a third party which may be liable for payment of the emergency care (such as in the case of a work-related injury or a motor vehicle accident, for example). In the interest of ensuring that scarce VA medical care funds are protected, the Committee expects that VA will act aggressively in this regard both in the development of implementing policies as well as in the day-to-day management of this new authority, to ensure that it is obtaining all needed information from both the veteran and the provider of care.

In that regard, the Committee understands that as part of its enrollment process the VA now seeks information from veterans on insurance coverage. With the enactment of section 102, obtaining complete information on health insurance coverage is not only essential to the success of VA's current collection efforts, but would help ensure sound administration of this proposed new authority. It is not clear, in that connection, that the current policy fully elicits such information, however. Moreover, it does not identify other benefit programs for which a veteran may be eligible, including Medicare and Medicaid. The Committee recommends, accordingly, that the Department expand and strengthen its efforts to obtain all necessary information regarding health insurance and benefits coverage. In the Committee's view, such effort should be undertaken as part of the enrollment process (rather than in the context of an individual or entity filing a claim for reimbursement when there may be a greater incentive for less than full disclosure).

The reported bill further provides that VA will promulgate regulations which would establish the basis under which it would make payments for "the reasonable value" of non-VA emergency treatment. It is the Committee's view that in setting such payment regulations VA should avoid a policy which gives providers of emer-

gency care a windfall. In that connection, the Committee takes notice of the frequency with which providers of emergency care “write off” such debts in cases where the debt is deemed uncollectable or the costs of collection exceed the likely recovery. VA serves a population which is substantially elderly, indigent, and chronically ill. Given that this bill covers a subset of this population which has no private or public medical insurance or coverage, it stands to reason that in most instances under current law providers would write off the debts arising from the provision of emergency care to these veterans. The Committee thus envisions that VA would establish rates that are significantly below those paid under the Medicare or Medicaid system (or under 38 United States Code, section 1728). Such lower rates should also provide a significant incentive to the providers of care to actively try and obtain reimbursement from those other benefit programs before seeking reimbursement from VA. As a further incentive to the providers of care, the bill also provides that they must accept VA’s payment as payment in full.

The reported bill also limits reimbursement for emergency treatment to enrolled veterans who have actually received some VA treatment in the preceding twelve months. That requirement is intended to ensure that the emergency treatment benefit is available only to veterans who rely on VA for their care, not those who have simply enrolled for VA care but typically obtain their care elsewhere. In including the provision, the Committee recognizes that situations may arise where a veteran has sought VA care in the previous twelve months, but has been unable to obtain care solely due to a VA scheduling problem or error. In this limited situation, the Committee contemplates that VA regulations might permit the Secretary to waive the treatment requirement if to deny reimbursement on that basis would be unfair to and likely to subject the veteran to personal expense. The Committee would anticipate that such waivers would be considered and used very sparingly.

In the event that the Department has made payment for emergency treatment under the terms of the bill and subsequently learns of a third party which is liable, the measure would provide a remedy. If a third party makes payment for care that VA has also paid, the bill would make VA’s payment an enforceable lien against any recovery the payee has received from that third party.

With the adoption of section 102, the Committee proposes to vest the Secretary with important new spending authority. In crafting the provision, the Committee has been very cognizant of the budget pressures already facing the VA health care system. Given existing program demands and budget constraints, the Committee has incorporated significant limitations into this measure to contain costs and avoid unwarranted outlays. A failure to establish meaningful administrative controls, however, could jeopardize that goal. The Committee is very concerned, accordingly, that in implementing, and designing appropriate administrative mechanisms for this important new authority the Department give the fullest consideration to the importance of instituting appropriate safeguards and controls. To that end, the Committee strongly encourages the Department to contract for appropriate consultant support to develop strong implementing regulations and shape sound mechanisms and controls to carry out this authority.

Enhanced revenues

Through its long years of service to America's veterans, the VA health care system has found support primarily as a system which is both dedicated to the care and rehabilitation of service-connected veterans and serves as a "safety net" for other veterans who lack medical insurance or other health care options. Consistent with this mission, Congress has long authorized VA to provide cost-free care.

Current law sets only very limited cost-sharing requirements on veterans. Only one category of veterans is subject to copayment requirements for outpatient care, hospital care and nursing home care. That requirement applies only to those who are not service-connected, have no special eligibility for care (such as status as a former prisoner of war or in-service exposure to radiation or other such hazards), and whose income exceeds the thresholds established under the law's "means test" formula. For other veterans, however, the only cost-sharing requirement under existing law is a modest \$2 copayment for each 30-day supply of medication furnished on an outpatient basis for treating a nonservice-connected condition. The requirement does not apply to veterans who are 50 percent or more service-connected disabled, or to those with low incomes.

Cost-sharing requirements in title 38 have their origin in the context of budget reconciliation deliberations. Uncertainty regarding the current budget has been a critical factor in bringing the subject of cost-sharing into renewed focus. In submitting a budget for fiscal year 2000 which proposed no increase in funding, the Administration acknowledged that VA would face a funding shortfall of more than \$1 billion. VA has conceded that it has no plan whatsoever to operate under such a funding shortfall, that there are no identified "management efficiencies" that could achieve cost-savings of that magnitude (other than reductions and cuts which would have a severe impact on patient care), and that network directors would simply be tasked to develop and execute plans to operate under such a constrained budget. At a budget hearing held by the Subcommittee on Health, a panel of network directors acknowledged that the level of funding proposed by the Administration would require massive reductions in workforce and "draconian cuts" in services, programs, and potentially even closure of needed facilities. While this Committee is clearly on record in support of a \$1.7 billion increase above the Administration's request for fiscal year 2000, the severe reductions anticipated under that budget raise the prospect that many nonservice-connected veterans who now enjoy free or nearly cost-free VA care could lose access to VA services entirely. In that regard, the Committee notes the marked contrast between cost-sharing in the VA health care system and the requirements applicable to military retirees under DoD medical programs, health plans offered under the Federal Employee Health Benefits Program, and other health plans.

Retirees who enroll under DoD's TRICARE Prime plan are liable for copayments for many medical services in addition to office visits, including a \$9 copayment for each 30-day prescription, a \$12 copayment for a home health care visit, and 20 percent of the contractor fee for durable medical equipment.

Cost sharing is used extensively in health plans in the private sector. A survey of copayment trends in 1996–7 found the most common copayment among members of the American Association of Health Plans to be \$10 for a primary care visit and prescription drug copayments in the range of \$5 to \$10 per prescription. Many managed care plans vary copayments for pharmacy benefit according to the brand of drug ordered, with a lower copayment often required for generic drugs than for brand name medications. A recent news account highlights that those with other health-care options would, for example, face managed care plan prescription copayments of \$5 for generic drugs, \$15 to \$20 for a brand-name drug on a plan's formulary, and up to \$40 for a brand-name non-formulary drug (Wall Street Journal, January 12, 1999).

In the Committee's view, authorizing the Secretary to set reasonable copayment increases on prescription drugs is a reasonable policy in the face of VA's mounting pharmaceutical costs—approaching \$2 billion annually. Notwithstanding an aggressive pharmacy benefits management policy, VA's pharmacy costs have nearly doubled since copayments were instituted some nine years ago. In that regard, as VA's Under Secretary for Health noted in discussing prescription copayments at its May 19 hearing, VA has become a very attractive provider—particularly because of the availability of free or very low-cost prescription drugs—to numbers of veterans who have other health care coverage, notably Medicare. The insight of VA's Under Secretary for Health on this point, as reflected in a colloquy at a May 19 Subcommittee hearing, is illuminating:

Mr. STEARNS: Do you have any indication whether Medicare-eligible veterans are turning to VA for prescription drugs?

Dr. KIZER: I can't quantify it in precise dollars, but it is a generally recognized phenomenon that is occurring across the country and for very understandable reasons. It is a hell of a deal to go to the VA for your drugs. I would expect that it is in the hundreds of millions of dollars range.

As with pharmaceuticals, VA has faced dramatically increased costs in prosthetics, with an annual budget now approaching \$500 million. Since the enactment of Public Law 104–262, which eased restrictions on providing needed prosthetics, VA costs have been increasing at a rate of some 18 percent annually. VA is providing large numbers of veterans hearing aids, eyeglasses and other devices which would either not be covered under other health plans or would be subject to significant out-of-pocket costs under copayment or deductible provisions. In contrast, nonservice-connected veterans, receiving a benefit not previously available (other than as needed in connection with hospitalization), bear no cost. The bill authorizes the Secretary to establish reasonable copayments on sensori-neural aids (such as hearing aids and eyeglasses), electronic equipment, and any other item or equipment (other than a wheelchair or artificial limb) furnished for a nonservice-connected condition.

The Committee believes it is necessary that the Secretary implement the cost-sharing policy authorized in the reported bill. As the

VA health care system in many areas has been under strain to serve the many new nonservice-connected veterans who have sought care, and has sought authority to provide new services such as emergency care, it is unrealistic for it to pursue such policies without the assurance of offsetting revenues. The Committee seeks improvements in veterans' access to care and in the quality of that care. Section 201 provides a mechanism to help achieve those objectives.

The Committee notes that the Secretary has relatively broad discretion under section 201. In exercising that discretion, however, the Committee believes the Secretary should take into account the payments required of military retirees under the TRICARE program as well as practices under other health plans, while exercising caution that copayments not be set so high as to result in veterans not seeking needed care and services (particularly in connection with rehabilitative programs). The Secretary should also give consideration to revising the manner in which existing copayments, particularly on prescription drugs, are administered. The failure to require such copayments at the time drugs are dispensed to the patient is a major factor underlying the poor collections' record in this area. At a time that veterans with other health care coverage appear increasingly to seek VA care for prescription drugs, VA must give greater consideration to securing these payments.

The Committee notes as well that the cost-sharing provisions of the reported bill would enable VA to reassess prior policy regarding medications which have been viewed as "quality of life" drugs. The Under Secretary for Health has issued a policy regarding one such drug, Viagra, which is not included on the VA formulary. VA's policy poses the dilemma that such a drug may be denied to even a service-connected veteran for whom it may be prescribed to overcome a service-connected condition, while other Federal programs have authorized furnishing the medications. To the extent that VA policy has been based on, or influenced by, the high cost of this drug, the proposed new copayment authority would provide a foundation for the Secretary to set higher copayments for particularly costly "quality of life" drugs prescribed for the treatment of a non-service-connected condition.

While the current VA cost-sharing burden on care of nonservice-connected conditions of category A veterans is very low, the copayments applicable to routine treatment afforded so-called "category C" veterans is extraordinarily high. Under current law, such veterans are liable to pay an amount for each outpatient visit equal to 20 percent of the estimated average cost of an outpatient visit to a VA facility. The Committee understands that the current requirement under that provision subjects the veteran to a \$45 copayment, without regard to whether the patient is seen for a routine office visit or for ambulatory surgery. Notwithstanding that veterans who are liable for such copayments are deemed under law to be able "to defray the expenses of necessary care", this amount—in the case of routine office visits, in particular—may in many cases approach the full cost for the episode of treatment. Requiring so high a copayment for a routine, primary care visit appears to the Committee to be unreasonable. Section 201 of the reported bill would require the Secretary to establish a new copayment policy with respect to so-

called category C outpatient visits. The Committee recommends that the Secretary not set a single copayment amount, but consider practices within the health care industry to differentiate between primary care and specialty clinic visits.

Section 202 of the reported bill would establish a new fund in the Treasury for deposit of payments under section 201 and other specific categories of payments provided for under this act. Amounts in the fund would be available without fiscal year limitation (and without any requirement that such funds be specifically appropriated) for providing care and treatment to veterans. The Committee envisions that such payments would help in covering the cost of the new emergency treatment authority, opening new community-based clinics, and covering the increasing costs of drugs and prosthetics.

Military retirees

Section 104 of the reported bill addresses a longstanding concern regarding military retirees' access to medical care. With the downsizing and closure of military treatment facilities and other changes in DoD health care programs, many who made a career of military service have voiced frustration at what they view as a broken promise, an assurance of free medical care at military treatment facilities. Over the years, some retirees—eligible for government care as veterans—have turned to the VA. Historically, however, military retirees' career status and years of service have afforded them no special eligibility for VA medical care. Specifically, retirees who have no service-connected disabilities, have no other special eligibility status (such as is accorded former prisoners of war or those exposed to herbicides during the Vietnam War), and whose income exceeds the law's "means test" threshold have generally had limited access to VA medical services. This legislation reflects a recognition that the VA health care system can and should be an option for retirees who do not otherwise have a priority for VA care.

Congress has historically sought to maximize opportunities for closer coordination and sharing between the VA and DoD health care programs. With the enactment in 1982 of the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, Public Law 97-174, Congress established a framework to stimulate increased sharing of health care resources between VA and DoD in an effort to minimize duplication and underuse of those resources. That law sought to encourage medical facilities of the respective departments to provide services on a reimbursable basis to primary beneficiaries of the other department.

Congress expanded this concept further with the enactment in title II of the Veterans Health Care Act of 1992 of a provision authorizing VA to treat DoD beneficiaries as a subcontractor to DoD contractors. As the Subcommittee on Health learned in a field hearing in Boise, Idaho on June 30, 1998, the existence of a contract between a TRICARE contractor and a VA medical facility does not ensure that the contractor refers any patients to VA. Notwithstanding both repeated requests from VA to "activate" this con-

tract and the urging of the Chairman of the Subcommittee on Health, the contractor has not availed itself of VA's services.

In short, notwithstanding the mechanisms in law to expand interdepartmental sharing of health care resources and increased reliance on VA facilities to treat DoD beneficiaries, VA reports that TRICARE contractors have not made extensive use of VA as a provider. VA data for fiscal year 1999, for example, show that for the first six months of the fiscal year TRICARE reimbursements to VA facilities nationwide totalled only \$2.3 million.

This Committee recognizes that, with the implementation of the TRICARE program, the Department of Defense has established a national system that links the health care resources of the military services with networks of civilian health care professionals. All active duty members and their families, retirees and their families, and survivors who are not eligible for Medicare may participate in at least one of the three TRICARE options.

This legislation is not intended to damage the TRICARE program or to interfere with the Department of Defense's ability to maximize the use of military treatment facilities in order to provide cost effective services and support readiness training. The Secretaries of the Departments of Veterans Affairs and Defense shall take account of these requirements when negotiating the terms of the memorandum of agreement implementing this provision. Indeed, the number of those both eligible and likely to avail themselves of such benefits would not be large, in the Committee's view. Of the approximately 1.8 million military retirees, 54 percent are 65 or older, and thus not TRICARE-eligible, and accordingly, not eligible under this proposal. Some 218,000 of the approximately 885,000 TRICARE eligibles are disability retired, and thus already eligible for priority VA care. Another large cohort—estimated at almost 200,000—have compensable service-connected disabilities; they too, as well as a significant number of retired enlisted personnel whose income falls below the law's "means test" threshold, are already eligible for priority VA care. These retirees, all eligible for VA care under section 1710(a)(1) and (2), would not be covered by this provision. While the number eligible under this provision is estimated at less than 400,000, several considerations diminish the likelihood of widespread utilization of this benefit.

Only a fraction of retirees eligible for VA care live close enough to VA facilities to actually seek to use them. Of that number, the limitations associated with receiving care from VA under this provision may further diminish utilization among retirees, most of whom already have provider relationships under TRICARE. For example, the legislation would not give retirees' dependents access to VA care. The Committee believes that an individual with dependents would be somewhat unlikely to alter an arrangement where his or her family gets its care from a single plan to an arrangement where the retiree receives care from VA while the dependents get their care elsewhere. Similarly, the rules associated with enrolling for VA care would likely create disincentives that would diminish the likelihood that retirees would enroll in significant numbers. For example, a decision to enroll with VA for care is effective for only a single year at a time, and a retiree's priority for VA enrollment under this provision would still be relatively low. It would be some-

what unlikely, therefore, for a retiree to opt out of a care plan which provided satisfactory care to enroll with VA given that VA care might not be “open” to the retiree in the second or following years.

These considerations offer some basis for assessing the impact of this legislation on the TRICARE program. Not only would the numbers seeking VA care not be large, but it appears most likely that those who might seek VA care under this new mechanism would do so cautiously, given its potential for change in access from year to year. It would appear more likely, accordingly, that individuals participating in TRICARE Standard, for example, who have the option of choosing any physician, would elect to receive some services from VA under the reported bill, than for an individual who had been enrolled in TRICARE Prime to switch out of that plan altogether for a previously untested alternative. In light of these considerations, the Committee encourages the VA to limit its enrollment efforts on military retirees who participate in the TRICARE “Standard” and “Extra” options rather than on “Prime” enrollees.

This section directs the respective Secretaries to enter into an agreement to implement this provision. The agreement must make provision for reimbursing VA at rates to be negotiated by the Secretaries. The section also makes clear that VA may not enter into an agreement with DoD with respect to any VA network or part of a network unless the Department would recover the costs of providing care to military retirees under this section, and unless VA has certified and documented (and so reports to Congress) that it has the capacity to provide such care in such areas.

