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VETERANS LONG-TERM CARE AND MENTAL HEALTH PROGRAMS ENHANCEMENT ACT OF 2002

AUGUST 1, 2002.—Ordered to be printed

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

REPORT

[To accompany S. 2043]

The Committee on Veterans' Affairs, to which was referred the bill S. 2043, to amend title 38, United States Code, to extend by five years the period for the provision by the Secretary of Veterans Affairs of noninstitutional extended care services and required nursing home care, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a committee substitute and an amendment to the title, and recommends that the bill, as amended, do pass.

INTRODUCTION

On April 25, 2002, the Committee held a hearing to review factors underlying the lack of action by the Department of Veterans Affairs (hereinafter, "VA") in implementing the long-term care provisions of the Veterans Millennium Health Care and Benefits Act of 1999 (Public Law 106–117 (hereinafter, Millennium Act)). Those testifying at the hearing included: Robert Roswell, MD, Under Secretary for Health, VA; Marsha E. Goodwin, RN, MSN, Acting Chief Consultant, Geriatrics and Extended Care, and Director, Geriatrics Program, VA; Cynthia A. Bascetta, Director, Health Care, Veterans' Health and Benefits Issues, United States General Accounting Office (hereinafter, "GAO"); Jim Musselwhite, Assistant Director, Health Care, GAO; Gladys Dickerson, RN, Home Based Primary Care Coordinator, Dallas VA Medical Center; Paula Hemmings, RN, Geriatrics and Extended Care Line Manager, Vet-

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erans Integrated Service Network #2, representing the Alzheimer's Association; Thomas McClure, LCSW, Coordinator, VA Medical Foster Home Program, Little Rock VA Medical Center; and Jennifer Moye, PhD, Director, Geriatric Mental Health Clinic/UP-BEAT, Brockton VA Medical Center, and Associate Professor of Psychology, Department of Psychiatry, Harvard Medical School.

Prior to this hearing, on March 21, 2002, Committee Chairman John D. Rockefeller IV introduced S. 2043, which would extend by five years the period for the provision by VA of noninstitutional extended care services and required nursing home care.

On September 6, 2001, Chairman Rockefeller introduced S. 1408, with Committee Members Daniel Akaka, Paul Wellstone, Ben Nelson, and Zell Miller joining later as cosponsors. S. 1408 would standardize the income threshold for copayments for outpatient medications with the income threshold currently used to determine a veteran's inability to defray necessary expenses of care.

On October 25, 2001, Chairman Rockefeller introduced S. 1576, which would extend for ten years the special eligibility for health care provided to veterans who served in Southwest Asia during the Persian Gulf War.

On March 21, 2002, Chairman Rockefeller introduced S. 2044, which would expand and improve programs for the provision of specialized mental health services to veterans.

On April 18, 2002, Chairman Rockefeller introduced S. 2205, which would provide VA with permanent authority to offer veterans counseling and treatment for sexual trauma suffered during active duty in service.

On April 23, 2002, Chairman Rockefeller introduced S. 2227, with Senator Max Cleland joining later as a cosponsor. S. 2227 would clarify the effective date of the modification of treatment for retirement annuity purposes of part-time service before April 7, 1986, of certain VA health-care professionals.

On April 30, 2002, Chairman Rockefeller introduced S. 2228, which would authorize VA to operate up to 15 centers for mental illness research, education, and clinical activities.

On May 2, 2002, the Committee held a hearing to receive testimony on the aforementioned bills, and on other measures. Those testifying at the hearing included: Tim McClain, General Counsel, VA; Frances M. Murphy, MD, Deputy Under Secretary for Health, Veterans Health Administration, VA; Robert Epley, Associate Deputy Under Secretary for Policy and Program Management, Veterans Benefits Administration, VA; John Thompson, Deputy General Counsel, VA; Claude Kicklighter, Assistant Secretary for Policy and Planning/Acting Director, Office of Operations, Security and Preparedness, VA; Vincent Barile, Deputy Under Secretary for Management, National Cemetery Administration, VA; James Fischl, Director, National Veterans Affairs and Rehabilitation Commission, The American Legion; Joseph A. Violante, National Legislative Director, Disabled American Veterans; David Tucker, Associate Legislative Director, Paralyzed Veterans of America; and Dennis Cullinan, Director, National Legislative Service, Veterans of Foreign Wars.

COMMITTEE MEETING

On June 6, 2002, the Committee met in open session to consider, among other matters, S. 2043 with an amendment in the nature of a substitute incorporating provisions from Section 2 of S. 1408, S. 1576, S. 2044, Section 2 of S. 2205, S. 2227, and S. 2228, and amendments offered by Senator Frank H. Murkowski regarding a State Home grant of $16 million to the State of Alaska for the Pioneers' Homes, and by Senator Patty Murray requiring VA to establish two medical outreach programs in the State of Washington.

Present were Chairman Rockefeller, Ranking Member Arlen Specter, and Senators James M. Jeffords, Wellstone, Murray, Miller, Ben Nelson, Strom Thurmond, Murkowski, Tim Hutchinson and Kay Bailey Hutchison. The Committee voted unanimously to report favorably S. 2043, as amended, to the Senate.

SUMMARY OF S. 2043 AS REPORTED

S. 2043, as reported (hereinafter, "Committee bill") consists of three titles, summarized below.

TITLE I—LONG-TERM CARE AND MENTAL HEALTH ENHANCEMENTS

Subtitle A—Long-term Care

Section 101 extends for five years the provision set forth in the Millennium Act requiring that VA provide non-institutional extended care services and nursing home care services to certain veterans.

Subtitle B—Mental Health Programs

Section 111 increases from $15 million (as specified in Section 116 of Public Law 107–135) to $25 million per year funding set aside for a program designed to expand and improve services relating to the treatment of post-traumatic stress disorder (PTSD) and substance use disorders; requires VA to ensure that this funding is in excess of a baseline amount; clarifies that these funds are to be provided on an annual basis for a three-year period; and requires the Secretary to ensure that not less than $10 million be allocated by direct grants to programs identified by the Mental Health Strategic Health Care Group and the Committee on Care of Severely Chronically Mentally Ill Veterans, not less than $5 million be allocated for PTSD programs, and not less than $5 million be allocated for substance use disorder programs.

Section 112 provides permanent authority for counseling and treatment of sexual trauma. Authority for this program is currently scheduled to expire on December 31, 2004.

Section 113 authorizes VA to operate up to 15 centers for mental illness research, education and clinical activities. The current authority provides for up to five such centers.

TITLE II—CONSTRUCTION AUTHORIZATION

Section 201 authorizes the following Administration-requested construction projects: seismic corrections to Building 2 at the Palo Alto VAMC in the amount of $14 million; seismic corrections to Building 4 at the Palo Alto VAMC in the amount of $22 million;

seismic corrections to the West Los Angeles VAMC in the amount of $27 million; and seismic corrections to the San Francisco VAMC in the amount of $31 million. In addition, the Committee bill includes a modification to a prior authorization for a nursing home project at the Beckley, West Virginia VAMC and extends a prior authorization for the nursing home project at the Lebanon, Pennsylvania VAMC.

Section 211 changes to $9 million the monetary threshold used for determining when a construction project will be classified as a major construction project.

Section 212 allows VA to make a grant of not more than $16 million to the State of Alaska for the purpose of expanding, remodeling or altering space in six separate Pioneers' Homes and specifies that following such grant, the space be treated as a single State home facility for the purposes of subchapter III of chapter 81 of title 38, United States Code.

TITLE III—GENERAL HEALTH CARE MATTERS

Subtitle A—Prescription Copayment Adjustment

Section 311 modifies the income threshold amount for prescription drug copayments by specifying that that income threshold amount be the same as the income threshold used to determine a veteran's qualification for free outpatient and inpatient care.

Subtitle B—Extensions of Authorities

Section 321 provides that the effective date of the amendment made by Section 132 of Public Law 107–135 shall be January 23, 2002, and requires that the Office of Personnel Management recompute the annuities of each covered health care professional who retired before January 23, 2002, but after April 7, 1986.

Section 322 extends for ten years the eligibility for health care services of veterans who served in Southwest Asia during the Persian Gulf War.

Subtitle C—Other Matters

Section 331 provides hourly-rate employees of the Veterans Canteen Service with transfer rights to title 5 positions.

Section 332 requires that VA establish a two-year pilot project on medical care outreach at two locations in the State of Washington.

BACKGROUND AND DISCUSSION

TITLE I—LONG-TERM CARE AND MENTAL HEALTH ENHANCEMENTS

Long-Term Care Authorities

There is clearly an expanding need for long-term care in our country, and in VA that demand is even more pressing.

Approximately 37 percent of the veteran population is 65 years of age or older; the veteran population exceeding age 65 will grow dramatically in the next few years. In an effort to respond to the burgeoning need for long-term care services, Congress enacted comprehensive long-term care legislation for veterans in November 1999 as part of the Millennium Act. Section 101 of the Millennium Act directed that VA provide nursing home care to any veteran

who is in need of such care for a service-connected condition, or who is more than 70 percent disabled due to a service-connected condition. In addition, VA was directed to provide non-institutional care, such as respite and adult day health care, to all enrolled veterans requiring such services. Within three years of the bill's enactment, VA was required to evaluate and report to the House and Senate Committees on Veterans' Affairs on VA's experience in providing services under both of these provisions, and to make recommendations on extending or making permanent these provisions. These programs were given an expiration date of four years from the date of enactment so that the effects on the VA health care system and its patients could be adequately studied and, if need be, the programs modified.

A key element of the Millennium Act is a provision that requires VA to furnish non-institutional long-term care as part of VA's standard benefits package. While the Millennium Act was signed into law at the end of 1999, VA did not issue interim guidance on new long term care benefits until October 2001—nearly two years later. This interim guidance, VHA Directive 2001–061, required facilities either to have non-institutional long-term care services available or to develop a plan for providing such services. In order to assess whether facilities had made non-institutional services universally available, Chairman Rockefeller and House Veterans' Affairs Committee Ranking Member Lane Evans requested that the GAO inventory non-institutional long-term care programs then existing within VA.

At the Committee's hearing on April 25, 2002, GAO witnesses testified that:

> . . . more than two years after enactment, VA has not completed its response to the Millennium Act . . . we have found that several facilities reported offering at least eight of the non-institutional long-term care services, but some offered one non-institutional service or none at all. The results of our survey are similar to the distribution of services noted almost four years ago by the Advisory Committee on the Future of VA Long-Term Care.

Veterans Service Organizations shared their concerns at the Committee's May 2, 2002, hearing on pending legislation. Dennis Cullinan testified that, "[t]he VFW is deeply disappointed that these services, as provided for [in the Millennium Act] almost three years ago, have yet to be properly implemented by VA."

Following the hearing, on May 17, 2002, VA issued regulations authorizing non-institutional long-term care services. In addition to designating non-institutional adult day care, non-institutional geriatric evaluation, and non-institutional respite care as a part of the medical benefits package, the regulations also established copayments for extended care services.

Since Millennium Act provisions relating to both non-institutional and inpatient long term care services are due to expire next year, Section 101 of the Committee bill would extend the expiration dates of both long-term care authorities for an additional five years, until December 31, 2008.

Mental Health Enhancements

As the Committee has previously sought to improve and expand the provision of veterans' long-term care, so too has the Committee worked to improve mental health services provided by VA. Historically, as many as one-third of veterans seeking care at VA have received mental health treatment, and research suggests that serious mental illnesses affect at least one-fifth of veterans who use the VA health care system.[1] About 450,000 of the approximately 2.3 million veterans who receive compensation from VA have service-connected psychiatric and neurological disorders.[2] These statistics do not reflect problems that affect veterans alone; in 1999, the Surgeon General of the United States reported that mental disorders account for more than 15 percent of the overall burden of disease from all causes—slightly more than all forms of cancer.[3] Major depression alone ranked second only to heart disease in impact.

Grants to Improve Specialized Mental Health Programs

From its inception, the VA health care system has been challenged to meet the special needs of veterans, such as spinal cord injuries, injuries requiring prosthetic devices, blindness, traumatic brain injury, homelessness, and post-traumatic stress disorders (PTSD), as well as substance use disorders that frequently accompany these other afflictions. Over the years, VA has developed widely-commended expertise in providing specialized services to meet these needs. Unfortunately, these programs have been negatively affected by budget constraints, a shift in focus from inpatient to outpatient care, and the introduction by VA of a new resource allocation system. In 1996, Congress recognized that VA efforts to serve more veterans with a limited budget made these costly specialized services disproportionately vulnerable to reductions, and it took steps to protect them. The Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104–262, required the Secretary of Veterans Affairs to maintain VA's capacity to treat specific special needs of disabled veterans at then-current levels, and to report to Congress annually on the maintenance of those specialized services.

Subsequently, internal VA advisory committees and the GAO reported that these protections did not go far enough.[4] Many specialized programs particularly for substance use disorders and PTSD were closed, reduced in size, or understaffed, offering little or no care to veterans suffering from these seriously debilitating disorders which can result from combat experiences. VA's own annual capacity reports evidenced that these programs had failed to pro-

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[1] E. P. Fischer, S. R. Mardner, G. R. Smith, R. R. Owen, L. Rubenstein, S. C. Hedrick, and G. M. Curran. Quality Enhancement Research Initiative in Mental Health. *Medical Care,* June 2000; 38(6 Suppl. 1): 170–81.