This section includes a provision which permits reimbursement under the memorandum of agreement to be made by the Secretary of Defense or by a Department of Defense TRICARE Managed Care Support contractor. This provision is intended only to minimize disruptions in the management of the Department of Defense TRICARE Managed Care Support Contracts, by providing a mechanism to avoid instituting a bid price adjustment to these contracts. This provision is not intended to replicate or in any way interfere with any arrangements the managed care support contractors may already have with VA treatment facilities participating as network providers in the TRICARE managed care networks.

The Committee contemplates that the implementing VA-DoD agreement would include other provisions needed to effectuate the purposes of the section. Among these are provisions which the Committee believes would be necessary to ensure ongoing health care coverage for retirees. Under law, VA can offer a veteran an opportunity to enroll for only a year at a time (subject to the possibility that resource limitations in the following year might not permit re-enrollment). The Committee urges that provision be made in the implementing agreement to address that contingency to ensure that a retiree who elects to receive care from VA under this section is not precluded from subsequently re-enrolling for TRICARE coverage in the event that a funding shortfall precludes VA from re-enrolling the individual in a subsequent year.

The section also provides for a phased implementation process, given existing DoD TRICARE Managed Care Support Contracts. Thus, the enhanced priority afforded certain military retirees

under section 104 would take effect in any area of the country only if that area is covered by a TRICARE contract which is entered into after the date of enactment or by an existing TRICARE contract, the terms of which have been extended after the date of enactment. The measure also directs DoD to include in each TRICARE contract entered into or extended after the date of enactment provisions to implement the required VA-DoD agreement.

Pilot program for veterans' dependents

Section 106 of the reported bill would authorize the Secretary to carry out a three-year pilot program in up to four of VA's networks to provide primary care services (subject to reimbursement) to dependents of veterans.

As this Committee works to maintain and strengthen an independent health care system for America's veterans, it has from time to time identified untested ideas, and where they have merit, proposed time-limited programs or pilot programs. Last year, representatives of The American Legion urged the Subcommittee on Health to consider authorizing a pilot program targeted at veterans' dependents. It proposed that such an initiative could benefit the VA health care system. In the Legion's view, it could bring VA new revenues, helping to meet the goal of the Under Secretary for Health that ten percent of VA health care revenues come from non-appropriated funds. It could improve the effectiveness of existing programs—such as women's clinics—by increasing utilization, and hence quality, of such services. And it could help sustain the health of veterans as their caregivers receive good care.

VA treatment of non-veterans, with appropriate safeguards to avoid displacing veterans, is no longer a remarkable phenomenon. Under provisions of law in effect since 1992, numbers of VA facilities provide treatment to DoD dependents, including children. Under the CHAMPVA program authorized under section 1713 of title 38, United States Code, dependents and survivors of certain veterans are eligible for care under a program modelled on the former Civilian Health and Military Program of the Uniformed Services (CHAMPUS). Significantly, section 1713 provides that in "cases in which Department medical facilities are equipped to provide the care and treatment," VA may treat these patients in VA facilities. A number of facilities which have the capacity provide such care directly. Still other VA facilities provide services ranging from primary care to diagnostic studies to non-veterans under so-called "sharing" agreements. The revenues from such sharing agreements and TRICARE contracts help support the treatment of veterans.

Section 106 proposes a pilot to permit VA managers to test the concept of treating certain veterans' dependents. To help foster the success of this proposal, the measure provides specific direction on where such programs should be mounted. In contrast to other pilot programs authorized or directed in law, section 106 includes no requirement for siting this initiative in geographically-dispersed locations. Of more significance regarding this proposal, the Committee notes the variability from network to network and facility to facility in VA's capacity to enroll (and provide services to) additional primary care patients (without displacing or delaying care to veter-

ans) and in VA's success in billing and collecting from third-party payers. Both elements would be critical to the pilot's success, and should therefore be key elements in selecting the participating networks. By way of further clarification, the Committee does not envision that the pilot would necessarily be mounted throughout an entire network. More likely, the program might start at limited numbers of facilities, and if successful and deemed feasible, might be expanded within a participating network during the program period. The measure reflects a preference for selecting facilities for participation which operate women veterans' clinics. While the existence of such a clinic would not be a requirement for participation, giving priority to such facilities, particularly for the start-up phase, would help realize the pilot's potential. In establishing that priority, the Committee underscores its intention that the operation of this program reflect fiscal prudence. In that regard, the Committee envisions that, to the extent possible, the costs of providing such services will be on the margin (adding new patients without employing additional staff, for example), and that the program will be administered so that VA not "lose money". The Committee seeks to avoid a situation where the medical care appropriation substantially subsidizes dependents' care. To that end, the measure provides for GAO monitoring, to include determining whether the collection of reasonable charges reasonably covers the marginal costs (as applicable) of providing care and services.

The Committee recognizes that unlike veterans who are liable only for a portion of the cost of their VA medical care, dependents under this measure must agree to pay an amount representing VA's reasonable charges for that care as determined by the Secretary. (In that regard, the Committee believes that participation in the pilot program should be limited to individuals who have health care coverage, and expects VA to take measures (to include verification with the carrier) to ensure the person has health coverage.) In order to maximize VA's recoveries from such health plans, the Committee envisions that VA's reasonable charges under this bill will be the same as those utilized for third party health-plans under section 1729 of title 38.

In considering the issue of balance billing to dependents (their remaining liability after payment by their health-plan), the Committee notes that individuals in the private sector are often protected against such personal liability by provider agreements which compel the provider to accept the plan's payment as payment in full. Furthermore, under section 1729 of title 38, United States Code, as well as this bill, health plans are protected against VA charges that they can demonstrate are above the amount they usually pay for such services in the private sector.

VA is unlike private sector providers who often negotiate agreements with health-plans that eliminate balance billing to the patient. VA's authority to collect from health plans and patients is statutory, not contractual. Thus, with respect to the issue of balance billing, insured dependents could be placed at a disadvantage when obtaining medical care from VA. The Committee envisions that the Secretary will give consideration to issuing regulations that minimize or eliminate that disadvantage to dependents. The Committee also envisions that the Secretary's regulations will ad-

dress appropriate adjustments to VA's charges to a dependent in instances where, for example, the dependent's plan denies coverage.

PROGRAM ADMINISTRATION

Enhanced-use Leasing

One of the tools the Committee contemplates VA would deploy in carrying out enhanced services programs under section 107 is long-term leasing under subchapter V of chapter 81 of title 38, United States Code. Congress, in Public Law 102-86, authorized VA to enter into long-term (up to 35 years) agreements—which it termed “enhanced-use leases”—under which VA could permit development of non-VA uses or activities on VA property, provided that such uses are not inconsistent with VA's mission and the overall objective of the lease enhances a VA mission. The measure authorizes VA, in return for the lease, to accept any combination of monetary consideration, services, facilities or other benefits deemed to be “fair consideration”.

Enhanced-use leasing has offered VA an opportunity to benefit from capital assets that the agency is not using to provide care or services to veterans. This authority has permitted VA to partner with private sector enterprises to develop new uses ranging from child care centers to cost-effective laundry, energy generation, and parking projects. One medical center at Indianapolis will lease a facility to a private nursing home which will provide discounted care to veterans among its other patients.

The Committee believes, however, given the capital resources at VA's disposal, that long-term leasing could be used even more extensively to enhance health care delivery to veterans. VA estimates that it owns and operates a physical plant of more than 22,000 acres of land, 4,700 buildings, and 140 million square feet of owned or leased space at more than 1200 sites. Exactly how much of this plant is necessary for mission-critical service delivery is unknown. However, in its March 10, 1999 testimony to the Subcommittee on Health, the General Accounting Office estimated that VA spends approximately a quarter of its appropriated dollars on asset ownership—much of it on “underused and inefficient buildings”.

In its budget for VA for fiscal year 2000, the Administration proposed legislation under which VA would “sell, transfer, or exchange excess and underutilized properties” in up to 30 locations. The Administration failed to submit such legislation, and its assumptions remain unclear to the Committee. Although VA developed some considerable experience and sophistication in long-term leasing and associated development of VA property, VA has little or no experience in sale or other disposal of its capital assets. Moreover, it is not at all clear to the Committee that the Administration's goals in proposing such authority—to generate revenue from unneeded VA capital assets, and apply such revenue to improve VA care—cannot be realized through long-term leasing arrangements similar to those VA has successfully employed under its existing authority. The reported bill, in section 207, would expand VA's leasing authority to accomplish that goal.

Accordingly, the key elements of section 207 would make several changes to VA's enabling law on enhanced-use leasing. First, it would extend the maximum term of leasing from the current 35 years to 75 years. The Committee understands that the current 35-year maximum term is at variance with standard commercial lending practices, and even with the requirements of other Federal agencies. Based on expert advice, the Committee believes that extending the maximum term to 75 years would enable VA to tailor leases to real property development practice, market consideration, and thus realize maximum benefit to VA.

The measure would also provide the Secretary the latitude to enter into such a long-term lease—not simply to enhance VA property with an activity that contributes to the VA mission—but to realize the broader goal of improving services to veterans in the area. That is, this leasing authority could be used to accomplish the purpose described above—to generate revenue from unneeded VA capital assets, and apply such revenue to improve VA care. To that end, section 207 would require a finding, based on a business plan, that applying the consideration under such a lease to the VA's provision of medical care and services would result in a demonstrable improvement of services to veterans in the network in which the property is located. To assure such an outcome, section 207 also calls for depositing any funds VA receives from a lease under subchapter V, of chapter 81 of title 38, United States Code, into a new fund (to be used for furnishing VA medical care and services as authorized under chapter 17) established under section 202 of the reported bill.

The measure would also amend existing law (title 38, United States Code, section 8162(b)(4)) which limits VA to using medical care monies to fund any costs associated with leasing under that section. Section 207 of the reported bill would permit VA to use minor construction funds as needed under the terms of these leasing arrangements. This provision would give the Department additional flexibility to allocate funds so as to provide the greatest benefit or return.

While the Committee believes section 207 would be beneficial in enabling VA to reinvest savings from unneeded property into improved health care delivery, it does not contemplate that such leasing authority would be used to “privatize” the very services VA is currently providing at a facility. The Committee will monitor the implementation of this authority to ensure it is not used for such purpose.

Bed Closure Reporting

The Committee has become increasingly concerned over the impact that closing inpatient beds is having on veterans with complex health problems which may require ongoing, costly care (such as psychiatric care, intensive rehabilitation, and subacute care for other chronic conditions). Over the years, VA has developed special expertise in these areas. It is not clear, however, that the steady transformation of VA health care from a bed-based model to reliance on ambulatory care is taking adequate account of such special patient needs. With the accompanying decentralization of authority to 22 network directors, and mere consultant role played by clinical

experts in VA's headquarters, the Committee lacks a satisfactory mechanism to monitor the impact of these changes on VA patients or to be assured that the special needs of often voiceless patients are being met despite bed closures.

Information from direct care providers and veterans calls into question whether adequate steps are being taken from network to network to ensure that the clinical expertise which had resided in VA's inpatient mental health and rehabilitative care units is available to veterans who must now depend on community and ambulatory programs. One troubling indicator—a declining number of so-called “dual diagnosis” patients being treated for both substance abuse problems and mental illness—suggests that the answer to that question is “no”. With their multiple needs for resource-intensive, specialized care, these veterans present a special challenge. A decline in the number of these patients suggests that system changes may be causing some of VA's most-in-need patients to “fall between the cracks”.

Section 301 would establish new reporting requirements associated with certain proposed bed closures. This provision is not intended to proscribe bed closures but to institute what the Committee believes is a needed safeguard. The Committee is not opposed to well-planned alternatives to inpatient care. The Committee has found Intensive Psychiatric Community Care programs operating at more than twenty VA medical centers to exemplify a well conceived, cost-effective alternative to inpatient care. What is troubling, however, are closures of specialized inpatient beds which are undertaken simply to avoid costs and without developing adequate alternatives.

The Committee is pleased that VA has outlined a plan to manage more aggressively its mental health programs. Aware of the pressures its field managers now face in managing costly care under fiscal restraints, the Under Secretary reported on plans to direct field managers to report any significant changes in behavioral health program operations to his office for approval. This would be a welcome intervention and could diminish the need for Congressional reports in the future.

Sexual Trauma Counseling

On April 23, 1998, the Subcommittee on Health of the Committee on Veterans' Affairs, held a hearing at which it heard testimony on the VA's sexual trauma counseling program. Witnesses at the hearing included officials from VA, the Department of Defense (DoD), the General Accounting Office (GAO) and AMVETS, a national veterans' service organization; Vietnam Veterans of America also submitted testimony.

In providing testimony assessing the program, GAO found that VA has made impressive headway since implementing the program in 1993. In particular, GAO cited VA's extensive efforts in educating staff to deal with sexual trauma and in performing outreach that has produced significant program growth. Witnesses attested to the need for the program. VA testified that between 15–20 percent of women veterans reported being raped or sexually assaulted during military service, while 35–50 percent reported sexual harassment of some sort. In 1995, DoD reported that 55 percent of

women in service claimed at least one incident of sexual harassment in the past year. GAO reported that symptoms experienced by sexually-traumatized women include post-traumatic stress disorder, stress, impaired concentration, and nightmares.

In recognition of the ongoing need for VA to provide these services, Congress, in Public Law 105-368, extended the program for three years through December 31, 2001. With the “benefit” of an additional year’s perspective, however, the Committee has concerns as it relates to this program regarding the uncertainty and potential inadequacy of funding for the coming fiscal year. With the possibility of a serious funding problem, the Committee is concerned that VA might consider scaling back or even ceasing to provide sexual trauma counseling. Based on its reading of similar provisions of law, VA could construe the program to be “merely discretionary”. Clearly, this is not the intent of the Committee, and, accordingly, the reported bill would provide both that VA “shall” operate this program and that the program be extended for an additional year.

Questions have also arisen over the course of the program as to the scope of eligibility for this benefit. The VA’s General Counsel addressed those questions in a precedent opinion of July 1, 1997 (VAOPGCADV 17-97). Among its holdings, the General Counsel concluded that “[b]ecause VA provides sexual trauma counseling and care pursuant to title 38, United States Code, section 1720D only for sexual trauma-related disabilities which the Department determines are incurred in service, the minimum length of service requirement in section 5303A does not apply to the provision of these benefits.” In light of that precedent, with which the Committee concurs, there is no need to amend section 1720D, as some advocates have suggested, to provide specifically that the two-year service requirement in section 5303A does not apply. As regards another facet of that decision, the Committee has seen only minimal information regarding the scope of any similar problems in the reserve components of the armed forces. The reported bill, accordingly, calls on VA to conduct a study regarding the extent of such problems in the reserves, the extent to which former reservists have sought sexual trauma counseling from VA, and the resource implications associated with expanding eligibility for such counseling to former members of the reserves.

Under current law (section 1720D of title 38, United States Code), VA, in addition to providing counseling, may provide appropriate care and services to a veteran for an injury, illness, or other psychological condition that VA determines to be the result of a battery, assault or sexual harassment. In general, section 1720D provides authority for mental health care; the scope of practice under that provision is limited in nature. It is not a general treatment authority and does not enlarge the scope of treatment VA is otherwise authorized to provide an eligible veteran. Section 108 of the reported bill would not enlarge the scope of VA’s treatment authority under section 1720D or permit VA to change the scope of its practice under that section.

Compensated Work Therapy Program

The Compensated Work Therapy Program (CWT) is a therapeutic program which VA employs in the rehabilitation of veteran-

patients. Veterans are paid for work performed on contracts with governmental and industrial entities. This work-based model helps veterans re-enter the work force while enabling them to increase self confidence and improve their ability to adjust appropriately to the work setting. VA data indicate that some 85 percent admitted to the program have substance abuse problems; 56 percent are homeless, and 44 percent have been diagnosed with major psychiatric disability. The program has enjoyed success in assisting these often challenging patients in making the transition from medical settings into the community by developing the capacity for work and increasing their self-esteem.

Over 13,000 veterans were treated in 100 different CWT programs throughout the country in fiscal year 1997. These veterans earned over \$29 million for work performed on more than 3,100 contracts. The traditional CWT setting was in the nature of a sheltered workshop environment at the VA medical center. Work may range from simple collating tasks to fabrication of elaborate electromechanical subassemblies or machine shop operations using technologically sophisticated equipment. VA employs a second model, in the nature of a "transitional work experience," in which participants work at industry sites (including VA medical centers and other Federal agency settings). The latter mode has proven highly effective in helping veterans transition to full employment.

The Committee has become aware that as the "transitional work experience" component of the program has grown, more program participants are placed at risk of work-related injury for which they can receive no compensation. Although the Committee is not aware of the occurrence of any such on-the-job injuries, the risk is very real with therapeutic work opportunities being provided in manufacturing settings, at construction sites, and at other locations having inherent risks.

In the event of work-related injury while participating in a CWT program, participants are not entitled to any workers' compensation benefits. As participants in a CWT program, veterans are not considered "employees" of either the United States, or of the private entity where they may work. Rather, their status is as patients and the work they are performing is a form of medical treatment. To ensure that these participants in the work therapy program are protected financially in the event of work-related injury, the reported bill would make them eligible for compensation benefits under title 38, United States Code, section 1151 without regard to whether the injury was the result of negligence.