[2] Department of Veterans Affairs, Veteran Data and Information. Program Statistics: FY 1999 Annual Accountability Report Statistical Appendix, September 30, 1999.

[3] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[4] U.S. Department of Veterans Affairs. Special Committee on Post-Traumatic Stress Disorder. *Report to the Under Secretary for Health,* 2002, pp. 6, 7, 11, and 13; and U.S. Department of Veterans Affairs. Committee on the Care of Veterans with Serious Mental Illness. *Report to the Under Secretary for Health,* 2002, pp. 4, 6, and 16.

vide services to veterans at the needed levels. They also evidenced that VA had failed to preserve equal access to such services throughout the VA system.[5]

In December 2001, Congress strengthened protection of specialized services through the Department of Veterans Affairs Health Care Programs Enhancement Act of 2002, Public Law 107–135, which described the manner in which VA is to maintain capacity. In addition to protecting VA's capacity to treat veterans' special needs, Public Law 107–135 contained a designated $15 million in VA funding specifically to assist medical facility efforts to improve care for veterans with substance use disorders and PTSD. The funds for these mental health grant programs will soon revert to a general medical care fund.

In order to distribute these designated funds, VA sought proposals from facilities interested in expanding and improving their substance use disorder and PTSD treatment programs. VA began to release these funds at the end of 2001. As of March 2002, eight of the sixteen PTSD treatment programs awarded funding were operational, but only one-third of these had hired a full complement of authorized and funded staff.[6] Of the substance use disorder programs funded through this act, 18 of 31 have not completed staffing.[7]

Despite a slow start, funding has resulted in new PTSD and substance use disorder treatment programs being made available to veterans. More than 100 staff members have been hired in 18 of VA's 21 service networks to treat substance use disorders. Nine new programs in Baltimore, Atlanta, San Francisco, Dayton and elsewhere have initiated or intensified opioid substitution programs for veterans who have not responded well to drug-free treatment regimens. Other new programs, such as those in Tampa, Cincinnati, Columbia, Missouri and Loma Linda, California, put special emphasis on treating veterans with more complex conditions that include PTSD and substance use disorders. Additional funding has also enabled VA to develop better outpatient substance use disorder and PTSD treatment programs, outpatient dual-diagnosis programs, more PTSD community clinical teams, and more residential substance use disorder rehabilitation programs.

Due to these grants, VA has made improvements. However, many VA medical center directors have been reluctant to hire specialized substance use disorder or PTSD treatment staff when, in fiscal year 2003, funding for these programs will be subject to a population-based resource allocation system that would likely cause funding to disappear. Section 111 ensures that this funding will remain "protected" for three more years. In addition, Section 111 would increase the total amount of funding identified specifically for treatment of substance use disorders and PTSD from $15 million to $25 million.

Of the $25 million authorized for this program, $15 million would be allocated to individual medical facilities responding to calls for

[5] U.S. Department of Veterans Affairs. *Report to the Committees on Veterans' Affairs of the Senate and House of Representatives,* as required by Public Law 104–262, 2002, pp. 11–12.

[6] U.S. Department of Veterans Affairs. Program Evaluation Resources Center, VA Palo Alto, California. *Millennium Bill Implementation for Substance Abuse Programs as of July 15, 2001.*

[7] Ibid.

proposals. The remaining $10 million would be provided as direct grants to VA treatment facilities, based on veterans' needs as identified by VA's Mental Health Strategic Health Care Group and the Committee on Care of the Severely Chronically Mentally Ill.

Veterans Service Organizations have impressed upon the Committee the need to set aside funding for specialized services, especially for PTSD and substance use disorder programs. Joseph Violante, National Legislative Director of the Disabled American Veterans, testified at the Committee hearing on S. 2044. During his testimony, he noted:

> As part of The Independent Budget,[8] DAV has urged Congress to improve specialized mental health services, particularly programs for the treatment of post-traumatic stress disorder and substance abuse . . . The treatment and rehabilitation of veterans with mental disorders is among the highest priorities for the Veterans Health Administration. This bill will begin to address necessary programmatic expansion and funding needs of these important mental health programs.

Sexual Trauma Counseling

Almost a decade ago, the Committee on Veterans' Affairs held a hearing on the needs of the Nation's growing numbers of women veterans. Subsequent to that hearing, investigations revealed that women veterans are eight times more likely to report having experienced sexual assault during service than women civilians of the same age.

In 1992, Congress authorized VA to provide counseling to women who had experienced sexual trauma during active service. Two years later, recognizing that sexual trauma is not limited to women, Congress expanded VA's mandate to offer counseling and treatment to victims of sexual harassment or sexual assault without regard to gender. The Millennium Act broadened VA's responsibilities toward victims of sexual trauma further, strengthening outreach efforts and extending the programs through December 2004.

VA has worked—internally and with the Department of Defense—to educate health care professionals about the physical and emotional legacies of sexual trauma. Those who have endured such trauma need counseling and appropriate treatment, both during and following service. While we must hope that sexual violence will be eliminated from our forces, the programs that VA has established will likely continue to be needed. Section 112 would authorize VA to continue its counseling and treatment programs for veterans who have experienced military sexual trauma beyond 2004.

The Committee on Veterans' Affairs continues to await a VA report, mandated by the Millennium Act and due in March 2001, on rates of sexual trauma among National Guard members and Reservists. Upon receipt of that report, the Committee will be better equipped to decide whether authority for counseling and treatment services to members of the Armed Forces who might have experi-

[8] A publication published jointly by AMVETS, Disabled American Veterans, Paralyzed Veterans of America and the Veterans of Foreign Wars to present policy positions and make budget recommendations on programs conducted by the Department of Veterans Affairs.

enced sexual trauma while on active duty for training will be needed.

Mental Illness Research, Education, and Clinical Centers

In 1996, Congress authorized VA to establish five centers dedicated to mental illness research, education, and clinical activities. These Mental Illness Research, Education, and Clinical Centers (hereinafter, "MIRECCs") integrate basic and clinical research with a training mission that allows VA to translate new findings into improved patient care. Research undertaken within these centers has helped to increase fundamental understanding of mental illnesses, and has given VA care givers more and better tools to treat patients with mental disorders so they can function more easily within their communities.

Because they have proved so effective at fostering scientific, clinical, and educational improvements in mental health care, Section 113 authorizes VA to expand the number of MIRECCs from five to fifteen. VA researchers have already started three more centers—expanding the number of existing programs to eight—and have demonstrated their willingness to open more in the near future.