In proposing to provide CWT participants with such financial protection in the event of injury, the Committee is proposing the same remedy as Congress took three years ago in an analogous situation. In that instance it provided such protection to participants in VA's Vocational Rehabilitation Program. Under that program, as under the CWT program, participants work in community settings where they are at risk for injury. In 1996, Congress provided that veterans injured while working in the vocational rehabilitation program could receive compensation benefits under title 38, United States Code, section 1151 without regard to whether the injury was the result of negligence. The reported bill would provide the same coverage to CWT program participants.

Licensure of health care professionals

The law governing the qualifications of physicians, dentists, and most other categories of health care practitioners employed by the Department of Veterans Affairs currently requires, with respect to licensure, that a VHA practitioner have a full, active, and unrestricted license (registration or certification, as applicable) in a state. The law does not require these practitioners (except social workers) to be licensed in the state in which they work for the Department. Historically, such flexibility in VHA's employment qualifications has permitted the Department to assign and transfer its health care professionals throughout the nationwide system as needed to meet changing staffing requirements.

The Committee has become aware, however, that this particular flexibility can, in the rare instance, lead to an undesired result. A VHA health care professional who is licensed (registered or certified) by more than one state remains qualified for VHA employment even when one of those licenses is terminated for cause as long as the individual maintains other active, full, and unrestricted license. In contrast VHA health care practitioners licensed in only one state automatically become ineligible for VHA employment in the event their license is terminated for cause.

Section 208 of the reported bill would make any practitioner who is licensed to practice in more than one state ineligible for VHA employment if the practitioner has or had one of those licenses terminated for cause. It would further make a practitioner ineligible for VHA employment if the practitioner licensed by more than one state voluntarily relinquishes one of those licenses upon learning that it may be terminated for cause.

The Committee has a long record of concern regarding issues of care-quality in the VA, and believes this provision is needed to ensure patient safety and quality of care.

Chiropractic care

Disabling back pain is a prevalent health problem in the United States. "Back pain is one of the most frequent reasons that patients visit primary care physicians and is the second most common reason for time taken off from work." (Carey TS et al. *New England Journal of Medicine* 1995;333:913-7). A 1997 survey of U.S. adults found that 11 percent of U.S. adults chose chiropractic treatment (principally for low back pain); on average, they visited chiropractors ten times per year (Eisenberg DM et al. *Journal of the American Medical Association* 1998;280:1569-75). Back problems were not only the most frequently reported health problem (24.0 percent), but also a problem for which a large proportion of patients (47.6 percent) used "alternative" therapy. Thus, while still an "alternative" therapy, chiropractic is also becoming "mainstream" (Cherkin DC, Mootz RD. Agency for Health Care Policy and Research. 1997).

While still controversial, substantial scientific evidence supports the use of chiropractic treatment of low back pain. ". . . [T]here is as much or more evidence for the effectiveness of spinal manipulation as for other non-surgical treatments for back pain" (AHCPR 1997). "That spinal manipulation is a somewhat effective symptomatic therapy for some patients with low back pain is, I believe,

no longer in dispute" (Shekelle PG. *New England Journal of Medicine* 1998;339:1074–5). The effectiveness of chiropractic manipulation has been most clearly demonstrated in the acceleration of short-term recovery from acute low back pain. In addition, several studies indicate that patient satisfaction in the relief of low back pain is as great or greater with chiropractic than with other approaches, even when volunteer patients are randomly assigned to a treatment approach.

In 1995, the annual national cost attributable to back pain was \$25 billion for medical services alone. A 1997 survey indicated that approximately 56 percent of chiropractic services in the U.S. were completely or partially covered by insurance (including Medicare and Medicaid), a proportion that grew substantially since the prior survey in 1990. Perhaps because of the frequency of visits incurred, chiropractic treatment of low back pain has generally been found to be more expensive than primary care treatment, but comparable to treatment by orthopedic surgeons (Carey et al. *New England Journal of Medicine* 1995;333:913–7).

In 1985, Congress required the VA to conduct a pilot program "to evaluate the therapeutic benefits and cost-effectiveness of furnishing certain chiropractic services to veterans eligible for medical services . . ." (Public Law 99–166). Unfortunately, as indicated in the program evaluation report (Department of Veterans Affairs, 1990), the law restricted the patient population to a small and unrepresentative fraction of the low back pain patients. Further, it did not cover the cost of the range of standard chiropractic services; thus, it did not represent standard chiropractic methods. Participation criteria were so restrictive that, during the course of the pilot program, three of ten VAMCs had to drop out of the program because they could not recruit sufficient numbers of patients. While the study design projected a study population of 700, only 204 patients finished the study, and recruitment of these patients required more time than provided by law. Furthermore, because patients were allowed to choose a therapeutic approach (i.e., usual VA care or chiropractic care) and were not randomly assigned to one treatment or the other, the pilot program could not effectively evaluate the therapeutic benefits of the chiropractic approach, as required by the law. Notwithstanding its limitations the pilot program suggested that patients with chronic, recurrent, unresolved low back pain had similar outcomes whether treated under medical or chiropractic approaches. However, it raised questions about cost-effectiveness in that treatment costs over a three-month period were greater with the chiropractic manipulation than with (out-patient) medical treatment.

The Committee recognizes the growing use of complementary health care in traditional medical practice, and notes that, despite the above-described medical literature, VA has made only the most limited use of chiropractic care.

In recognition of evolving medical practice, section 304 of the reported bill would require VA to establish a policy which would permit greater access to chiropractic care, particularly in rural and medically underserved areas. VA should consult with Doctors of Chiropractic to assist VHA in the development and implementation of its chiropractic treatment policy.

Nonprofits corporations to foster education

Under a provision of Public Law 100-322, VA has established nonprofit research corporations at 73 VA medical centers to accept and administer gifts and grants to carry out clinically-relevant research. The corporations have played a significant role in support of the VA research program. In 1998, for example, they received \$100 million for VA research activities, funds which would not otherwise have been available to VA. The Committee views these corporations as an extremely important mechanism to further VA's research mission.

Given this proven mechanism for administering grants and other funds, the Committee finds merit in expanding the ambit of such corporations to further VA's responsibilities in the area of medical education. That is, just as the nonprofit corporation has proven a flexible funding mechanism for research, the Committee supports the creation of new corporations, or the expansion of existing ones, to administer gifts and grants for appropriate educational purposes. Under such a mechanism, VA can readily avail itself of funds to support continuing medical education needs of its employees (which VA itself may not have sufficient funds to support), such as training, and related travel, for technicians in the use of new medical equipment. The National Association of Veterans' Research and Education Foundations estimates its member corporations could reasonably expect to receive some \$15 to 20 million annually in support for such VA-approved activities.

Assisted Living

The June 1998 Report of the Federal Advisory Committee on the Future of VA Long-Term Care, *VA Long-Term Care at the Crossroads*, noted that assisted living programs might be an appropriate and cost-saving option for VA patients. The report also noted that VA financial support of assisted living is not authorized by law. The Committee recommended that the VA "... take advantage of this remarkable development in selected long-term care markets." The report acknowledged, however, that the term "assisted care" was not well defined in terms of even its most basic characteristic, i.e., the care provided.

In response to the Chairman's questioning regarding the Federal Advisory Committee report at the Subcommittee's April 22 hearing, VA Under Secretary for Health Dr. Kenneth Kizer released a draft document entitled "A Strategic Plan for Long-Term Care Provided by the Veterans Health Administration." Addressing the issue of assisted living as a VA program, the plan proposed in one brief statement to "initiate a request for new legislative authority for payment or copayment of facilitated residential living (assisted living) for eligible veterans." The plan included no information regarding VA choices among the wide range of assisted living program options currently available in the U.S. or the processes by which the VA would conduct a program appropriate for its user population.

A recent GAO report (GAO/HEHS-99-27), *Assisted Living. Quality-of-Care and Consumer Protection Issues in Four States*, notes that "there is no uniform assisted living model, and considerable variation exists in what is labeled as assisted living facility." For

example, almost all programs provide housekeeping, meals, laundry; fewer programs provide special diets, supervision of medication and transportation; still fewer programs provide skilled therapy, hospice, skilled nursing, iv therapy, and tube feeding. Further, while some facilities provide for the increasing needs of their clients, others require that clients whose needs exceed staff capacities be immediately discharged. Skill level requirements for staff in assisted living facilities also vary by state. The GAO report notes that many assisted living facilities do not provide prospective clients with information on services and policies adequate for informed decisions about those facilities. The GAO survey of 622 facilities in four states found a range of monthly charges from less than \$1,000 to more than \$4,000, probably associated with differences in services provided. Medicaid funds are used to support assisted living programs in some states and could offset support which might be provided for veterans.

States also differ substantially in their requirements and regulation of assisted living programs (GAO/HEHS-97-93; GAO/HEHS-99-27). For example, frequencies of required inspection vary by state and by level of services offered. The GAO report notes three topics variously specified under state regulations, i.e., requirements for the living unit, admission and retention, and the types and levels of services provided. It found that 27 percent of the facilities surveyed were reported to have five or more noteworthy problems in client care during the survey period (including inadequate care, insufficient staffing, medication errors, abuse, and improper discharge).

In the Committee's view, VA must explore and resolve a series of issues before it could reasonably request Congress to enact legislation to enable it to provide support to veterans in need of assisted living services. Among these complex issues are the following.

1. *Services offered.* The VA must specify for purposes of such a benefit what "assisted living" means and what minimal services must be provided.
2. *Eligibility criteria.* The VA must determine what degree of functional impairment would establish a need, and eligibility, for assisted living services.
3. *VA role.* The VA must consider the nature of such a program, whether, for example, it would (a) be limited to VA's providing partial payment to or on behalf of a veteran who makes his or her own arrangements, (b) involve VA's planning and approving the particular placement, or (c) VA's contracting for a time-limited placement. In that regard, VA must consider the extent to which it would oversee the operation of the facility and establish requirements which might exceed those established by some states.

If the above questions can be satisfactorily resolved, VA must also address complex financing questions, central to design of any legislative proposal. The Committee notes that neither the Department or program officials have resolved or even fully addressed these questions. The reported bill, accordingly, directs the Secretary, by way of exploring the feasibility of an assisted living pilot program, to address the above and other related questions and to

report to Congress. The bill envisions receipt of a report by next April, providing sufficient time for Congress to consider the merits of any proposed legislation in the next session.

Construction authorization

In Public Law 105-368, the Committee authorized funding for fiscal years 1999 and 2000 for several major construction projects. Funds were not appropriated for several of these projects, of which the following had been identified as high VA priorities: an ambulatory care addition in Washington, DC; seismic corrections in Palo Alto, CA; a spinal cord injury unit in Tampa, Florida; and a mental health addition in Dallas. Although the Administration has not requested appropriations for these projects (and instead proposed two new projects in its budget request for fiscal year 2000), each is identified in the VA's Capital Plan for fiscal year 2000 as a pending proposal and three of the four were recommended by VA for funding in fiscal year 2000. The Committee believes these projects are needed, and continues to recommend that they be funded. With the compelling need for a large increase in medical care funding for fiscal year 2000, and a list of needed, but still-unfunded construction projects "in the queue", the Committee is reluctant to recommend that additional funds be appropriated for more than a single additional major construction project this year. The Committee would authorize funding for construction of new surgical space at the VA Medical Center in Kansas City, Missouri, as the highest-ranked VA project on which construction could begin if funds were made available. This recommendation is made without prejudice to consideration next year of VA's proposal to renovate psychiatric-care facilities in Murfreesboro, Tennessee.

SECTION-BY-SECTION ANALYSIS

Section 101(a) would amend chapter 17 to add a new section 1710A. That section would direct VA, subject to the availability of appropriations, to operate and maintain a program to provide extended care services to eligible veterans. The measure specifies in new subsection (a) that extended care services range from geriatric evaluations to nursing home care, and include noninstitutional alternatives to nursing home care. New section 1710A(b) would provide that the Secretary shall provide those services as needed to 50 percent or more service-connected veterans and service-connected veterans requiring such care for a service-connected condition. Those two categories of veterans would also have highest priority for placement in a VA nursing home. New section 1710A(c)(1) would require VA to prescribe regulations for additional specified priorities for nursing home placement. New section 1710A(c)(2) would provide that VA may not furnish extended care services for more than 21 days in any year (other than to those two classes of service-connected veterans described above) unless the veteran agrees to pay a copayment. New section 1710A(d) would describe the methodology VA is to employ in establishing these copayments. New section 1710A(e) would establish an extended care revolving fund in the Treasury.

Section 101(b) would require VA to develop and begin to implement a plan to increase (above the level provided as of September 30, 1998) the level of services and options available, and extent of the budget, for furnishing home and community based care to eligible veterans.

Section 101(c) would amend current law to lift the six-month limitation on provision of adult day health care services.

Section 101(d) would amend current law to lift the limitation that respite care services must be provided in VA facilities, and would authorize VA to contract for provision of respite care.

Section 101(e) would amend current law to condition VA's obligation under law to provide extended care services to the availability of appropriations.

Section 101(f) would amend current law to authorize VA to establish a program of per diem payments to State homes for noninstitutional care services and respite care (as well as adult day health care, authorized under current law).

Section 101(g) would state that the provisions of the section would be effective on the day of enactment, except that the copayment requirements under new section 1710A(c)(2) would be effective on the effective date of the regulations establishing those copayments; subsection (g) would also provide that the current copayment requirement on provision of nursing home care to so-called "category C" veterans would cease to be effective as of the date of those new regulations.

Section 102 would authorize, but not require, VA to make payments (at levels VA would establish) for emergency care on behalf of certain veterans. VA could make such payments for a veteran who meets the following criteria: the veteran is described in paragraphs (1) through (6) of section 1705(a); is enrolled in, and has received VA care within the year preceding the emergency treatment; has no health insurance (comprehensive or limited) or any other entitlement to health care; is personally liable to the provider for emergency treatment (as defined) and has no other recourse against a third party which would even partially extinguish the veteran's liability. The measure would grant VA broad authority to limit the amount and circumstances under which reimbursement would be paid (to include the availability of appropriations therefor); and would provide that VA payment to a provider, unless rejected, would extinguish any liability on the part of the veteran. The measure would also establish that the government has an independent right to recover any amount which a third party subsequently pays to the provider, and would provide means to ensure that the government can effect such recovery. Lastly, it would authorize the Secretary to waive recovery of a payment made to the veteran.

Subsections (b), (c), and (d), respectively, of section 102 would make conforming amendments, establish an effective date for the section 180 days after enactment of the act, and provide for reports on implementation.

Section 103 would amend current law to establish specific eligibility (and a priority for enrollment) for VA health care for a veteran who was injured in combat (as that term is defined).

Section 104(a) would amend current law to establish specific eligibility (and a priority within so-called “category A” for enrollment) for VA health care for a veteran who has retired from active military service, is eligible for care under the TRICARE program, and is not otherwise eligible for VA care under “category A”.

“Section 104(b) would require VA and DoD to enter into an implementing agreement not later than nine months after enactment under which DoD would reimburse VA at rates to be agreed upon by the Secretaries. (If the Secretaries are unable to reach agreement, they are to report jointly on the reasons therefor and on a plan for removing any impediments to final agreement.) The section further provides that VA may not enter into an agreement to provide care to military retirees under this new authority in any network or facility unless VA would recover its costs of providing such care and has certified and documented that it has the capacity to provide such care.

Section 104(c) would provide for VA to deposit such DoD payments in a new fund established under section 202.

Section 104(d) would (1) require the Secretary of Defense to include in each TRICARE contract entered into after the date of enactment provisions to implement the VA-DoD agreement under section 104(b), and (2) provide for phased implementation of the pertinent provisions of section 104.

Section 105 would amend section 1151(a)(2) of title 38, United States Code, to establish entitlement to VA compensation in cases in which a veteran who is disabled or dies as a result of participation in the compensated work therapy program under section 1718 of that title.

Section 106(a) would amend current law to authorize VA to conduct a three-year pilot program in up to four of its networks under which it could provide health care services (as defined) to dependents of enrolled veterans.

Section 106(b) would provide for the General Accounting Office (GAO) to monitor and report on the conduct of the pilot program, and for VA to take such appropriate remedial steps as necessary in light of GAO recommendations.

Section 107 would provide for the establishment of enhanced service programs (described in the section) in designated locations in order to improve access and quality of service provided to veterans in such locations. Subsection (a) makes findings of fact relating to the requirement to establish such programs.

Subsection (b) would describe the circumstances under which the VA would designate a location for such a program.

Subsection (c) would establish the requirements for development of a plan for such an enhanced service program, and would provide VA tools for implementing such a plan (to include contracting (as further authorized in subsection (g)), and long-term leasing authority. Subsection (d) and (e), respectively, would establish protections for employees who might be displaced under this section and a re-

quirement that veterans' organizations, employee unions, and others participate in the development of a plan.

Subsection (f) would establish a reporting requirement to provide for congressional review before implementation of the plan.

Subsection (h) would require that 90 percent of the funds that would have been used to maintain and operate a facility (or a part of a facility) for a service or services which (under an enhanced services plan) would no longer be provided at such facility are to be made available to implement the plan to enhance accessibility and quality of services in the catchment area of that facility.