While the Committee bill contains no legislative initiatives to assist the National Center for PTSD, the Committee commends the Center for its work at the forefront of research and education on the etiology, diagnosis, and treatment of PTSD and other adverse consequences of exposure to stress. Its consistent record of accomplishment is one reason VA has emerged as a national and world leader in this field. National Center programs supporting VA clinicians, benefits personnel, researchers and other officials result in improved treatment and claims adjudication for veterans. The Committee believes that the National Center for PTSD is a unique and valuable resource that deserves continued strong support from VA.

TITLE II—CONSTRUCTION MATTERS

Subtitle A—Construction Authorization

Sections 201–203. Major Medical Facility Construction

VA may not obligate or expend funds on any "major medical facility project" unless that project has been specifically authorized by law. A major medical facility project is one that would involve the construction, alteration, or acquisition of a medical facility involving the total expenditure of more than $4 million.

Section 201 of the Committee bill would authorize the following major medical facility projects: seismic corrections to Building 2 at the Palo Alto VAMC in the amount of $14 million; seismic corrections to Building 4 at the Palo Alto VAMC in the amount of $22 million; seismic corrections to the West Los Angeles VAMC in the amount of $27 million; and seismic corrections to the San Francisco VAMC in the amount of $31 million.

The Committee bill also increases the amount of the authorization for a previously-authorized project at the Beckley, West Virginia VAMC. It also extends a previously-enacted authorization for a long-term care project at the Lebanon, Pennsylvania VAMC.

VA identifies—in accordance with 38 U.S.C. § 8107(d)(1), (2), and (3)—the major construction projects that have the highest priority within the Department. Utilizing guidance contained in the Office of Management and Budget's Circular A–11, Planning, Budgeting, and Acquisition of Capital Assets, the VA's Strategic Management Council prioritized the major medical construction projects for FY 2003. The top fifteen projects, in order of priority, are:

1. Palo Alto, CA, Building 2, Seismic Corrections
2. Cleveland, OH, Ambulatory Surgery and Clinical Consolidation
3. San Francisco, CA, Building 203, Seismic Corrections
4. Anchorage, AK, VA Health Care System and Regional Office Construction
5. West Los Angeles, CA, Building 500, Seismic Corrections
6. West Haven, CT, Ward Renovation
7. Long Beach, CA, Building 7, Seismic Corrections
8. Palo Alto, CA, Building 4, Seismic Corrections
9. Tampa, FL, Ambulatory Care Expansion
10. VISN 4 Outpatient Improvements
11. Beckley, WV, Nursing Home Construction
12. Lebanon, PA, Building 2 Renovations
13. San Diego, CA, Building 1, Seismic Corrections
14. Hines, IL, Spinal Cord Injury and Blind Rehabilitation Construction
15. San Juan, PR, Main Building, Seismic Corrections

While the Committee bill includes authorizations for each project requested by the Administration in the President's Fiscal Year 2003 Budget, the Committee is concerned about the methodology used by VA to rank projects and how that ranking relates to the Administration's requests for funding. The four seismic correction projects requested by the Administration appear on various points along VA's priority list, namely, first, third, fifth, and eighth. Funding and authorization for other projects which appear, in some cases, as higher priority projects is not sought by the Administration. For example, the Cleveland, Ohio ambulatory surgery and clinical consolidation project appears as the Department's second-highest rated project; yet, the project does not appear in the Administration's budget request. The Committee intends to monitor the process closely during the next budget cycle and urges the Department to review its construction request methodology.

Subtitle B—Other Matters

Sec. 211. Increase in Threshold for Major Medical Facility Projects

Section 211 of the Committee bill increases the threshold for major construction projects from $4 million to $9 million. Currently, VA medical center projects with a minor improvement component of less than $4 million are funded from the Minor Construction appropriation and need not be authorized individually by Congress. However, all such projects are subjected to internal review and approval by VA's Strategic Management Council. The application process includes an assessment of needs; a ten-year cost-effectiveness analysis; a study of the impact on Capital Asset Realign-

ment for Enhanced Services activities; risk analysis; and alternative analysis of issues such as quality, access, waiting times and increased benefits. Projects are first screened by the Capital Asset Board in the Veterans Health Administration. They are then prioritized and referred by the Under Secretary for Health to the Department's Strategic Management Council, chaired by the Department's Deputy Secretary. Minor improvement projects include structural changes, space utilization changes, and construction of new or additional space.

Initially, 38 U.S.C. § 8104 made no distinction between major and minor construction projects. In 1988, Public Law 100–322 defined major construction projects as those costing more than $2 million and required that those projects be authorized and individually appropriated by Congress. In 1993, Public Law 103–79 changed the threshold for a major project from $2 million to $3 million, and in 1996, Public Law 104–262 increased the threshold to $4 million. Over a period of 14 years, the threshold has only increased an average of less than $150,000 per year.

The Independent Budget for Fiscal Year 2003 addressed the issue of minor construction by noting:

> . . . the $4 million limit on minor construction projects imposed by Congress continues to be a major problem. Realignment and consolidation and the CARES initiative will call for extensive construction investments in many facilities in all VISNs. Accordingly, the current ceiling on minor construction projects is too low to finance the scope of many of these projects . . . Network Directors are forced to string together a series of minor construction projects to make the architectural changes that are needed to realign facilities to new missions. Project scheduling is dictated by financing gimmicks rather than by good design and engineering principles. Facility operations are disrupted and veterans are inconvenienced by drawn-out construction activities.

An example of the how VA "works around" the current minor construction limit is the Augusta VAMC's Spinal Cord Injury (hereinafter, "SCI") unit. VA needed to replace the unit because current privacy and infrastructure (plumbing, electrical, AC and ventilation) standards were not met. A replacement unit would have cost approximately $14 million—an amount well above the minor construction limit. Rather than pursuing approval for major construction project funding, facility and VISN management decided to remodel the current SCI unit in two phases using funding for two minor construction projects (totaling around $7 million). The first phase, which was a renovation of inpatient areas, was approved and construction has begun. Another minor construction project will be requested in fiscal year 2003 to complete the remodeling of the outpatient areas. By doing the project in two phases, VA will take 50 percent longer to complete the project. Additional inconvenience to veterans and disruptions during construction will result.

Sec. 212. State Home Facilities for Furnishing Care to Veterans in the State of Alaska

Section 212, provides VA the authority to grant to the State of Alaska up to $16 million to improve space in six existing Pioneer Homes.

Since 1888, the Federal government has provided funding to States to assist in the care of elderly veterans. 38 U.S.C. § 8135(a) requires any State desiring assistance with the construction of State home facilities to submit an application to the Secretary, certifying that the State has funding of not less than 35 percent of the costs needed with respect to such construction and that such funding will be available by July 1 of the fiscal year in which the application is made.