Subsection (i) and (j), respectively, would provide that this section does not alter the Secretary's obligations under title 38, United States Code, section 1706(b), and would provide that VA is to report to Congress within 12 months of implementing any plan under subsection (b).

Subsection (k) would provide that the section does not diminish the Secretary's authority to consolidate or otherwise change functions or missions at VA facilities, or create new facilities or activities.

Section 108(a) and (b) would amend current law to extend by one year VA's authority to provide sexual trauma counseling, and to provide that the VA "shall" operate such program during that period. Section 108(c) and (d), respectively, would require VA to expand its efforts to conduct outreach on the program, and to report on those expanded activities.

Section 108(e) would require VA to conduct a study relating to the need for and resource implications of expanding eligibility for such counseling to former members of the reserves. Section 108(f) would require a VA-DoD report on their joint efforts to inform separating servicemembers about these programs. Section 108(g) would require VA to provide a one-time report to Congress on veterans' use of services under the program.

Section 201(a) would amend current law to authorize VA to prescribe regulations to (1) increase prescription copayments (and to establish a maximum annual payment applicable to an individual with multiple outpatient prescriptions), (2) to establish copayment requirements (subject to the limitations in title 38, United States Code, section 1722A(a)(3) on VA's provision (for a nonservice-connected condition) of hearing aids, eyeglasses and other sensori-neural devices; electronic equipment; and any other costly item or equipment (other than a wheelchair or artificial limb). Such payments are for deposit in a fund to be established under section 202.

Section 201(b) would amend current law to direct VA to prescribe by regulation new copayment requirements applicable to providing outpatient treatment to a so-called "category C" veteran.

Section 202 would establish a new fund in the Treasury for deposit of specific categories of payments provided for under this act, with amounts in the fund to be available without fiscal year limitation (and without any requirement that such funds be specifically appropriated) for provision of care to veterans under chapter 17 of title 38.

Section 203 would add a new section 1729C in title 38, United States Code, which would establish a Veterans Tobacco Trust Fund in the Treasury to hold monies that are appropriated, credited, or donated to this trust fund. The measure would provide that monies (attributable to VA costs) recovered from any lawsuit brought against the tobacco industries by the United States in an effort to recover Government costs of tobacco-related health care are to be credited to the trust fund. Amounts in the trust fund are to be available to the Secretary of Veterans Affairs after fiscal year 2004 for use in providing medical care and services for tobacco-related illnesses. This trust fund would also provide monies to conduct medical research, rehabilitation research, and health systems research with particular emphasis in relation to tobacco addiction and diseases associated with tobacco use.

Section 204 would amend current law to expand the scope of activities which could be carried out by nonprofit corporations at VA medical facilities to include activities in support of VA's education missions.

Section 204(a) would authorize establishment of corporations to facilitate either or both research and education, and authorize existing corporations to so expand their charters.

Section 204(b) would specify that such corporations may foster education and training involving employees' continuing medical (and medical-related) education, patient education, and VA's core education mission described in section 7302 of title 38, United States Code.

Section 204(c) would clarify those members of the VA facility staff who should serve on the board of directors of such corporation.

Section 204(d) would specify the mechanisms through which VHA would establish policies governing corporation expenditures for education activities.

Section 205(a) would extend through December 31, 2003, VA's authority to provide so-called readjustment counseling to Vietnam-era veterans who have not previously sought such assistance.

Section 205(b) would extend, through 2003, the requirement in title 38, United States Code, section 7321, that VA support and receive reports from a Committee on Care of Severely Chronically Mentally Ill Veterans.

Section 205(c) would reinstate a requirement that VA support and receive reports from a Committee on Post-traumatic Stress Disorder.

Section 205(d) and (e), respectively, would extend through September 30, 2002, VA's authority to make grants under the Homeless Veterans Comprehensive Service Programs Act of 1992, and would lift the restriction in law on the number of grants which may be awarded which involve the procurement of vans.

Section 206(a) would amend section 8134 of title 38 to (1) provide greater specificity regarding the general regulations VA is to prescribe (and revise from time to time as needed) governing the number of nursing home and domiciliary beds for which VA grant assistance may be provided, and (2) to provide for additional regulations to determine eligibility for grant support.

Section 206(b) would amend section 8135 of title 38, United States Code, to establish (1) new requirements to govern award of a grant, (2) revised criteria for assigning the relative priority given any particular application for grant assistance.

Section 206(c) would establish a rule to govern the transition to the new priority system under subsection (b).

Section 206(d) would direct the VA to prescribe the initial regulations required under section 8134(a), as amended, not later than April 30, 2000.

Section 207(a) would amend current law to establish an additional, independent basis on which VA may enter into a so-called “enhanced-use” lease, namely on a determination that applying the consideration under such a lease to provide medical care and services (as proposed in a business plan) would demonstrably improve services to eligible veterans in the network where the leased property is located. Section 207(b) would amend current law to extend the maximum term of an enhanced-use lease, and to authorize VA to provide in the terms of such lease for it to use minor construction funds for capital contribution payments.

Section 207(c) and (d), respectively, would (1) make conforming amendments, and (2) provide that funds received under such a lease (after any necessary deductions under law) would be deposited to the new fund established in section 202, and VA is to make no less than 75 percent of the amount attributable to that lease available to the network in which the leased property is located.

Section 207(e) and (f), respectively, would repeal (1) section 8169 of title 38, United States Code, which had provided for sunseting the VA’s authority to enter into enhanced-use leases, and (2) obsolete provisions of section 8162.

Section 208 would amend current law to provide that a “title 38” health care professional may not be employed by VHA if the person has been licensed, certified, or registered in more than one state and one of those licenses has been terminated for cause, or the individual has voluntarily terminated his or her professional credentials after being notified by that state in writing of his or her potential termination for cause.

Section 301 would amend current law to establish new reporting requirements relating to the (1) proposed closure of the certain beds (psychiatric, intermediate, neurology, rehabilitative medicine, extended care (other than nursing home), and domiciliary beds), (2) the closure of medical and surgical beds, and (3) mission changes in nursing home units.

Section 302 would amend current law relating to the Veterans Canteen Service. Subsection (a) would delete restrictions in law on the sale of items or services for off-premises use. Subsection (b) would clarify that canteens may be established and operated at any VA medical facility, not simply “hospitals and homes”.

Section 303 would provide for VA to report to the Committees on Veterans Affairs no later than April 1, 2000, on the potential for establishing a pilot program to assist veterans in receiving assisted living services. The Secretary is to include recommendations on the staffing and services that should be provided under this pilot pro-

gram, the design of the program, and the issues the program should address.

Section 304 would require the Under Secretary for Health of the Department of Veterans Affairs to establish a policy for the Veterans Health Administration regarding the role of chiropractic treatment in the care of veterans under chapter 17 of title 38, United States Code.

Section 401 would authorize two major medical construction projects, (1) renovations to provide a domiciliary in Orlando, Florida, using \$2.4 million in previously appropriated funds, and (2) a surgical addition in Kansas City, Missouri, of up to \$13 million.

Section 402 would authorize two major medical facility leases.

Section 403 would authorize appropriations for fiscal years 2000 and 2001 of \$13 million in major construction and \$2.1785 million for leases.

DEPARTMENT VIEWS

The Department testified at an April 22, 1999 hearing on a draft bill which, with some modifications, was introduced as H.R. 2116. In testifying, VA expressed strong support for the concepts proposed in that measure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

The following letter was received from the Congressional Budget Office concerning the cost of the reported bill:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 28, 1999.

Hon. BOB STUMP,
*Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: At your request, the Congressional Budget Office (CBO) has prepared the enclosed cost estimate for H.R. 2116, the Veterans' Millennium Health Care Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sunita D'Monte, who can be reached at 226-2840.

Sincerely,

DAN L. CRIPPEN,
Director

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

*H.R. 2116—Veterans' Millennium Health Care Act, As introduced
on June 9, 1999*

SUMMARY. The bill contains several provisions that would have a significant budgetary impact, including provisions to increase access to long-term care for certain veterans, allow the Department of Veterans Affairs (VA) to reimburse veterans or providers for the cost of emergency care, extend medical benefits to combat-injured

veterans, and permit VA to spend some of the money that the United States might receive from litigation with tobacco companies. Assuming appropriation of the necessary amounts, CBO estimates that the bill would entail discretionary costs of about \$138 million in 2000 and about \$1.4 billion in 2004. In addition, the provisions to spend proceeds from tobacco litigation would raise direct spending by about \$20 million in 2003, \$30 million in 2004, and \$170 million in 2009. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

H.R. 2116 contains intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). The costs to state, local, and tribal governments as a result of the mandates would not exceed the threshold specified in the act (\$50 million, adjusted annually for inflation). Similarly, costs of the private-sector mandate are unlikely to exceed the corresponding threshold specified in UMRA (\$100 million, adjusted annually).

ESTIMATED COST TO THE FEDERAL GOVERNMENT. The estimated budgetary impact of H.R. 2116 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans' affairs).

(By fiscal year, in millions of dollars)						
	1999	2000	2001	2002	2003	2004
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law for Veterans' Medical Care						
Estimated Authorization Level ¹	17,862	17,862	17,862	17,862	17,862	17,862
Estimated Outlays	17,609	17,958	17,975	17,782	17,751	17,751
Proposed Changes:						
Extended Care Services						
Estimated Authorization Level	0	50	250	600	800	1,000
Estimated Outlays	0	40	230	560	780	980
Reimbursement for Emergency Care						
Estimated Authorization Level	0	90	270	380	390	400
Estimated Outlays	0	80	250	360	380	400
Care for Combat-Injured Veterans						
Estimated Authorization Level	0	5	15	21	22	23
Estimated Outlays	0	5	14	21	22	23
Extension and Revision of Authorities						
Estimated Authorization Level	0	15	18	21	10	10
Estimated Outlays	0	14	18	21	11	10
Other Provisions						
Estimated Authorization Level	0	2	2	2	2	2
Estimated Outlays	0	2	2	2	2	2
Total—Proposed Changes						
Estimated Authorization Level ...	0	160	553	1,022	1,222	1,433
Estimated Outlays	0	138	512	961	1,193	1,413
Spending Under the Bill for Veterans' Medical Care						
Estimated Authorization Level	17,862	18,022	18,415	18,884	19,084	19,295
Estimated Outlays	17,609	18,096	18,487	18,743	18,944	19,164
CHANGE IN DIRECT SPENDING						
Estimated Budget Authority	0	3	3	3	31	51
Estimated Outlays	0	3	3	3	21	31

¹ The figure shown for 1999 is the amount appropriated for that year.

² CBO does not have enough information to estimate the costs of some provisions.

³ Less than \$500,000.

Spending Subject to Appropriation

EXTENDED CARE SERVICES.—Spending for veterans' medical care is limited by discretionary appropriations. An enrollment system ensures that care is provided to veterans with the highest priority. These priorities established in law require VA to treat veterans with service-connected disabilities before other beneficiaries. The law states that VA shall provide medical services such as hospital and outpatient care and may provide nursing home care. Thus, VA has discretion whether to provide nursing home care to high-priority beneficiaries or to use its resources to provide additional hospital or outpatient care to other veterans.

VA currently provides nursing home care to about 34,000 veterans each day. In total, it provides nursing home or other long-term care to approximately 65,800 veterans a day at an annual cost of about \$2.6 billion. Of the veterans who receive long-term care from VA on any given day, about 11,000 have service-connected disabilities of 50 percent or greater even though about 535,000 veterans in total are disabled to that degree.

The need for long-term care by veterans is very large because many veterans are disabled or elderly. According to the Federal Advisory Commission on the Future of VA Long-Term Care about 610,000 veterans a day needed some form of long-term care in 1997. Among the veterans with higher priority for medical care from VA, so-called Category A veterans, the daily need totaled an estimated 295,000. (Category A veterans are those with service-connected disabilities, those who fall into special categories (such as former prisoners of war), and those with incomes below a certain threshold. Most Category A veterans have relatively low incomes, and low-income veterans comprise most of the roughly 3 million veterans who enroll with VA for health care).

Section 101 of H.R. 2116 would limit the discretion allowed to VA under current law by requiring that extended care be available for veterans whose service-connected disabilities are rated 50 percent or greater or who require long-term care because of a service-connected disability. The program of care would include geriatric evaluations, nursing home care (in VA and community-based facilities), domiciliary services, respite care, and adult day health care. CBO estimates that this section would take three to four years to implement and would eventually cost about \$1.0 billion a year in fiscal year 2000 dollars.

CBO's estimate relies on data from VA, the 1992 National Survey of Veterans, and the National Long-Term Care Survey (NLTCS). CBO determined the probability of a person being institutionalized as a function of his age, marital status, and number of limitations in activities of daily living—one indicator of an individual's need for long-term care. Applying those probabilities to a distribution of veterans with service-connected disability ratings of 50 percent or higher, CBO estimates that by 2010 about 45,000 additional veterans would receive care in nursing homes for an annual cost of \$1.2 billion. This method of estimation takes into account that spouses often act as caregivers within the home to veterans who might otherwise require a nursing home stay. In the near term, demand for nursing home care through the VA would be

lower because some veterans currently rely on Medicaid, private insurance, relatives, and certain Medicare-funded services to provide or finance their care. Initially, those veterans might not want to change their arrangements with providers. CBO assumes that eventually veterans with ratings of 50 percent or higher who enter nursing homes would turn to the VA for their care because, unlike other private or public insurance programs, it would be free to them. CBO expects that most nursing home patients would be placed in community nursing homes for an average stay of 179 days and at a cost of about \$152 a day per patient (in 2000 prices). (Nursing homes owned and operated by VA are almost twice as expensive as privately operated homes.)

In addition, veterans who have disability ratings of 50 percent or more may need long-term, personal care short of that provided in a nursing home, often in their own home. CBO estimates that 62,000 such veterans would require home-based care at an annual cost of \$0.1 billion (an average of 2½ hours of care per week at an hourly cost of \$18).

The bill would require copayments from veterans receiving long-term care if the veteran does not have a service-connected disability rated at 50 percent or greater. VA would be allowed, without further appropriation, to spend these amounts on providing long-term care. VA would be required to base the copayment on the assets and income of the veteran and spouse. The maximum monthly copayment would allow for protecting the spouse from financial hardship and for the veteran to retain a monthly personal allowance.

CBO estimates that collections from copayments would amount to \$0.3 billion in 2010. The estimate assumes that veterans with no service-connected disability or with a disability rating less than 50 percent would be charged copayments on about 69,000 stays at VA nursing homes, community nursing homes, and VA domiciliaries if that stay were longer than 21 days. CBO also assumes that single veterans would keep a minimum personal allowance of \$1,000 per year, while those with a living spouse would retain at least \$13,000 per year. Based on VA's Patient Treatment Files, the vast majority of the 69,000 stays would be low-income veterans who would be unable to defray the full cost of their care. If VA were to require veterans to draw down their personal assets or if it pursued estate recoveries, copayment revenues might be higher.

REIMBURSEMENT FOR EMERGENCY CARE.—Section 102 would significantly expand VA's authority to reimburse veterans and institutions for emergency care. It would allow VA to pay for care stemming from life- or health-threatening emergencies involving a veteran who is enrolled with VA for care, has no other coverage for emergencies, and has received care from VA within the 12 months preceding the emergency. CBO estimates that this provision would increase spending by about \$80 million in 2000 about \$400 million a year by 2004, assuming appropriation of the necessary amounts. Those costs would stem from the costs of emergency room care and any subsequent hospital care.

Of the 3 million veterans enrolled with VA, CBO estimates that about 750,000 are uninsured and would be eligible for benefits under the bill. Emergency room care represents about 3 percent of

the costs of private health plans. Emergency room costs would be two to three times greater for veterans covered by the bill, however, based on their generally poorer health. Thus, CBO estimates that the immediate costs of emergencies would amount to about \$155 million annually (in 2000 dollars).

CBO estimates that two-thirds of all visits to the emergency room would be urgent and that 16 percent of those visits would lead to admitting the veteran for an inpatient stay. For veterans under 65 years of age, the average hospital stay would cost about \$7,000. For veterans 65 years old or older, Medicare would cover the hospital costs, but VA would pay physicians' costs for those veterans without Part B coverage; CBO estimates that those costs would average about \$1,000 for the small fraction of veterans who lack Part B coverage. The costs of the subsequent hospital stay would raise the annual bill to VA under this provision by about \$195 million (also in 2000 dollars).

CARE FOR COMBAT-INJURED VETERANS.—VA currently accords highest priority to veterans with service-connected disabilities that are rated at least 50 percent disabling. The lowest priority is given to veterans without such disabilities and with incomes over a certain threshold. Section 103 would raise the priority status for medical care of combat-injured veterans. Because medical care is a discretionary program, available appropriations limit the number of veterans who receive care, and this bill would make it more likely that VA would provide care to a combat-injured veteran who does not receive a high priority under current law. CBO estimates that this provision would raise the costs of veterans' medical care by about \$20 million a year, assuming that additional appropriations would allow VA to treat the new beneficiaries as well as veterans who would receive care under current law.

For this estimate, CBO assumes that the population of combat-injured veterans is about as large as the number of individuals who have been awarded a Purple Heart. According to data from the Military Order of the Purple Heart, about 550,000 veterans with the award were still living in 1995. Roughly half of those veterans already qualify for priority-level care based on service-connected disabilities or income, according to data from VA.

Although the remaining veterans—roughly 250,000—would be eligible for priority care, it is likely that only a small portion would seek VA services—only about 2 percent of all veterans in the lowest priority category used VA's medical services in 1996. We assume that the same percentage of such veterans who were injured in combat currently seek care from VA and would use VA's medical services a bit more intensively under this bill. We also assume that another 2 percent of those veterans would become new users of VA care under the bill. CBO assumes the average cost of care for combat-injured veterans would be the same as that of other veterans in the same priority grouping.

EXTENSION AND REVISION OF AUTHORITIES.—Section 205(a) would extend the eligibility of Vietnam-era veterans for readjustment counseling from January 1, 2000, through January 1, 2003. Vietnam-era veterans currently account for 19 percent of the patients in this program and an estimated 15 percent of the pro-

gram's total costs—about \$70 million in 1999. CBO estimates that this provision would cost about \$8 million in 2000 and \$34 million over the 2000–2004 period.

Section 205(d) would amend the Homeless Veterans Comprehensive Service Programs Act and would extend the program's ability to make grants through fiscal year 2002, from its current deadline at the end of fiscal year 1999. Based on recent experience in this program, CBO expects annual grants to construct shelters for homeless veterans in the amount of \$6 million over the 2000–2002 period. These grants would lead to a stream of payments to operate the shelters in subsequent years. The construction and operating expenses would total \$37 million through 2004.

Section 205(e) would allow the Homeless Veterans Program to subsidize the purchase of vans for the purpose of outreach to homeless veterans. Based on the number of vans purchased in earlier years, CBO estimates annual expenditure of \$520,000 to assist in the purchase of 20 vans a year for four years.

OTHER PROVISIONS.—CBO does not have enough information to estimate the budgetary impacts of some provisions in the bill. Section 104 would allow VA to provide medical care to certain military retirees on a priority basis and be reimbursed by the Department of Defense (DoD) at the rate that DoD would have paid to a contractor under TRICARE. For the most part, the payments by DoD to VA would not add to the costs of TRICARE, but the provision could lead to somewhat greater use of medical benefits and thus higher overall payments by DoD. DoD would incur extra expenses to the extent that retirees increase their use of medical care because VA's copayments are less than under TRICARE.

Section 106 would authorize VA to conduct a three-year pilot program to provide medical care for certain dependents of enrolled veterans. The provision would require payment of a reasonable charge by the dependent or the dependent's parent or guardian. CBO estimates that this provision would probably raise costs to VA but by a small amount. Most enrolled veterans have low incomes, and although ability to pay would be a criterion for care, it is likely that some of the dependents would be unable to make the payment.

Section 107 would require VA to establish a program designed to improve access to and utilization of medical centers. Under current law, the Secretary already has broad powers to allocate resources to facilities and to lease, renovate, and close facilities. CBO estimates this provision would have little or no budgetary impact.

Section 108 would extend by one year a counseling and treatment program for veterans who have experienced sexual trauma. The program would be extended from December 31, 2001, to December 31, 2002, and would probably cost a few million dollars.

Section 207 would expand VA's program of enhanced-use leases. Such leases provide VA with cash or other items of value in exchange for the right to use assets of the department. Under current law, these arrangements usually result in barter instead of cash payments to VA because cash proceeds must be returned to the Treasury. The bill would allow VA to spend any proceeds from enhanced-use leases; thus, VA would be more likely to accept cash payment. Although the increase in receipts would equal the in-

crease in spending, using the proceeds from the leases could offset an equal amount of discretionary appropriations.

Direct Spending

VETERANS' TOBACCO TRUST FUND.—Section 203 of the bill would give VA direct spending authority over any amounts the federal government receives on its behalf from the tobacco industry for recovery of costs associated with tobacco-related illnesses. CBO estimates that the additional resources available to VA would total \$80 million over the 2000–2004 period and \$0.8 billion over the 2000–2009 period. Because of normal lags in spending this provision would increase federal outlays by about \$50 million over the 2000–2004 period and about \$640 million over the 2000–2009 period. These outlays could supplement or supplant discretionary spending for veterans' medical care.

There is substantial uncertainty about whether the federal government will file a lawsuit against the tobacco industry, whether it would win or settle, and if so, for what amounts. Earlier this year the Justice Department announced its intent to file a suit, and it is currently assessing the legal theories and strategies it will use. The President's budget request includes \$20 million for preparing the lawsuit, but the report accompanying the Senate-reported appropriation bill for the Department of Justice states that no funds are provided for tobacco litigation.

To develop an estimate that would fall within the range of possible outcomes, CBO made assumptions about three factors. First, how much would the federal government recover if it won or settled a lawsuit? Second, what proportion would be attributable to the costs of the VA? Finally, what is the likelihood that the federal government will enter into a lawsuit and either win or settle?

Amount of Potential Recoveries.—To estimate the amount that the federal government could recover in any lawsuit against the tobacco industry, CBO examined available research on the cost of smoking and considered the arguments made by the states in their recent lawsuits. Many studies have examined the medical and other costs associated with smoking and have arrived at different conclusions. Smoking probably increases the net costs of some federal programs but decreases the costs of others. Two methods typically used by researchers to estimate the costs of smoking are the prevalence-based method, which estimates the costs of smoking by calculating the average difference in costs over a given period between smokers and nonsmokers, and the life-cycle method, which makes a similar comparison over the lifetimes of smokers and nonsmokers. In general, the two methods reach different conclusions because smokers, on average, have shorter life spans than nonsmokers. By comparing the costs of only living smokers and nonsmokers, the prevalence-based method does not include either the avoided costs or lost tax revenue from smokers in years in which they are no longer alive. In contrast, the life-cycle method accounts for the shorter life spans of smokers relative to nonsmokers.

CBO's review of the research finds that estimates of the cost to the federal government of cigarette smoking (for programs other than Medicaid) range from negligible under some of the life-cycle

estimates to as high as \$30 billion to \$40 billion a year under some of the prevalence-based estimates. The states based their lawsuits, at least partly, on a prevalence-based analysis that showed the costs of smoking to Medicaid in fiscal year 1993 was \$13 billion.¹ This figure could correspond to as much as \$40 billion in current dollars for other federal programs. In another study, the Centers for Disease Control estimated the total costs of smoking in 1993 to be \$50 billion, with federal programs other than Medicaid paying for 30 percent and state programs (including Medicaid) paying for about 13 percent.² This finding would suggest total federal costs of about \$20 billion this year and total state costs of about \$9 billion.

The annual payments under the November 1998 settlement between tobacco companies and the states ultimately rise to about \$9 billion a year before adjustments for inflation and the volume of cigarette sales. The Justice Department contends that the amount of money paid out by the federal government for smoking related illnesses is even larger than that paid out by the states through the Medicaid program.³ For the purpose of this estimate, CBO assumes that if the federal government wins a lawsuit or settles with tobacco companies, it will receive slightly over twice the amounts the states are slated to receive under their settlement. CBO further assumes that these amounts will be adjusted for inflation and cigarette sales in the same manner as in the state settlement, resulting in payments of between \$16 billion and \$25 billion a year over the 2000–2009 period.

Proportion Attributable to Veterans' Programs.—In 1998 the federal government spent about \$18 billion on health care for veterans through VA. That figure represents 7 percent of spending on all federal non-Medicaid health care benefits (including Medicare, the Federal Employee Health Benefits Program, the Department of Defense health care programs, and the Indian Health Service). For this estimate CBO assumes that 7 percent of the amounts recovered under a federal lawsuit would be attributable to the VA.

Probability of Recovery of Amounts.—CBO assumes that there is ultimately a ten percent probability that the federal government will enter into a lawsuit and win or settle for recoveries in these amounts. Because the timing is unclear, CBO assumes no recoveries until 2003 and a lower but growing probability of recoveries over the 2003–2006 period.

OTHER COPAYMENTS AND COLLECTIONS.—The bill contains several other provisions that would allow VA to collect and spend funds. The bill would allow VA to charge higher copayments for prescriptions and outpatient visits of certain veterans and to set copayments for certain costly items of equipment other than wheelchairs and artificial limbs. The proceeds from these charges would be either used for medical care or deposited in the Treasury.

¹ Leonard S. Miller and others, "State Estimates of Medicaid Expenditures Attributable to Cigarette Smoking, Fiscal Year 1993," *Public Health Reports*, vol. 113 (March/April 1998).

² Centers for Disease Control and Prevention, "Medical-Care Expenditures Attributable to Cigarette Smoking—United States, 1993," *Morbidity and Mortality Weekly Report*, vol. 43, no 26 (1994).

³ U.S. Department of Justice, "Developing a Plan to Take the Tobacco Industry to Court" (Department of Justice Fact Sheet, Washington D.C., January 1999).

The budgetary effects of using these authorities would be felt in mandatory and appropriated accounts. The provisions would have an impact on direct spending because the receipts and subsequent spending would not be subject to appropriation, but the net effect would be negligible in a typical year because the extra spending would roughly equal the corresponding receipts. The extra spending could reduce the need for appropriated funds if VA would otherwise request funding for the expenses met through the use of the receipts. CBO does not expect, however, that VA would make much use of these authorities.

COMPENSATED WORK THERAPY PROGRAM.—Section 105 would make veterans eligible for disability compensation benefits for injuries proximately caused by the veteran's receipt of care in the Compensated Work Therapy Program (CWT). CWT is a therapeutic work program for veterans that takes place in various types of workplaces. Under current law, these veterans are not eligible for disability compensation benefits because of injuries suffered while participating in the program. The budgetary impact of this provision would depend on how many veterans are participating in this program and the rate at which they are injured while working. Information from VA indicates that about 15,000 veterans a year participate in this program. Based on data from the Bureau of Labor Statistics on the incidence of occupational illnesses and injuries, CBO estimates that the provision would increase direct spending by less than \$500,000 a year over the 2000–2002 period and by about \$1 million a year thereafter.

PAY-AS-YOU-GO CONSIDERATIONS. Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

[By fiscal year, in millions of dollars]											
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Changes in outlays	0	0	0	0	21	31	61	91	121	151	171
Changes in receipts					Not Applicable						

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT. Section 102 of the bill would authorize the Department of Veterans Affairs to reimburse providers for the reasonable cost of emergency treatment furnished to certain veterans. The provision would impose a private-sector and intergovernmental mandate on providers (including public hospitals) because, in the event of a dispute over reasonable cost, it would extinguish any liability on the part of the veteran for that treatment unless the provider rejects and refunds the department's payment within 30 days. It is not clear whether the provision would lead to a net financial loss or gain for providers. All providers would face costs if the department's payment were lower than the amount billed. But some providers might experience a net gain under this provision if reimbursements from the

department more than offset liabilities that otherwise would not be collected and any associated collection costs. In any event, costs of the provision are unlikely to exceed the thresholds specified in UMRA for intergovernmental costs (\$50 million, adjusted annually for inflation) or private-sector costs (\$100 million, adjusted annually).

COMPARISON WITH OTHER ESTIMATES. The Administration's budget request for fiscal year 2000 contains a proposal for veterans' out-of-network emergency care that is similar to section 102 of H.R. 2116. The Administration's proposal, however, would cover fewer than half as many veterans. The budget request includes about \$244 million in 2000 to cover the out-of-network emergency care for uninsured, enrolled veterans with compensable disabilities related to military service. H.R. 2116 would cover that kind of care for all uninsured, enrolled veterans, including veterans whose eligibility is based on income.

ESTIMATE PREPARED BY:

Federal Costs:

Extended Care Services: Sunita D'Monte (226–2840), Stuart Hagen (225–2644), and Rachel Schmidt (226–2900).

Reimbursement for Emergency Care: Michael A. Miller (226–2840).

Care for Combat-Injured Veterans: Michael A. Miller (226–2840).

Extension and Revision of Authorities: Sarah T. Jennings (226–2840).

Veterans' Tobacco Trust Fund: Dorothy A. Rosenbaum (226–9010).

Compensated Work Therapy Program: Charles R. Riemann (226–2840).

Other Provisions: Sunita D'Monte (226–2840).

Impact on State, Local, and Tribal Governments: Susan Sieg (225–3220).

Impact on the Private Sector: Rachel Schmidt (226–2900).

ESTIMATE APPROVED BY:

Paul N. Van de Water, Assistant Director for Budget Analysis.

VA COMMITTEE REBUTTAL OF CBO'S COST ESTIMATE ON H.R. 2116

The Committee has ordered reported a bill which authorizes an expansion of certain medical benefits while providing for both new revenues (which can help offset program expansions) and significant reforms in the VA health care system. With the failure of the Congressional Budget Office (CBO) to meet the Committee's May 12 request for a cost estimate, the Subcommittee marked up this bill without the benefit of CBO's views on its cost implications. Still lacking a CBO estimate at the scheduled full committee markup of the bill, the Committee deferred final action on the measure in order to permit the Subcommittee to take testimony on the cost implications of the bill.

The Subcommittee's June 30 hearing on the bill's cost impact apparently served as a catalyst leading to CBO's submitting an estimate, published herein. But it also served to underscore the frail foundation underlying CBO's projections.

Significantly, CBO has acknowledged that its estimate is based on the tenuous assumption that there would be “appropriation of the necessary amounts” to fund the provisions authorized by the bill. As CBO testified at the June 30 hearing, however, “legislative changes such as those in H.R. 2116 authorizing long-term and emergency care for veterans do not raise federal outlays, because funding for them is subject to appropriation”. CBO noted that VA’s “appropriation limits how much the VA may actually spend regardless of how much spending is authorized.” Given historic (constrained) levels of funding for VA medical care (as described in CBO’s testimony of June 30), it is a misnomer to characterize CBO’s projections as a “cost estimate”.

CBO’s projections of the potential for increased spending under the bill—an additional \$1.4 billion in the fiscal year 2004—are clearly not insignificant. But closer scrutiny as reflected in the Subcommittee’s June 30 hearing, calls into question the underpinnings of CBO’s projections. It is apparent to this Committee, in the light of the points below, that those projections are not a reliable mirror of even potential costs.

1. *CBO attributes unreasonable costs to a population which has the highest priority for VA care and a high percentage of which VA is already serving:* CBO projects large new costs based on a provision directing VA to provide needed long-term care to service-connected veterans who are rated 50 percent or more disabled. These veterans *already* have the highest priority for VA long-term care. A VA long-term care expert testified at the June 30 hearing that the Department is already providing long-term care to approximately two-thirds of those service-connected veterans who need such care. Rather than exposing the Department to up to \$1 billion in new long-term care costs, that official testified that new costs would be under \$185 million per year, and might be entirely offset by VA’s implementation of required long-term care copayments under the bill.

Rather than witnessing a battle of experts, what the Subcommittee learned was that VA based its estimate on a sophisticated planning model while CBO began wrestling only recently with a question of first impression. VA’s model had only recently undergone a rigorous analysis (and approval) by a Federal advisory committee composed of top experts on long-term care from around the country. That committee had been established to study the future demand for VA care and the adequacy of VA programs to meet that demand. The VA, in developing its estimate of the impact of section 101, focused on the disabled service-connected population which actually uses VA services. The Congressional Budget Office, professing ignorance of VA’s model and insufficient time to refine its work, relied heavily on data which suggested that large numbers of 50 percent service-connected veterans would likely qualify for nursing home care based on degree of functional impairment. As CBO acknowledged, it based its estimate that by 2010 45,000 additional veterans would receive care in nursing homes on “the probability of a person being institutionalized as a function of his age, marital status, and number of limitations in activities of daily living.” What CBO did not factor, and in fact largely disregarded, is the

“real world” data on such veterans’ actual utilization of VA services. In short, the CBO assumption that vast numbers of 50 percent service-connected veterans who do not now rely on VA care would be induced to seek it under this bill simply has little evidence to support it. That assumption ignores the fact that those veterans *already* have the highest priority for VA long-term care and could readily receive VA care.

It is the Committee’s view that CBO has vastly overinflated the impact of this provision. First it fails to acknowledge that some veterans do not and would not use VA health care services, for any number of reasons. Secondly, CBO failed to address the fact that veterans, like other Americans, typically do not want to be institutionalized in a nursing home unless they have no other option. The fact that a large number of 50 percent service-connected veterans may qualify for such care (based on degree of functional impairment) is not a meaningful predictor of extensive utilization of VA nursing home care.

2. While projecting new long-term care costs to VA, CBO has failed to project the substantial savings to the Medicare and Medicaid programs which would necessarily result under its scenario.

Many veterans in need of long-term care are eligible for other Federal health care programs which fund such care. To illustrate, in a cost estimate developed last year on legislation to provide for Medicare to reimburse VA for care of certain dual-eligible veterans, (H.R. 3828, the Veterans Medicare Access Improvement Act of 1998), CBO noted the extent to which veterans have dual eligibility for VA medical care and for Medicare. CBO projected that the proportion of veterans who are at least 65 will increase from 36 percent in 1997 to 41 percent in 2008. VA is already heavily subsidizing the Medicare program. In its estimate on H.R. 3828, CBO estimated that about one-half of the \$17 billion in VA health outlays in 1997 were for Medicare-covered services furnished to Medicare-eligible veterans.