The State of Alaska is one of three States that currently does not have a State Veterans Home. However, the State does maintain a residential housing program, known as Pioneers' Homes, for elderly citizens, including veterans and their spouses, in six different locations within the State.

The grant provided under this section would exempt the State from meeting the 35 percent funding requirement and would treat the space in the aggregate as a State home facility.

TITLE III—GENERAL HEALTH CARE MATTERS

Subtitle A—Prescription Copayment Adjustment

Sec. 311. Standardization of Income Thresholds for Copayment for Outpatient Medications and for Inability to Defray Necessary Expenses of Care

Under current law, veterans who are eligible for Medicaid, or those who meet an income threshold established by law, are eligible to receive free health care at VA facilities. Additionally, veterans who are—or would be—eligible for a VA pension receive free prescription drugs. However, the income threshold for pension eligibility is much lower than that set for Medicaid eligibility or the means test established by statute for free health care.

The prescription drug copayment was initially established by Public Law 101–508, the Omnibus Budget Reconciliation Act of 1990. The charge was $2 for each 30-day supply of medication prescribed by a VA physician. Public Law 101–508 also established the means test for determining the ability to pay copayments for outpatient medical care. The means test considers annual income (setting a threshold at approximately $24,300) and net property worth (setting a threshold at $80,000). Public Law 101–508 did not, however, include an income threshold for prescription drug copayments. As a consequence, all veterans, except those with a 50 percent or greater service-connected disability, were charged the $2 medication copayment prescribed for drugs to treat nonservice-connected conditions. Later, Public Law 102–568, exempted veterans whose annual income did not exceed the maximum annual rate of VA pension (approximately $9,500 today) from paying the prescription drug copayment.

For veterans with financial hardships, VHA Directive 2002–005, dated January, 2002, provides authority and guidance to field fa-

cilities for processing waiver requests for medical care and prescription drug copayment debts.

On February 4, 2002, VA raised the prescription copayment from $2 to $7—a 350 percent increase. This increase has been particularly burdensome for lower-income veterans. To illustrate the new financial burden imposed on those with low incomes, the Committee considered the case of a veteran who required ten prescriptions and had an income of approximately $10,000 a year. Because of VA's increase in the prescription drug copayment, such a veteran must now allocate 8.4 percent of his or her annual income, rather than 1.2 percent, on prescription medications.

Robert E. Wallace, Executive Director, Veterans of Foreign Wars, wrote in a letter to the VA Secretary, Anthony J. Principi:

> That scenario will probably result in one of two things for our category 5 veterans: they will either stop seeking needed medical care because the increased costs will soon "price" them out of the system or we will be faced with an inordinate increase in the number of waiver requests . . . the substantial increase of unintentional patient noncompliance will, in the long run, invariably result in overall higher medical costs than what would be recovered by the increased prescription copayment.

On May 2, 2002, the American Legion testified before the Committee about the need to modify the income threshold for prescription drugs.

> The American Legion has heard—loud and clear—the negative reactions of veterans to the recent medication copayment increase. . . . Clearly, the sizable percent of this increase has presented difficulties for certain veterans, especially those with low fixed incomes and those who are barely above the threshold for exemption—the pension rate of $9,556—as well as those veterans who require multiple or maintenance medications. Veterans also find the complex and arcane rules that govern eligibility difficult to understand. Standardizing the thresholds, as proposed, would help to simplify the copayment criteria, but most importantly, it would assist those least able to afford the increase in their prescription copayments.

Section 311 of the Committee bill standardizes the income threshold limitation for prescription copayments with the income threshold for outpatient medical care. The primary purpose for this modification is to reduce the financial burden of the VA's new $7 copayment imposed upon veterans in the lower income levels (between $9,500 and $24,300); however, there are administrative benefits associated with this provision as well.

The number of waivers requested by veterans has increased dramatically, as the Veterans of Foreign Wars predicted. For the first three months of the increase, $4.7 million more in copayment charges have been waived than during the same time period last year. One VA medical center reported that waiver applications had increased from only 4 in April 2001 to 48 in April 2002. Because the Committee expects that the number of waivers requested by veterans will be nearly eliminated by this provision, there would be a corresponding decrease in the manpower associated with filing, processing, and reviewing each claim.

Subtitle B—Extensions of Authorities

Sec. 321. Retirement Annuities for Part-Time VA Nurses

Section 321 of the Committee bill addresses an issue of fairness in retirement annuity benefits promised to part-time VA nurses prior to 1986. In December 2001, Congress enacted the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, Public Law 107–135. This legislation gave VA several tools to respond to the looming nurse crisis. In addition, it altered the way part-time service performed by certain title 38 employees would be considered when granting retirement credit.

Previously, the law required that title 38 employees' part-time service prior to April 7, 1986, be prorated when calculating retirement annuities, resulting in lower annuities for these employees. Section 132 of Public Law 107–135 was intended to exempt all previously-retired registered nurses, physician assistants, and expanded-function dental auxiliaries from this limitation. However, the Office of Personnel Management has interpreted this provision to apply only to those health care professionals who retire after the measure's date of enactment.

Section 321 of the Committee bill would require OPM to recalculate the annuities for these retired health care professionals. This clarification would not extend retirement benefits retroactively to the date of retirement. It would, however, ensure that annuities are calculated fairly from now on for eligible employees who retired between April 7, 1986, and January 23, 2002.

Sec. 322. Eligibility for Persian Gulf War Veterans

Section 322, which is drawn from S. 1576, as introduced by Chairman Rockefeller, extends eligibility for health care to veterans who served in Southwest Asia during the Persian Gulf War.

Service members returning from the Gulf in 1991 reported a range of unexplained illnesses that many believed might have resulted from service. Investigations by Congress, the Departments of Defense and Veterans Affairs, and the Institute of Medicine showed that the men and women who served in Operation Desert Storm might have been exposed to many battlefield hazards, including smoke from oil-well fires, pesticides, organic solvents, the drug pyridostigmine bromide, numerous vaccinations, and sarin nerve gas.

Success in determining whether any or all of these hazards might be linked to specific symptoms has been limited by poor data, a lack of research into the long-term effects of low-dose exposures, and incomplete military record keeping. In response to concerns about the health of Gulf War veterans, Congress enacted Public Law 102–585, authorizing health examinations, tasking the National Academy of Sciences to evaluate scientific evidence regarding potential Gulf War exposures, and establishing the Gulf War Veterans Health Registry. In addition, Congress enacted Public Law 102–310, authorizing VA to provide health care services on a priority basis to Gulf War veterans through December 31, 2001. Public Law 107–135 extended this provision granting access to health care on a priority basis through December 31, 2002.