The Congressional Research Service (CRS) recently estimated that about 60 per cent of the nation’s long-term care expenditures are paid by the Federal and state governments. CRS reported that Medicare pays for over half of the home and community-based care, and Medicaid pays more than 40 percent of the costs of nursing home care. In projecting substantial increases in VA expenditures for both nursing home care and home and community-based long-term care, CBO’s estimate is strikingly silent regarding the impact of these changes on Medicare or Medicaid. One would expect that if veterans qualify for long-term care benefits under Medicare and Medicaid at the same rate as other Americans, there should be a 60 percent savings in these programs for each additional dollar spent by VA.

At the Subcommittee’s hearing on June 30, CBO conceded that there could be savings to the Medicaid program of some \$150 million annually, but inexplicably its prepared testimony and written cost estimate failed to reflect that. CBO failed to offer any persuasive explanation for assuming no savings to Medicare.

3. CBO projects new costs, but fails to project any offsetting revenues provided for in other provisions of the bill.

H.R. 2116 was intended to provide some balance between program expansion and programmatic reforms which would provide offsetting revenues. CBO's estimate of the costs of the bill is altogether misleading in failing to identify and credit offsetting revenues.

Cost-savings or new revenues should have been projected for the following provisions:

- a. Section 201 of the bill would substantially revise current VA rules on cost-sharing. It envisions VA's increasing a \$2 copayment on pharmaceuticals and establishing copayment requirements on provision of hearing aids and other costly items. It would also require VA to revise copayment requirements on outpatient visits by so-called category C veterans. CBO's estimate fails to identify any revenue associated with those provisions. Nor did CBO offer any revenue projection at the June 30 hearing, despite testimony from VA that the Department intended to implement these authorities. CBO's failure to provide any such projection is particularly troubling given its projections to the Congress as recently as April 1999 to the effect that additional revenues of some \$200 million per year could be realized through legislation to increase VA drug copayment requirements.
- b. Section 207, which would extend and expand VA's authority to enter into long-term leases of underused VA property, should result in VA's gaining additional revenues.

CBO's projections are strikingly inconsistent. CBO appeared to discount the significance of the bill's revenue-generating provisions either because they are authorizations (rather than explicit requirements) or because the pertinent provisions of the bill were not more explicit. Ironically, CBO was not unwilling to provide very specific estimates of the *cost* of a provision, such as emergency care payments under section 102. Like the drug copayment provision section 102 simply authorizes VA to establish a new program and leaves broad discretion on payment levels to the Department.

4. *CBO has ignored provisions which would limit the costs of the bill:*

Section 102 of the bill would authorize—but not require—VA to pay for emergency care for certain veterans who lack health insurance or any other health coverage. This section directs VA to set emergency care payment levels and to establish appropriate limitations on payment. As VA acknowledged at the June 30 hearing it has an obvious incentive to set low rates so as to limit its liability. CBO fails to take account of VA's authority to limit its liability under the bill, and clearly assumed that VA would make payments at the same reimbursement rate as private health plans. VA indicated in its testimony that it would not be reasonable to base a cost estimate of this measure on the experience of private health plans. The Committee believes the CBO projection that this measure would entail additional costs of up to \$400 million in fiscal year 2004 is not only unreasonably speculative but based on entirely faulty assumptions. In contrast, VA staff projected the cost

of implementing this measure to be approximately \$150 million/year.

5. *CBO has a poor track record on estimating demand for VA care.*

The Committee has two additional reasons for questioning CBO's cost estimate and concluding that that estimate is not a reliable basis for gauging the fiscal impact of enacting H.R. 2116. First, the Committee notes the inherent difficulty of making long-term projections in a dynamic sector like health care, particularly as it involves the VA health care system, which is itself still undergoing dramatic changes. Second, the Committee notes the lack of success CBO has had in the recent past in estimating with any degree of reliability the impact of changing provisions of law governing eligibility for particular health care benefits.

The enactment of H.R. 2116 would have a substantial, and the Committee believes, beneficial impact on the VA health care system. The bill represents the most significant legislative change since the enactment of the Veterans Health Care Eligibility Act of 1996, which expanded veterans' eligibility for outpatient care. CBO, in its 1996 estimate of the costs attributable to enacting that legislation, projected that "the new benefit for outpatient care would entail net costs of about \$3 billion each year." In fact, the "costs" of that expansion of eligibility have largely been offset by savings, as VA had projected. The Committee would expect much the same under this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The reported bill would not be applicable to the legislative branch under the Congressional Accountability Act, Public Law 104-1, because it would apply only to certain Department of Veterans Affairs programs and activities.

STATEMENT OF FEDERAL MANDATES

The reported bill would not establish any significant federal mandate under the Unfunded Mandates Reform Act, Public Law 104-4.

STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to Article I, section 8 of the U.S. Constitution, the reported bill would be authorized by Congress' power to "provide for the common Defence and general Welfare of the United States."

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

TITLE 38 UNITED STATES CODE

* * * * *

PART II—GENERAL BENEFITS

* * * * *

CHAPTER 11—COMPENSATION FOR SERVICE- CONNECTED DISABILITY OR DEATH

* * * * *

§ 1151. Benefits for persons disabled by treatment or vocational rehabilitation

(a) * * *

* * * * *

(2) the disability or death was proximately caused (A) by the provision of training and rehabilitation services by the Secretary (including by a service-provider used by the Secretary for such purpose under section 3115 of this title) as part of an approved rehabilitation program under chapter 31 of this title, or (B) by participation in a program (known as a “compensated work therapy program”) under section 1718 of this title.

* * * * *

CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

* * * * *

SUBCHAPTER I—GENERAL

Sec.

1701.

Definitions.

* * * * *

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

1710. Eligibility for hospital, nursing home, and domiciliary care.

1710A. Requirement to provide extended care.

* * * * *

1713A. Medical care for certain dependents and enrolled veterans: pilot program.

* * * * *

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

1721. Power to make rules and regulations.

* * * * *

【1722A. Copayment for medications.】

1722A. Copayments for medications and certain costly items and equipment.

* * * * *

1725. Reimbursement for emergency treatment.

* * * * *

1729B. Health Services Improvement Fund.

1729C. Veterans Tobacco Trust Fund.

* * * * *

SUBCHAPTER I—GENERAL

§ 1701. Definitions

For the purposes of this chapter—

(1) * * *

* * * * *

(10) *The term “injured in combat” means wounded in action as the result of an act of an enemy of the United States or otherwise wounded in action by weapon fire while directly engaged in armed conflict (other than as the result of willful misconduct by the wounded individual).*

* * * * *

§ 1705. Management of health care: patient enrollment system

(a) * * *

* * * * *

(3) Veterans who are former prisoners of war *or who were injured in combat*, veterans with service-connected disabilities rated 10 percent or 20 percent, and veterans described in subparagraphs (B) and (C) of section 1710(a)(2) of this title.

* * * * *

(6) All other veterans eligible for hospital care, medical services, and nursing home care under section 1710(a)(2) of this title *(other than subparagraph (H) of such section)*.

(7) *Veterans who are eligible for hospital care, medical services, and nursing home care under section 1710(a)(2)(H) of this title.*

[(7)] (8) Veterans described in section 1710(a)(3) of this title.

* * * * *

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

* * * * *

§ 1710. Eligibility for hospital, nursing home, and domiciliary care

(a)(1) The Secretary (subject to paragraph (4)) shall furnish hospital care and medical services, and [may furnish nursing home care,] which the Secretary determines to be needed—

* * * * *

(2) The Secretary (subject to paragraph (4)) shall furnish hospital care and medical services, and may furnish nursing home care, which the Secretary determines to be needed to any veteran—

(A) * * *

* * * * *

(D) who is a former prisoner of war *or who was injured in combat*;

* * * * *

(F) who was exposed to a toxic substance, radiation, or other conditions, as provided in subsection (e); **[or]**

(G) who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title**[.]**; *or*

(H) who has retired from active military, naval, or air service in the Army, Navy, Air Force, or Marine Corps, is eligible for care under the TRICARE program established by the Secretary of Defense, and is not otherwise described in paragraph (1) or in this paragraph.

* * * * *

(4) The requirement in paragraphs (1) and (2) that the Secretary furnish hospital care and medical services, *and the requirement in section 1710A of this title that the Secretary provide a program of extended care services*, shall be effective in any fiscal year only to the extent and in the amount provided in advance in appropriations Acts for such purposes.

* * * * *

(g)(1) The Secretary may not furnish medical services under subsection (a) of this section (including home health services under section 1717 of this title) to a veteran who is eligible for hospital care under this chapter by reason of subsection (a)(3) of this section unless the veteran agrees to pay to the United States **[the amount determined under paragraph (2) of this subsection]** *in the case of each outpatient visit the applicable amount or amounts established by the Secretary by regulation.*

(2) A veteran who is furnished medical services under subsection (a) of this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such services shall be liable to the United States, in the case of each visit in which such services are furnished to the veteran, for an amount **[equal to 20 percent of the estimated average cost (during the calendar year in which the services are furnished) of an outpatient visit in a Department facility. Such estimated average cost shall be determined by the Secretary.]** *which the Secretary shall establish by regulation.*

* * * * *

§ 1710A. Extended care services

(a) The Secretary (subject to section 1710(a)(4) of this title and subsection (c) of this section) shall operate and maintain a program to provide extended care services to eligible veterans in accordance with this section. Such services shall include the following:

(1) Geriatric evaluation.

(2) Nursing home care (A) in facilities operated by the Secretary, and (B) in community-based facilities through contracts under section 1720 of this title.

(3) Domiciliary services under section 1710(b) of this title.

(4) Adult day health care under section 1720(f) of this title.

(5) Such other noninstitutional alternatives to nursing home care, including those described in section 1720C of this title, as the Secretary considers reasonable and appropriate.

(6) Respite care under section 1720B of this title.

(b)(1) *In carrying out subsection (a), the Secretary shall provide extended care services which the Secretary determines are needed (A) to any veteran in need of such care for a service-connected disability, and (B) to any veteran who is in need of such care and who has a service-connected disability rated at 50 percent or more.*

(2) *The Secretary, in making placements for nursing home care in Department facilities, shall give highest priority to veterans (A) who are in need of such care for a service-connected disability, or (B) who have a service-connected disability rated at 50 percent or more. The Secretary shall ensure that a veteran described in this subsection who continues to need nursing home care shall not after placement in a Department nursing home be transferred from the facility without the consent of the veteran, or, in the event the veteran cannot provide informed consent, the representative of the veteran.*

(c)(1) *The Secretary, in carrying out subsection (a), shall prescribe regulations governing the priorities for the provision of nursing home care in Department facilities so as to ensure that priority for such care is given (A) for patient rehabilitation, (B) for clinically complex patient populations, and (C) for patients for whom there are not other suitable placement options.*

(2) *The Secretary may not furnish extended care services for a non-service-connected disability other than in the case of a veteran who has a service-connected disability rated at 50 percent or more unless the veteran agrees to pay to the United States a copayment for extended care services of more than 21 days in any year.*

(d)(1) *A veteran who is furnished extended care services under this chapter and who is required under subsection (c)(2) to pay an amount to the United States in order to be furnished such services shall be liable to the United States for that amount.*

(2) *In implementing subsection (c)(2), the Secretary shall develop a methodology for establishing the amount of the copayment for which a veteran described in subsection (c) is liable. That methodology shall provide for—*

(A) establishing a maximum monthly copayment (based on all income and assets of the veteran and the spouse of such veteran);

(B) protecting the spouse of a veteran from financial hardship by not counting all of the income and assets of the veteran and spouse (in the case of a spouse who resides in the community) as available for determining the copayment obligation; and

(C) allowing the veteran to retain a monthly personal allowance.

(e)(1) *There is established in the Treasury of the United States a revolving fund known as the Department of Veterans Affairs Extended Care Fund (hereinafter in this section referred to as the "fund"). Amounts in the fund shall be available, without fiscal year limitation and without further appropriation, exclusively for the purpose of providing extended care services under subsection (a).*

(2) *All amounts received by the Department under this section shall be deposited in or credited to the fund.*

* * * * *

§ 1712A. Eligibility for readjustment counseling and related mental health services

(a)(1)(A) * * *

(B) Subparagraph (A) applies to the following veterans:

(i) * * *

* * * * *

(ii) Any veteran (other than a veteran covered by clause (i)) who served on active duty during the Vietnam era who seeks or is furnished such counseling before January 1, [2000] 2003.

* * * * *

§ 1713A. Medical care for certain dependents of enrolled veterans: pilot program

(a) *The Secretary may, during the program period, carry out a pilot program to provide primary health care services for eligible dependents of veterans in accordance with this section.*

(b) *For purposes of this section:*

(1) *The term “program period” means the period beginning on the first day of the first month beginning more than 180 days after the date of the enactment of this section and ending three years after that day.*

(2) *The term “eligible dependent” means an individual who—*

(A) *is the spouse or child of a veteran who is enrolled in the system of patient enrollment established by the Secretary under section 1705 of this title; and*

(B) *is determined by the Secretary to have the ability to pay for such care or services either directly or through reimbursement or indemnification from a third party.*

(c) *The Secretary may furnish health care services to an eligible dependent under this section only if the dependent (or, in the case of a minor, the parent or guardian of the dependent) agrees—*

(1) *to pay to the United States an amount representing the reasonable charges for the care or services furnished (as determined by the Secretary); and*

(2) *to cooperate with and provide the Secretary an appropriate assignment of benefits, authorization to release medical records, and any other executed documents, information, or evidence reasonably needed by the Secretary to recover the Department’s charges for the care or services furnished by the Secretary.*

(d)(1) *The health care services provided under the pilot program under this section may consist of such primary hospital care services and such primary medical services as may be authorized by the Secretary. The Secretary may furnish those services directly through a Department medical facility or, subject to paragraphs (2) and (3), pursuant to a contract or other agreement with a non-Department facility (including a health-care provider, as defined in section 8152(2) of this title).*

(2) *The Secretary may enter into a contract or agreement to furnish primary health care services under this section in a non-Department facility on the same basis as provided under subsections (a) and (b) of section 1703 of this title or may include such care in an existing or new agreement under section 8153 of this title when*

the Secretary determines it to be in the best interest of the prevailing standards of the Department medical care program.

(3) Primary health care services may not be authorized to be furnished under this section at any medical facility if the furnishing of those services would result in the denial of, or a delay in providing, access to care for any enrolled veteran at that facility.

(e)(1) In the case of an eligible dependent who is furnished primary health care services under this section and who has coverage under a health-plan contract, as defined in section 1729(i)(1) of this title, the United States shall have the right to recover or collect the reasonable charges for such care or services from such health-plan contract to the extent that the individual or the provider of the care or services would be eligible to receive payment for such care or services from such health-plan contract if the care or services had not been furnished by a department or agency of the United States.

(2) The right of the United States to recover under paragraph (1) shall be enforceable with respect to an eligible dependent in the same manner as applies under subsections (a)(3), (b), (c)(1), (c)(2), (d), (f), (h), and (i) of section 1729 of this title with respect to a veteran.

(f)(1) Subject to paragraphs (2) and (3), the pilot program under this section shall be carried out during the program period in not more than four veterans integrated service networks, as designated by the Secretary. In designating networks under the preceding sentence, the Secretary shall favor designation of networks that are suited to serve dependents of veterans because of—

(A) the capability of one or more medical facilities within the network to furnish primary health care services to eligible dependents while assuring that veterans continue to receive priority for care and services;

(B) the demonstrated success of such medical facilities in billings and collections;

(C) support for initiating such a pilot program among veterans in the network; and

(D) such other criteria as the Secretary considers appropriate.

(2) In implementing the pilot program, the Secretary may not provide health care services for dependents who are children—

(A) in more than one of the participating networks during the first year of the program period; and

(B) in more than two of the participating networks during the second year of the program period.

(3) In implementing the pilot program, the Secretary shall give priority to facilities which operate women veterans' clinics.

* * * * *

§ 1720. Transfers for nursing home care; adult day health care

(a) * * *

* * * * *

[(f)(1)(A) The Secretary is authorized to furnish adult day health care as provided for in this subsection. For the purpose only of authorizing the furnishing of such care and specifying the terms and

conditions under which it may be furnished to veterans needing such care—

(f)(1)(A) *The Secretary may furnish adult day health care services to a veteran enrolled under section 1705(a) of this title who would otherwise require nursing home care.*

* * * * *

§ 1720B. Respite care

(a) The Secretary may furnish respite care services to a veteran who is [eligible] *enrolled* to receive care under section 1710 of this title.

(b) For the purpose of this section, [the term “respite care” means hospital or nursing home care] *the term “respite care services” means care and services which—*

(1) [is] *are* of limited duration;

(2) [is] *are* furnished [in a Department facility] on an intermittent basis to a veteran who is suffering from a chronic illness and who resides primarily at home; and

(3) [is] *are* furnished for the purpose of helping the veteran to continue residing primarily at home.

(c) *In furnishing respite care services, the Secretary may enter into contract arrangements.*

* * * * *

§ 1720D. Counseling and treatment for sexual trauma

(a)(1) During the period through [December 31, 2001] *December 31, 2002*, the Secretary [may provide counseling to a veteran who the Secretary determines requires such counseling] *shall operate a program under which the Secretary provides counseling and appropriate care and services to veterans who the Secretary determines require such counseling and care and services to overcome psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty.*

[(2) During the period referred to in paragraph (1), the Secretary may provide appropriate care and services to a veteran for an injury, illness, or other psychological condition that the Secretary determines to be the result of a physical assault, battery, or harassment referred to in that paragraph.]

[(3)] (2) In furnishing counseling to a veteran under this subsection, the Secretary may, during the period through [December 31, 2001] *December 31, 2002*, provide such counseling pursuant to a contract with a qualified mental health professional if (A) in the judgment of a mental health professional employed by the Department, the receipt of counseling by that veteran in facilities of the Department would be clinically inadvisable, or (B) Department facilities are not capable of furnishing such counseling to that veteran economically because of geographical inaccessibility.

* * * * *

(c) The Secretary shall provide information on the counseling *and treatment* available to veterans under this section. Efforts by the Secretary to provide such information—

(1) shall include availability of a toll-free telephone number (commonly referred to as an 800 number); **[and]**

(2) *shall ensure that information about the counseling and treatment available to veterans under this section—*

(A) is revised and updated as appropriate;

(B) is made available and visibly posted at appropriate facilities of the Department; and

(C) is made available through appropriate public information services; and

[(2)] (3) shall include coordination with the Secretary of Defense seeking to ensure that individuals who are being separated from active military, naval, or air service are provided appropriate information about programs, requirements, and procedures for applying for counseling *and treatment* under this section.

* * * * *

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

* * * * *

【§ 1722A. Copayment for medications】

§ 1722A. *Copayments for medications and certain costly items and equipment*

(a) * * *

* * * * *

(b) *The Secretary, pursuant to regulations which the Secretary shall prescribe, may—*

(1) increase the copayment amount in effect under subsection (a);

(2) establish a maximum annual pharmaceutical copayment amount under subsection (a) for veterans who have multiple outpatient prescriptions; and

(3) require a veteran, other than a veteran described in subsection (a)(3), to pay to the United States a reasonable copayment for sensori-neural aids, electronic equipment, and any other costly item or equipment furnished the veteran for a non-service-connected condition, other than a wheelchair or artificial limb.

[(b)] (c) Amounts collected under **【this section】** subsection (a) shall be deposited in the Department of Veterans Affairs Medical Care Collections Fund. *Amounts collected through use of the authority under subsection (b) shall be deposited in Department of Veterans Affairs Health Services Improvement Fund.*

[(c)] (d) The provisions of subsection (a) expire on September 30, 2002.

* * * * *

§ 1725. Reimbursement for emergency treatment

(a) *GENERAL AUTHORITY.*—(1) Subject to subsections (c) and (d), the Secretary may reimburse a veteran described in subsection (b) for the reasonable value of emergency treatment furnished the veteran in a non-Department facility.

(2) In any case in which reimbursement is authorized under subsection (a)(1), the Secretary, in the Secretary's discretion, may, in lieu of reimbursing the veteran, make payment of the reasonable value of the furnished emergency treatment directly—

(A) to a hospital or other health care provider that furnished the treatment; or

(B) to the person or organization that paid for such treatment on behalf of such veteran.

(b) *ELIGIBILITY.*—(1) A veteran referred to in subsection (a)(1) is an individual who is an active Department health-care participant who is personally liable for emergency treatment furnished the veteran in a non-Department facility.

(2) A veteran is an active Department health-care participant if the veteran—

(A) is described in any of paragraphs (1) through (6) of section 1705(a) of this title;

(B) is enrolled in the health care system established under such section; and

(C) received care under this chapter within the 12-month period preceding the furnishing of such emergency treatment.

(3) A veteran is personally liable for emergency treatment furnished the veteran in a non-Department facility if the veteran—

(A) is financially liable to the provider of emergency treatment for that treatment;

(B) has no entitlement to care or services under a health-plan contract;

(C) has no other contractual or legal recourse against a third party that would, in whole or in part, extinguish such liability to the provider; and

(D) is not eligible for reimbursement for medical care or services under section 1728 of this title.

(c) *LIMITATIONS ON REIMBURSEMENT.*—(1) The Secretary, in accordance with regulations prescribed by the Secretary, shall—

(A) establish the maximum amount payable under subsection (a);

(B) delineate the circumstances under which such payments may be made, to include such requirements on requesting reimbursement as the Secretary shall establish; and

(C) provide that in no event may a payment under that subsection include any amount for which the veteran is not personally liable.

(2) Subject to paragraph (1), the Secretary may provide reimbursement under this section only after the veteran or the provider of emergency treatment has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such treatment.

(3) Payment by the Secretary under this section, on behalf of a veteran described in subsection (b), to a provider of emergency treatment, shall, unless rejected and refunded by the provider within 30

days of receipt, extinguish any liability on the part of the veteran for that treatment. Neither the absence of a contract or agreement between the Secretary and the provider nor any provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate the requirement in the preceding sentence.

(d) *INDEPENDENT RIGHT OF RECOVERY.*—(1) In accordance with regulations prescribed by the Secretary, the United States shall have the independent right to recover any amount paid under this section when, and to the extent that, a third party subsequently makes a payment for the same emergency treatment.

(2) Any amount paid by the United States to the veteran (or the veteran's personal representative, successor, dependents, or survivors) or to any other person or organization paying for such treatment shall constitute a lien in favor of the United States against any recovery the payee subsequently receives from a third party for the same treatment.

(3) Any amount paid by the United States to the provider that furnished the veteran's emergency treatment shall constitute a lien against any subsequent amount the provider receives from a third party for the same emergency treatment for which the United States made payment.

(4) The veteran (or the veteran's personal representative, successor, dependents, or survivors) shall ensure that the Secretary is promptly notified of any payment received from any third party for emergency treatment furnished to the veteran. The veteran (or the veteran's personal representative, successor, dependents, or survivors) shall immediately forward all documents relating to such payment, cooperate with the Secretary in the investigation of such payment, and assist the Secretary in enforcing the United States right to recover any payment made under subsection (c)(3).

(e) *WAIVER.*—The Secretary, in the Secretary's discretion, may waive recovery of a payment made to a veteran under this section that is otherwise required by subsection (d)(1) when the Secretary determines that such waiver would be in the best interest of the United States, as defined by regulations prescribed by the Secretary.

(f) *DEFINITIONS.*—For purposes of this section:

(1) The term "emergency treatment" means medical care or services furnished, in the judgment of the Secretary—

(A) when Department or other Federal facilities are not feasibly available and an attempt to use them beforehand would not be reasonable;

(B) when such care or services are rendered in a medical emergency of such nature that delay would be hazardous to life or health; and

(C) until such time as the veteran can be transferred safely to a Department facility or other Federal facility.

(2) The term "health-plan contract" includes any of the following:

(A) An insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement under which health services for individuals are provided or the expenses of such services are paid.

(B) *An insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of such Act (42 U.S.C. 1395j).*

(C) *A State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.).*

(D) *A workers' compensation law or plan described in section 1729(a)(2)(A) of this title.*

(E) *A law of a State or political subdivision described in section 1729(a)(2)(B) of this title.*

(3) *The term "third party" means any of the following:*

(A) *A Federal entity.*

(B) *A State or political subdivision of a State.*

(C) *An employer or an employer's insurance carrier.*

(D) *An automobile accident reparations insurance carrier.*

(E) *A person or entity obligated to provide, or to pay the expenses of, health services under a health-plan contract.*

* * * * *

§ 1729A. Department of Veterans Affairs Medical Care Collections Fund

(a) * * *

(b) *Amounts recovered or collected after June 30, 1997, under any of the following provisions of law shall be deposited in the fund:*

(1) * * *

* * * * *

(6) *Section 1725 of this title.*

[(6)] (7) *Public Law 87-693, popularly known as the "Federal Medical Care Recovery Act" (42 U.S.C. 2651 et seq.), to the extent that a recovery or collection under that law is based on medical care or services furnished under this chapter.*

* * * * *

§ 1729B. Health Services Improvement Fund

(a) *There is established in the Treasury of the United States a fund to be known as the "Department of Veterans Affairs Health Services Improvement Fund".*

(b) *Amounts received or collected after the date of the enactment of this section under any of the following provisions of law shall be deposited in the fund:*

(1) *Section 1713A of this title.*

(2) *Section 1722A(b) of this title.*

(3) *Section 8165(a) of this title.*

(4) *Section 104(c) of the Veterans' Millennium Health Care Act.*

(c) *Amounts in the fund are hereby available, without fiscal year limitation, to the Secretary for the purposes stated in subparagraphs (A) and (B) of section 1729A(c)(1) of this title.*

§ 1729C. Veterans Tobacco Trust Fund

(a) *There is established in the Treasury of the United States a trust fund to be known as the “Veterans Tobacco Trust Fund”, consisting of such amounts as may be appropriated, credited, or donated to the trust fund.*

(b) *If a lawsuit is brought by the United States against the tobacco manufacturers seeking recovery of costs incurred or to be incurred by the United States that are attributable to tobacco-related illnesses, there shall be credited to the trust fund from any amount recovered by the United States pursuant to that lawsuit, without further appropriation, the amount that bears the same ratio to the amount recovered as the amount of the Department’s costs for health care attributable to tobacco-related illnesses for which recovery is sought in the suit bears to the total amount sought by the United States in the suit.*

(c) *After September 30, 2004, amounts in the trust fund shall be available, without fiscal year limitation, to the Secretary of Veterans Affairs for the following purposes:*

(1) *Furnishing medical care and services under this chapter, to be available during any fiscal year for the same purposes and subject to the same limitations (other than with respect to the period of availability for obligation) as apply to amounts appropriated from the general fund of the Treasury for that fiscal year for medical care.*

(2) *Conducting medical research, rehabilitation research, and health systems research, with particular emphasis on research relating to prevention and treatment of, and rehabilitation from, tobacco addiction and diseases associated with tobacco use.*

* * * * *

SUBCHAPTER V—PAYMENTS TO STATE HOMES

* * * * *

§ 1741. Criteria for payment

(a)(1) * * *

* * * * *

(2) The Secretary may pay each State per diem at a rate determined by the Secretary for each veteran receiving [adult day health care in a State home] *extended care services described in any of paragraphs (4) through (6) of section 1710A(a) of this title under a program administered by a State home*, if such veteran is eligible for such care under laws administered by the Secretary.

(b) In no case shall the payments made with respect to any veteran under this section exceed one-half of the cost of the veterans’ care in such State home.

* * * * *

PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

* * * * *

CHAPTER 73—VETERANS HEALTH ADMINISTRATION— ORGANIZATION AND FUNCTIONS

* * * * *

SUBCHAPTER II—GENERAL AUTHORITY AND ADMINISTRATION

* * * * *

§ 7321. Committee on Care of Severely Chronically Mentally Ill Veterans

(a) * * *

* * * * *

(d)(1) * * *

(2) Not later than February 1, 1998, and February 1 of each of the ~~three~~ *five* following years, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing information updating the reports submitted under this subsection before the submission of such report.

* * * * *

SUBCHAPTER IV—RESEARCH CORPORATIONS

* * * * *

§ 7361. Authority to establish; status

(a) The Secretary may authorize the establishment at any Department medical center of a nonprofit corporation to provide a flexible funding mechanism for the conduct of approved research *and education* at the medical center. Except as otherwise required in this subchapter or under regulations prescribed by the Secretary, any such corporation, and its directors and employees, shall be required to comply only with those Federal laws, regulations, and executive orders and directives which apply generally to private nonprofit corporations. *Such a corporation may be established to facilitate either research or education or both research and education.*

* * * * *

§ 7362. Purpose of corporations

Any corporation established under this subchapter shall be established solely to facilitate research as described in section 7303(a) of this title *and education and training as described in sections 7302, 7471, 8154, and 1701(6)(B) of this title* in conjunction with the applicable Department medical center. Any funds received by the Secretary for the conduct of research *or research* at the medical center other than funds appropriated to the Department may

be transferred to and administered by the corporation for [that purpose] *these purposes.*

* * * * *

§ 7363. Board of directors; executive director

(a) The Secretary shall provide for the appointment of a board of directors for any corporation established under this subchapter. The board shall include—

(1) the director of the medical center, the chief of staff of the medical center, and [the assistant chief of staff for research of the medical center; and] *as appropriate, the assistant chief of staff for research for the medical center and the associate chief of staff for education for the medical center, or, in the case of a facility at which such positions do not exist, those officials who are responsible for carrying out the responsibilities of the medical center director, chief of staff, and, as appropriate, the assistant chief of staff for research and the assistant chief for education; and*

(2) subject to subsection (c), members who are not officers or employees of the Federal Government and who are familiar with issues involving medical and scientific research *or education, as appropriate.*

* * * * *

(c) An individual appointed under subsection (a)(2) to the board of directors of a corporation established under this subchapter may not be affiliated with, employed by, or have any other financial relationship with any entity that is a source of funding for research *or education* by the Department unless that source of funding is a governmental entity or an entity the income of which is exempt from taxation under the Internal Revenue Code of 1986.

* * * * *

§ 7364. General powers

(a) * * *

* * * * *

(c)(1) *A corporation established under this subchapter may not spend funds for an education activity unless the activity is approved in accordance with procedures prescribed by the Under Secretary for Health.*

(2) *The Under Secretary for Health shall prescribe policies and procedures to guide the expenditure of funds by corporations under paragraph (1) consistent with the purpose of such corporations as flexible funding mechanisms.*

* * * * *

CHAPTER 74—VETERANS HEALTH ADMINISTRATION— PERSONNEL

* * * * *

SUBCHAPTER I—APPOINTMENTS

* * * * *

§ 7402. Qualifications of appointees

(a) * * *

* * * * *

(f) *A person may not be employed in a position under subsection (b) (other than under paragraph (4) of that subsection) if—*(1) *the person is or has been licensed, registered, or certified (as applicable to such position) in more than one State; and*(2) *either—*(A) *any of those States has terminated such license, registration, or certification for cause; or*(B) *the person has voluntarily relinquished such license, registration, or certification in any of those States after being notified in writing by that State of potential termination for cause.*

* * * * *

CHAPTER 78—VETERANS' CANTEEN SERVICE

* * * * *

§ 7802. Duties of Secretary with respect to Service

The Secretary shall—

(1) *establish, maintain, and operate canteens where deemed necessary and practicable at [hospitals and homes] medical facilities of the Department and at other Department establishments where similar essential facilities are not reasonably available from outside commercial sources;*

* * * * *

(11) *authorize the use of funds of the Service when available, subject to such regulations as the Secretary may deem appropriate, for the purpose of cashing checks, money orders, and similar instruments in nominal amounts for the payment of money presented by veterans hospitalized or domiciled at [hospitals and homes] medical facilities of the Department, and by other persons authorized by section 7803 of this title to make purchases at canteens. Such checks, money orders, and other similar instruments may be cashed outright or may be accepted, subject to strict administrative controls, in payment for merchandise or services, and the difference between the amount of the purchase and the amount of the tendered instrument refunded in cash.*

* * * * *

§ 7803. Operation of Service**[(a)]** *The canteens at [hospitals and homes] medical facilities of the Department shall be primarily for the use and benefit of veterans hospitalized or domiciled at such [hospitals and homes] medical facilities. Service at such canteens may also be furnished to personnel of the Department and recognized veterans' organizations employed at such [hospitals and homes] medical facilities and to other persons so employed, to the families of all the foregoing persons who reside at the [hospital or home] medical facility con-*

cerned, and to relatives and other persons while visiting any of the persons named [in this subsection; however, service to any person not hospitalized, domiciled, or residing at the hospital or home shall be limited to the sale of merchandise or services for consumption or use on the premises] *in this section.*

[(b) Service at canteens other than those established at hospitals and homes shall be limited to sales of merchandise and services for consumption or use on the premises, to personnel employed at such establishments, their visitors, and other persons at such establishments on official business.]

* * * * *

PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

* * * * *

CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED-USE LEASES OF REAL PROPERTY

* * * * *

SUBCHAPTER V—ENHANCED-USE LEASES OF REAL PROPERTY

Sec.						
8161.	Definitions.					
		*	*	*	*	*
[8169.	Expiration.]					
		*	*	*	*	*

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

* * * * *

§ 8110. Operation of medical facilities

(a)(1) * * *

* * * * *

(d) *The Secretary may not in any fiscal year close more than 50 percent of the beds within a bed section (of 20 or more beds) of a Department medical center unless the Secretary first submits to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report providing a justification for the closure. No action to carry out such closure may be taken after the submission of such report until the end of the 21-day period beginning on the date of the submission of the report.*

(e) *The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives, not later than January 20 of each year, a report documenting by network for the preceding fiscal year the following:*

(1) *The number of medical service and surgical service beds, respectively, that were closed during that fiscal year and, for*

each such closure, a description of the changes in delivery of services that allowed such closure to occur.

(2) The number of nursing home beds that were the subject of a mission change during that fiscal year and the nature of each such mission change.