More than a decade after the war, scientific research still has not determined the causes of veterans' symptoms, or the long-term health consequences of Gulf War exposures. The Department of Defense recently released new estimates of the number and locations of service personnel exposed to nerve agents. To meet the medical needs of Gulf War veterans, now and in the future, Section 322 of the Committee bill would extend this period for providing health care services on a priority basis for 10 more years.

Subtitle C—Other Matters

Sec. 331. Transfer Rights for VA Canteen Workers

Section 331 of the Committee bill would provide transfer rights for hourly rate Veterans Canteen Service (hereinafter, "VCS") employees to title 5 VA positions through internal competitive procedures. VCS hourly-rate employees are Federal employees hired under authority of 38 U.S.C. § 7802. And while this authority provides many of the same benefits that title 5 federal employees enjoy, (e.g., workers compensation, health benefits, retirement, and veterans' preference) there are benefits to which they are not entitled. For example, VCS hourly employees do not have the same transfer rights to other VA positions that VCS managers have.

VCS hires through a merit system; however, VA may hire canteen workers without regard to title 5 competitive civil service procedures. As a result, VCS hourly employees applying for VA food service positions, VA housekeeping positions, and other VA positions are not treated as internal competitive service candidates. Their years of service are irrelevant, as they cannot easily transfer to another job at VA without first going through civil service competitions.

In 1979, the Office of Personnel Management (hereinafter, "OPM") approved an interchange agreement with VA that permitted two-way movement between the two hiring authorities. VA attempted to establish an interchange agreement for the hourly employees in 1984, 1987 and 1998, but OPM did not approve these proposals.

Sec. 332. Pilot Project on Medical Care Outreach for Veterans in the State of Washington Through Outreach Clinics

Section 332 requires VA to establish a program, during fiscal years 2003 and 2004, to provide health care services for veterans in the State of Washington through two outreach clinics. The clinics would be located in Whatcom County, Washington and in north central Washington, in or near Leavenworth, Washington.

Each clinic would provide basic health care services, including diagnosis and referral to other VA facilities, at least one day per week. VA would be required, by June 1, 2004, to provide to the Veterans Committees of the Senate and the House a report on the program describing personnel utilized, patient workload and costs, and making recommendations regarding the modification or expansion of the pilot project.

COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by CBO, estimates that, compared to the CBO baseline, there would be costs resulting from enactment of the Committee bill.

The cost estimate provided by CBO follows:

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 24, 2002.

Hon. JOHN D. ROCKEFELLER IV,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 2043, the Veterans Long-Term Care and Mental Health Programs Enhancement Act of 2002.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sam Papenfuss.

Sincerely,

BARRY B. ANDERSON,
for DAN L. CRIPPEN, *Director.*

Enclosure.

S. 2043 Veterans Long-Term Care and Mental Health Programs Enhancement Act of 2002 (As ordered reported by the Senate Committee on Veterans' Affairs on June 6, 2002)

SUMMARY

S. 2043 contains several provisions that would affect health care provided by the Department of Veterans Affairs (VA). CBO estimates that enacting the bill would increase direct spending by $6 million in 2003, $30 million over the 2003–2007 period, and $64 million over the 2003–2012 period. Because the bill would affect direct spending, pay-as-you-go procedures would apply. In addition, S. 2043 would modify provisions governing discretionary spending for veterans' health care programs, which CBO estimates would result in outlays of $28 million in 2003 and $880 million over the 2003–2007 period, assuming appropriation of the estimated amounts.

The bill would extend for five years certain requirements that specify how VA is to provide long-term care to veterans. S. 2043 also would increase the amount of appropriated funds spent on mental health services and would increase the number of centers at VA hospitals that focus on mental health research and services. In addition, the bill would permanently extend the authority to provide counseling and treatment for veterans who suffer from sexual trauma and establish a pilot program of outreach clinics in the state of Washington. S. 2043 also would require retirement annuities to be recalculated for certain former VA employees.

S. 2043 also would allow more veterans to become eligible for free prescription drugs by raising the income threshold for deter-

mining which veterans need to make a prescription drug copayment. Because the bill would not extend the authority to collect prescription drug copayments, which expires on September 30, 2002, enacting this provision would have no budgetary effect over the 2003–2007 period. The provision could increase direct spending in fiscal year 2002, however, if the bill is enacted soon. If the bill is enacted before the end of the fiscal year, CBO estimates that raising the income thresholds for eligibility for free prescription drugs could increase direct spending by no more than $9 million in 2002, and that this increase would be offset by savings of $7 million in 2003 and $2 million in 2004.

Finally, the bill would authorize appropriations for construction projects and would raise the threshold for projects to be financed out of the appropriation for major medical facility construction from $4 million to $9 million. (Thus, under the bill projects costing up to $9 million would be considered minor construction.)

S. 2043 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 2043 is shown in Table 1. For this estimate CBO assumes that the bill will be enacted near the beginning of fiscal year 2003, and that both the authorized and estimated amounts will be appropriated each year. The costs of this legislation fall within budget functions 600 (income security) and 700 (veterans benefits and services).

Table 1.—Estimated Budgetary Impact of S. 2043

[By Fiscal Year, in Millions Dollars]

	2003	2004	2005	2006	2007
CHANGES IN DIRECT SPENDING					
Estimated Budget Authority	6	6	6	6	6
Estimated Outlays	6	6	6	6	6
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Estimated Authorization Level	150	192	197	179	186
Estimated Outlays	28	208	237	213	194

[a] Enacting S. 2043 could also increase direct spending in fiscal year 2002 if the bill is enacted before the end of the fiscal year. In that case, CBO estimates raising the income threshold for determining which veterans are eligible for free prescription drugs could increase direct spending by no more than $9 million in 2002, depending on the date of enactment, but that this increase would be offset by savings of $7 million in 2003 and $2 million in 2004.

BASIS OF ESTIMATE

Direct Spending

The legislation would affect direct spending in all future years for retirement annuities to certain former VA employees. The bill could also affect direct spending in 2002 by allowing more veterans to become eligible for free prescription drugs, but those potential effects are not included in Table 1 because we assume the bill will be enacted near the beginning of fiscal year 2003 for the purposes of this cost estimate.

Retirement Annuities for Certain Retirees with Part-time Service. S. 2043 would require retirement annuities to be recalculated for federal retirees who performed part-time service as reg-

istered nurses, physician's assistants, and certain dental technicians at VA prior to April 7, 1986. The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (Public Law 107–135), enacted on January 23, 2002, made changes to the way retirement benefits are determined for those workers who retired on or after the date that legislation was enacted. That legislation treated pre-April 7, 1986, part-time service as full-time service for the purpose of calculating retirement annuities. S. 2043 would extend these changes to the types of workers covered by Public Law 107–135, but who retired between April 6, 1986, and January 23, 2002. Retirement benefits for these workers currently are set according to a formula that prorates all part-time service performed in these positions. For most other federal workers, including those covered by Public Law 107–135, part-time service performed prior to April 7, 1986, is treated as full-time service when calculating retirement annuities. In most cases, the changes result in higher retirement benefits.