(f) For purposes of this section:

(1) The term “closure”, with respect to beds in a medical center, means ceasing to provide staffing for, and to operate, those beds. Such term includes converting the provision of such bed care from care in a Department facility to care under contract arrangements.

(2) The term “bed section”, with respect to a medical center, means psychiatric beds (including beds for treatment of substance abuse and post-traumatic stress disorder), intermediate, neurology, and rehabilitation medicine beds, extended care (other than nursing home) beds, and domiciliary beds.

(3) The term “justification”, with respect to closure of beds, means a written report that includes the following:

(A) An explanation of the reasons for the determination that the closure is appropriate and advisable.

(B) A description of the changes in the functions to be carried out and the means by which such care and services would continue to be provided to eligible veterans.

(C) A description of the anticipated effects of the closure on veterans and on their access to care.

* * * * *

SUBCHAPTER III—STATE HOME FACILITIES FOR FURNISHING DOMICILIARY, NURSING HOME, AND HOSPITAL CARE

* * * * *

§ 8134. General regulations

[(a) Within six months after the date of enactment of any amendment to this section with respect to such amendment, the Secretary shall prescribe the following by regulation:

[(1) The number of beds required to provide adequate nursing home care to veterans residing in each State.]

(a)(1) *The Secretary shall prescribe regulations for the purposes of this subchapter.*

(2) In those regulations, the Secretary shall prescribe for each State the number of nursing home and domiciliary beds for which assistance under this subchapter may be furnished. Such regulations shall be based on projected demand for such care 10 years after the date of the enactment of the Veterans Millennium Health Care Act by veterans who at such time are 65 years of age or older and who reside in that State. In determining such projected demand, the Secretary shall take into account travel distances for veterans and their families.

(3)(A) In those regulations, the Secretary shall establish criteria under which the Secretary shall determine, with respect to an application for assistance under this subchapter for a project described in subparagraph (B) which is from a State that has a need for additional beds as determined under subsections (a)(2) and (d)(1),

whether the need for such beds is most aptly characterized as great, significant, or limited. Such criteria shall take into account the availability of beds already operated by the Secretary and other providers which appropriately serve the needs which the State proposes to meet with its application.

(B) This paragraph applies to a project for the construction or acquisition of a new State home facility, to a project to increase the number of beds available at a State home facility, and a project to replace beds at a State home facility

(4) The Secretary shall review and, as necessary, revise regulations prescribed under paragraphs (2) and (3) not less often than every four years.

(b) The Secretary shall prescribe the following by regulation:

[(2)] (1) General standards of construction, repair, and equipment for facilities constructed or acquired with assistance received under this subchapter.

[(3)] (2) General standards for the furnishing of care in facilities which are constructed or acquired with assistance received under this subchapter, which standards shall be no less stringent than those standards prescribed by the Secretary pursuant to section 1720(b) of this title.

[(b)] (c) The Secretary may inspect any State facility constructed or acquired with assistance received under this subchapter at such times as the Secretary deems necessary to insure that such facility meets the standards prescribed in subsection **[(a)(3)]** (b)(2).

(d)(1) In prescribing regulations to carry out this subchapter, the Secretary shall provide that in the case of a State that seeks assistance under this subchapter for a project described in subsection (a)(3)(B), the determination of the unmet need for beds for State homes in that State shall be reduced by the number of beds in all previous applications submitted by that State under this subchapter, including beds which have not been recognized by the Secretary under section 1741 of this title.

(2)(A) Financial assistance under this subchapter for a renovation project may only be provided for a project for which the total cost of construction is in excess of \$400,000 (as adjusted from time to time in such regulations to reflect changes in costs of construction).

(B) For purposes of this paragraph, a renovation project is a project to remodel or alter existing buildings for which financial assistance under this subchapter may be provided and does not include maintenance and repair work which is the responsibility of the State.

§ 8135. Applications with respect to projects; payments

(a) Any State desiring to receive assistance for a project for construction of State home facilities (or acquisition of a facility to be used as a State home facility) must submit to the Secretary an application. Such application shall **[set forth—]** *set forth the following:*

(1) **[the]** *The amount of the grant requested with respect to such project which may not exceed 65 percent of the estimated cost of construction (or of the estimated cost of facility acquisition and construction) of such project[.].*

(2) **[a]** *A description of the site for such project[.].*

(3) **[plans]** *Plans* and specifications for such project in accordance with regulations prescribed by the Secretary pursuant to section 8134(a)(2) of this title**[,]**.

(4) **[reasonable]** *Reasonable* assurance that upon completion of such project the facilities will be used principally to furnish to veterans the level of care for which such application is made and that not more than 25 percent of the bed occupancy at any one time will consist of patients who are not receiving such level of care as veterans**[,]**.

(5) **[reasonable]** *Reasonable* assurance that title to such site is or will be vested solely in the applicant, a State home, or another agency or instrumentality of the State**[,]**.

(6) **[reasonable]** *Reasonable* assurance that adequate financial support will be available for the construction of the project (or for facility acquisition and construction of the project) by July 1 of the fiscal year for which the application is approved and for its maintenance and operation when complete**[,]**.

(7) **[reasonable]** *Reasonable* assurance that the State will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and give the Secretary, upon demand, access to the records upon which such information is based**[,]**.

(8) **[reasonable]** *Reasonable* assurance that the rates of pay for laborers and mechanics engaged in construction of the project will be not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1931 (40 U.S.C. 276a-276a-5) (known as the Davis-Bacon Act)**[, and]**.

(9) **[in]** *In* the case of a project for acquisition of a facility, reasonable assurance that the estimated total cost of acquisition of the facility and of any expansion, remodeling, and alteration of the acquired facility will not be greater than the estimated cost of construction of an equivalent new facility.

(b)(1) *Any State seeking to receive assistance under this subchapter for a project that would involve construction or acquisition of either nursing home or domiciliary facilities shall include with its application under subsection (a) the following:*

(A) *Documentation (i) that the site for the project is in reasonably proximity to a sufficient concentration and population of veterans who are 65 years of age and older, and (ii) that there is a reasonable basis to conclude that the facilities when complete will be fully occupied.*

(B) *A financial plan for the first three years of operation of such facilities.*

(C) *A five-year capital plan for the State home program for that State.*

(2) *Failure to provide adequate documentation under paragraph (1)(A) or to provide an adequate financial plan under paragraph (1)(B) shall be a basis for disapproving the application.*

[(b)] (c)(1) Upon receipt of an application **[for a grant under subsection (a) of this section]** under subsection (a) for financial assistance under this subchapter, the Secretary—

(A) * * *

* * * * *

(2) Subject to paragraphs (3) and (5)(C) of this subsection, the Secretary shall accord priority to applications in the following order:

(A) An application from a State that has made sufficient funds available for **the construction or acquisition of** the project for which the grant is requested so that such project may proceed upon approval of the grant without further action required by the State to make such funds available for such purpose.

[(B) An application from a State that does not have a State home facility constructed or acquired with assistance under this subchapter (or for which such a grant has been made).

[(C) An application from a State which the Secretary determines, in accordance with criteria and procedures specified in regulations which the Secretary shall prescribe, has a greater need for nursing home or domiciliary beds or adult day health care facilities than other States from which applications are received.

[(D) An application that meets such other criteria as the Secretary determines are appropriate and has established in regulations.]

(B) An application from a State for a project at an existing facility to remedy a condition or conditions that have been cited by an accrediting institution, by the Secretary, or by a local licensing or approving body of the State as being threatening to the lives or safety of the patients in the facility.

(C) An application from a State that has not previously applied for award of a grant under this subchapter for construction or acquisition of a State nursing home.

(D) An application for construction or acquisition of a nursing home or domiciliary from a State that the Secretary determines, in accordance with regulations under this subchapter, has a great need for the beds to be established at such home or facility.

(E) An application from a State for renovations to a State home facility other than renovations described in subparagraph (B).

(F) An application for construction or acquisition of a nursing home or domiciliary from a State that the Secretary determines, in accordance with regulations under this subchapter, has a significant need for the beds to be established at such home or facility.

(G) An application that meets other criteria as the Secretary determines appropriate and has established in regulations.

(H) An application for construction or acquisition of a nursing home or domiciliary from a State that the Secretary determines, in accordance with regulations under this subchapter, has a limited need for the beds to be established at such home or facility.

(3) In according priorities to projects under paragraph (2) of this subsection, the Secretary—

[(A) shall accord priority only to projects which would involve construction or acquisition of either nursing home or

domiciliary buildings or construction (other than new construction) of adult day health care buildings; and】

(A) may not accord any priority to a project for the construction or acquisition of a hospital; and

* * * * *

【(c)】 *(d)* No application submitted to the Secretary under this section shall be disapproved until the Secretary has afforded the applicant notice and an opportunity for a hearing.

【(d)】 *(e)* The amount of a grant under this subchapter shall be paid to the applicant or, if designated by the applicant, the State home for which such project is being carried out or any other agency or instrumentality of the applicant. Such amount shall be paid, in advance or by way of reimbursement, and in such installments consistent with the progress of the project as the Secretary may determine and certify for payment to the Secretary of the Treasury. Funds paid under this section for an approved project shall be used solely for carrying out such project as so approved.

【(e)】 *(f)* Any amendment of any application, whether or not approved, shall be subject to approval in the same manner as an original application.

* * * * *

SUBCHAPTER V—ENHANCED-USE LEASES OF REAL PROPERTY

* * * * *

§ 8162. Enhanced-use leases

(a)(1) The Secretary may in accordance with this subchapter enter into leases with respect to real property that is under the jurisdiction or control of the Secretary. Any such lease under this subchapter may be referred to as an “enhanced-use lease”. The Secretary may dispose of any such property that is leased to another party under this subchapter in accordance with section 8164 of this title. The Secretary may exercise the authority provided by this subchapter notwithstanding section 8122 of this title, section 321 of the Act of June 30, 1932 (40 U.S.C. 303b), sections 202 and 203 of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 483, 484), or any other provision of law (other than Federal laws relating to environmental and historic preservation) inconsistent with this section. 【The applicability of this subchapter to section 421(b) of the Veterans’ Benefits and Services Act of 1988 (Public Law 100–322; 102 Stat. 553) is covered by subsection (c).】

(2) The Secretary may enter into an enhanced-use lease 【only if the Secretary】 *only if*—

(A) the Secretary determines that—

【(A)】 *(i)* at least part of the use of the property under the lease will be to provide appropriate space for an activity contributing to the mission of the Department;

【(B)】 *(ii)* the lease will not be inconsistent with and will not adversely affect the mission of the Department; and

【(C)】 *(iii)* the lease will enhance the use of the property【.】; *or*

(B) the Secretary determines that the implementation of a business plan proposed by the Under Secretary for Health for applying the consideration under such a lease to the provision of medical care and services would result in a demonstrable improvement of services to eligible veterans in the geographic service-delivery area within which the property is located.

* * * * *

(b)(1) If the Secretary has determined that a property should be leased to another party through an enhanced-use lease, the Secretary shall select the party with whom the lease will be entered into using selection procedures determined by the Secretary that ensure the integrity of the selection process.

(2) The term of an enhanced-use lease **may not exceed—**

[(A) 35 years, in the case of a lease involving the construction of a new building or the substantial rehabilitation of an existing building, as determined by the Secretary; or

[(B) 20 years, in the case of a lease not described in subparagraph (A).] may not exceed 75 years.

* * * * *

[(4) Any payment by the Secretary for the use of space or services by the Department on property that has been leased under this subchapter may only be made from funds appropriated to the Department for the activity that uses the space or services. No other such payment may be made by the Secretary to a lessee under an enhanced-use lease unless the authority to make the payment is provided in advance in an appropriation Act.]

(4) The terms of an enhanced-use lease may provide for the Secretary to—

(A) obtain facilities, space, or services on the leased property; and

(B) use minor construction funds for capital contribution payments.

[(c)(1) Subject to paragraph (2), the entering into an enhanced-use lease covering any land or improvement described in section 421(b)(2) of the Veterans' Benefits and Services Act of 1988 (Public Law 100-322; 102 Stat. 553) shall be considered to be prohibited by that section unless specifically authored by law.

[(2) The entering into an enhanced-use lease by the Secretary covering any land or improvement described in such section 421(b)(2) shall not be considered to be prohibited under that section if under the lease—

[(A) the designated property is to be used only for child-care services;

[(B) those services are to be provided only for the benefit of—

[(i) employees of the Department;

[(ii) individuals employed on the premises of such property; and

[(iii) employees of a health-personnel educational institution that is affiliated with a Department facility;

[(C) over one-half of the employees benefited by the child-care services provided are required to be employees of the Department; and

[(D) over one-half of the children to whom child-care services are provided are required to be children of employees of the Department.]

* * * * *

§ 8163. Designation of property to be leased

(a) * * *

(b) Before conducting such a hearing, the Secretary shall provide reasonable notice of the proposed designation and of the hearing. The notice shall [include—] *include the following*:

(1) [the] *The* time and place of the hearing[;].

(2) [identification] *Identification* of the property proposed to be leased[;].

(3) [a] A description of the proposed uses of the property under the lease[;].

(4) [a] A description of how the uses to be made of the property under a lease of the general character then contemplated—

[(A) would contribute in a cost-effective manner to the mission of the Department;

[(B) would not be inconsistent with the mission of the Department; and

[(C) would not adversely affect the mission of the Department; and]

(A) *would—*

(i) *contribute in a cost-effective manner to the mission of the Department;*

(ii) *not be inconsistent with the mission of the Department;*

(iii) *not adversely affect the mission of the Department; and*

(iv) *affect services to veterans; or*

(B) *would result in a demonstrable improvement of services to eligible veterans in the geographic service-delivery area within which the property is located.*

(5) [a] A description of how those uses would affect services to veterans.

(c)(1) * * *

* * * * *

(E) A description of how the proposed lease—

[(i) would contribute in a cost-effective manner to the mission of the Department;

[(ii) would not be inconsistent with the mission of the Department; and

[(iii) would not adversely affect the mission of the Department.]

(i) *would—*

(I) *contribute in a cost-effective manner to the mission of the Department;*

(II) *not be inconsistent with the mission of the Department;*

(III) *not adversely affect the mission of the Department; and*

(IV) affect services to veterans; or
 (ii) would result in a demonstrable improvement of services to eligible veterans in the geographic service-delivery area within which the property is located.

* * * * *

§ 8165. Use of proceeds

[(a)(1) Of the funds received by the Department under an enhanced-use lease and remaining after any deduction from such funds under subsection (b), 75 percent shall be deposited in the nursing home revolving fund established under section 8116 of this title and 25 percent shall be credited to the Medical Care Account of the Department for the use of the Department facility at which the property is located.]

(a)(1) Funds received by the Department under an enhanced-use lease and remaining after any deduction from those funds under subsection (b) shall be deposited in the Department of Veterans Affairs Health Services Improvement Fund established under section 1729B of this title. The Secretary shall make available to the designated health care region of the Veterans Health Administration within which the leased property is located not less than 75 percent of the amount deposited in the fund attributable to that lease.

* * * * *

(3) For the purposes of paragraph (1), the term “designated health care region of the Veterans Health Administration” means a geographic area designated by the Secretary for the purposes of the management of, and allocation of resources for, health care services provided by the Veterans Health Administration.

* * * * *

§ 8169. Expiration

[The authority of the Secretary to enter into enhanced-use leases under this subchapter expires on December 31, 2001.]

VETERANS' HEALTH CARE ACT OF 1984

* * * * *

TITLE I—HEALTH PROGRAMS

* * * * *

POST-TRAUMATIC-STRESS DISORDER

SEC. 110. (a) * * *

* * * * *

(e)(1) Not later than [March 1, 1985] *March 1, 2000*, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the implementation of this section. The report shall include the following:

(A) * * *

* * * * *

(2) Not later than **February 1, 1986** *February 1, 2001*, and February 1 of each of the three following years, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing information updating the reports submitted under this subsection before the submission of such reports.

* * * * *

HOMELESS VETERANS COMPREHENSIVE SERVICE PROGRAMS ACT OF 1992

* * * * *

SEC. 3. GRANTS.

(a) **AUTHORITY TO MAKE GRANTS.**—(1) * * *

(2) The authority of the Secretary to make grants under this section expires on **September 30, 1999** *September 30, 2002*.

(b) **CRITERIA FOR AWARD OF GRANTS.**—The Secretary shall establish criteria and requirements for the award of a grant under this section, including criteria for entities eligible to receive such grants. The Secretary shall publish such criteria and requirements in the Federal Register not later than 90 days after the date of the enactment of this Act [Nov. 10, 1992]. In developing such criteria and requirements, the Secretary shall consult with organizations with experience in the area of providing service to homeless veterans and to the maximum extent possible shall take into account the findings of the assessment of the Secretary under section 107 of the Veterans' Medical Programs Amendments of 1992 [Public Law 102-405, 38 U.S.C. 527 note]. The criteria established under this section shall include the following:

(1) * * *

(2) Specification as to the number of projects for which grant support is available, which shall include provision for no more than 25 service centers **and no more than 20 programs which incorporate the procurement of vans as described in paragraph (1).**

* * * * *