Information about retirees who would be covered by S. 2043 is limited, but based on data provided by VA and the Office of Personnel Management, CBO estimates that about 1,500 current retirees would have their benefits increased by the bill. CBO estimates that the new formula would increase benefits for affected retirees by 13 percent to 22 percent, depending on how much part-time service was performed prior to April 7, 1986. As a result, enacting S. 2043 would increase direct spending by $6 million in 2003, $30 million over the 2003–2007 period, and $64 million over the 2003–2012 period.

Prescription Copayments. Under current law, veterans who are eligible for a VA pension, eligible for Medicaid, or meet a certain income threshold are eligible to receive free health care at VA hospitals and clinics. That income threshold is currently $24,305 for a veteran with no dependents. Some veterans also can receive free prescription drugs, but the income threshold is much lower, currently $9,556 for a veteran with no dependents. (Both thresholds are adjusted annually for inflation.) Section 311 would raise the income threshold for receiving free prescription drugs to the same level needed to receive free health care and would allow all veterans with incomes less than the annually adjusted amount to be eligible for free prescription drugs.

Today, veterans who do not meet the income threshold for free prescription drugs must make a copayment when they have their prescriptions filled. VA currently collects a $7 copayment for each outpatient prescription it fills and deposits the first $2 of this copayment into the Medical Care Collections Fund (MCCF). Under current law, amounts deposited into the MCCF are considered to be offsets to discretionary appropriations and spending from the MCCF is subject to annual appropriation. The remaining $5 is deposited into the Health Services Improvement Fund (HSIF). Deposits into the HSIF are considered offsets to direct spending, and VA may spend amounts in the HSIF without appropriation action. That is, both the receipts and outlays of the HSIF constitute direct spending.

Using information from VA, CBO estimates that raising the income threshold for determining which veterans make prescription

drug copayments would reduce copayment collections by about 35 percent. Because the authority to collect prescription drug copayments expires on September 30, 2002, the impact of providing free prescription drugs to a larger number of veterans would only affect fiscal year 2002 and have no budgetary effect over the 2003–2012 period.

If S. 2043 were enacted before the end of the fiscal year, CBO estimates that collections deposited into the HSIF would decline by no more than $23 million. Because VA has the authority to spend the money in the HSIF without appropriation, any drop in collections would be matched by a drop in spending from the fund. Accounting for a lag in spending of HSIF deposits, we estimate that there could be a net increase in direct spending of up to $9 million in 2002. That increase would be offset exactly by savings of $7 million in 2003 and $2 million in 2004. Thus, enacting S. 2043 would have no net direct spending costs or savings over the 2002–2007 period.

Spending Subject to Appropriation

Table 2 shows the estimated effects of S. 2043 on discretionary spending for veterans' health care programs, assuming that appropriations are provided in the authorized and estimated amounts. Individual provisions that would affect discretionary spending are described below.

Table 2.—Changes in Spending Subject to Appropriation for S. 2043

[By Fiscal Year, Outlays in Millions of Dollars]

	2003	2004	2005	2006	2007
VETERANS' MEDICAL CARE					
Long-Term Care:					
Estimated Authorization Level	0	166	171	177	184
Estimated Outlays	0	151	169	176	182
Mental Health Care:					
Estimated Authorization Level	23	24	26	2	2
Estimated Outlays	21	24	26	4	2
Pilot Project on Medical Care Outreach:					
Estimated Authorization Level	2	2	0	0	0
Estimated Outlays	2	2	0	0	0
Subtotal for Veterans' Medical Care:					
Estimated Authorization Level	25	192	197	179	186
Estimated Outlays	23	177	195	180	184
MAJOR CONSTRUCTION OF VETERANS MEDICAL FACILITIES					
Authorization Level	109	0	0	0	0
Estimated Outlays	5	29	35	26	10
GRANTS FOR CONSTRUCTION OF EXTENDED CARE FACILITIES					
Authorization Level	16	0	0	0	0
Estimated Outlays	0	2	7	7	0
TOTAL CHANGES					
Estimated Authorization Level	150	192	197	179	186
Estimated Outlays	28	208	237	213	194

Veterans Medical Care. Federal spending for all veterans medical care totals more than $22 billion a year. Several sections of the bill would affect medical care for veterans. In total, CBO estimates that implementing these provisions would cost $23 million in 2003 and $759 million over the 2003–2007 period.

Long-Term Care. Section 101 would extend a requirement in current law that VA provide nursing home care to veterans that have a disability rating of 70 percent or greater. Under current law, this requirement expires on December 31, 2003. This provision would extend the requirement for five more years through December 31, 2008. Section 101 also would extend an authorization to treat noninstitutional extended care services as regular medical care. According to VA, the department currently spends about $3.5 billion a year providing long-term care services to veterans. Of that amount, VA spends more than $2 billion for nursing home care and less than $0.5 billion for noninstitutional extended care.

According to VA, it currently spends about $150 million a year out of the $3.5 billion to conform with the above requirements. Accordingly, CBO estimates that requiring VA to continue these services would cost $151 million in 2004 and $678 million over the 2004–2007 period, assuming appropriation of the estimated amounts.

Mental Health Care. Section 113 would require VA to establish not more than 15 centers for mental illness research, education, and clinical activities. VA can establish no more than five centers under current law. According to VA, there are eight such centers operating today, however. Thus, for this estimate, CBO assumes that VA would establish seven more centers for mental illness research, education, and clinical activities to implement this provision. Based on data from VA, CBO estimates that each center would cost about $2 million a year to operate. Assuming normal delays in organizing new centers and appropriation of the estimated amounts, CBO estimates that establishing seven new centers would cost $12 million in 2003 and $70 million over the 2003–2007 period.

Section 111 would require VA to spend an additional $25 million a year on mental health care over the 2003–2005 period. Under current law, VA is required to spend $15 million more each year than what they otherwise would have spent on post-traumatic stress disorder and substance use disorders; there is no expiration date associated with this requirement. Under section 111, VA would be required to spend $10 million more than specified under current law over the 2003–2005 period, but would then not be required to spend any additional amounts after 2005. Thus, CBO estimates that implementing this section would cost $9 million in 2003, cost $29 million over the 2003–2005 period, and save $28 million over the 2006–2007 period.

Section 112 would permanently extend VA's authority to provide counseling and treatment for veterans who suffered sexual trauma while a member of the armed services. Under current law, this provision expires on December 31, 2004. VA currently spends about $2 million a year providing this counseling and treatment. CBO estimates that extending this provision would cost $2 million in 2005 and $6 million over the 2005–2007 period, assuming appropriation of the estimated amounts.

Prescription Drug Copayments. Section 311 would raise the income threshold for receiving free prescription drugs to the same level needed to receive free health care and would allow all veterans with incomes less than the annually adjusted amount to be

eligible for free prescription drugs. The specifics of this proposal were discussed above under the heading of "Direct Spending." As mentioned earlier, CBO estimates the impact of providing free prescription drugs to a larger number of veterans would have no budgetary effect over the 2003–2007 period because the authority to collect prescription drug copayments expires on September 30, 2002. (As noted below, costs would be triggered if future legislation extends that authority.)

If S. 2043 were enacted before the end of the fiscal year, CBO estimates that this provision would decrease spending from the MCCF by no more than $10 million. Because spending from the MCCF is subject to appropriation, this reduction would represent a real cost to VA that would need to be paid for out of increased appropriations if the level of medical care were not reduced. CBO estimates that implementing S. 2043 could increase spending by as much as $10 million, if the bill were enacted before October 1, 2002, assuming the availability of appropriated funds.

In addition, if the authority to collect prescription drug copayments were extended through September 30, 2007, CBO estimates that VA would collect $634 million from prescription drug copayments in 2003 and almost $4 billion over the 2003–2007 period. If the collection authority is extended, CBO estimates that those collections would be reduced by about 35 percent or $222 million in 2003 and about $1.4 billion over the 2003–2007 period under S. 2043.

Pilot Project on Medical Care Outreach. Section 322 would authorize VA to establish and operate two VA clinics for fiscal years 2003 and 2004 as a pilot project in the state of Washington to provide outreach on health care and services for veterans in that state. These clinics would provide basic health care services to veterans in areas that do not currently have VA facilities and would be open at least one day a week. Based on information from VA, CBO estimates that each clinic would cost about $1 million a year to operate. Thus CBO estimates that implementing this provision would cost $4 million over the 2003–2004 period, assuming appropriation of the estimated amounts.

Major Construction of Veterans Medical Facilities. Sections 201 would authorize specific construction projects for seismic corrections along with one construction project for a long-term care facility, and would set spending limits for each project. Section 202 would authorize the appropriation of $108.5 million in 2003 for major construction projects. Finally, section 211 would raise the threshold for projects to be financed out of the appropriation for major medical facility construction from $4 million to $9 million. (Thus, under the bill projects costing up to $9 million would be considered minor construction.) CBO estimates that implementing these provisions would cost $5 million in 2003 and $105 million over the 2003–2007 period, assuming appropriation of the authorized amounts.

Grants for Construction of Extended Care Facilities. Section 212 would authorize up to $16 million to expand, remodel, or alter space in six Pioneer Homes in the state of Alaska that are dedicated to providing care for veterans. Under section 212, these modified Pioneer Homes would be considered a state home facility

for the state of Alaska for the purpose of laws administered by the Secretary of VA. CBO estimates that this provision would have no cost in 2003 but would cost $16 million over the 2004–2007 period, assuming appropriation of the authorized amounts.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending. The net changes in outlays that are subject to pay-as-you-go procedures are shown in Table 3. For the purposes of enforcing pay-as-you-go procedures, only the effects through fiscal year 2006 are counted.

Table 3.—Estimated Impact of S. 2043 on Direct Spending and Receipts

[By Fiscal Year, in Millions of Dollars]

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Changes in outlays	0	6	6	6	6	6	6	7	7	7	7
Changes in receipts *											

* Not applicable.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

S. 2043 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

PREVIOUS CBO ESTIMATE

On October 29, 2001, CBO transmitted a cost estimate for S. 1408, the Veterans' Copayment Adjustment Act, as introduced on September 6, 2001. S. 2043 and S. 1408 would both allow more veterans to become eligible for free prescription drugs by raising the income threshold for determining which veterans need to make a prescription drug copayment. Because neither bill would extend the authority to collect prescription drug copayments, which expires on September 30, 2002, the estimated costs of this provision are limited to fiscal year 2002 for both bills. CBO's estimate for S. 2043 does not include any costs for fiscal year 2002 because we assume the bill will be enacted near the beginning of fiscal year 2003. Differences in the cost estimates stem primarily from different assumed enactment dates.

Estimate prepared by: Federal Costs: Sam Papenfuss and Geoffrey Gerhardt. Impact on State, Local, and Tribal Governments: Elyse Goldman. Impact on the Private Sector: Sally S. Maxwell.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any

individuals and that the paperwork resulting from enactment would be minimal.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at its June 6, 2002 meeting. On that date, the Committee, by unanimous voice vote, ordered S. 2043, as amended, reported favorably to the Senate.

AGENCY REPORT

On May 2, 2002, the Honorable Tim McClain, General Counsel, Department of Veterans Affairs, appeared before the Committee and submitted testimony on, among other things, S. 1408, S. 1576, S. 2043, S. 2044, S. 2227, and S. 2228. Excerpts from this statement are reprinted below:

STATEMENT OF TIM McCLAIN, GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, Thank you for the opportunity to testify on a number of legislative items of interest to veterans.

* * * * * * *

S. 1408

This bill would increase the income threshold used to define the group of low-income veterans who are exempted from paying the outpatient pharmacy co-payment. The exempted group would be expanded to include veterans who, for purposes of receiving VA health care, are deemed unable to defray necessary expenses of care, i.e., those with incomes below VA's "means-test" threshold. A provision of the bill would also prohibit the Secretary from increasing the pharmacy co-payment until VA begins collecting co-payments for outpatient care.

Currently, the low-income exemption applies only to those veterans whose incomes do not exceed the maximum annual rate of pension payable under 38 U.S.C. § 1521 were they eligible for such pension. This is a much smaller group composed of very low-income veterans. Although VA appreciates the desire to standardize the definition of "low-income" veteran for purposes of both health care eligibility and the pharmacy co-payment exemption, VA cannot support S. 1408. The proposal would significantly reduce much-needed revenue upon which the Department relies to continue providing services. We also recommend deletion of the provision deferring increases in the amount of the pharmacy co-payment. VA is already implementing new regulations pertaining to both the pharmacy co-payment and the outpatient co-payment.

We estimate the PAYGO costs of S. 1408 to be $300 million dollars annually.

* * * * * * *

S. 1576

S. 1576 would extend through December 31, 2011, VA's special authority to treat Gulf War veterans for any disability, notwithstanding there is insufficient medical evidence to conclude that such disability may be associated with such service. That authority will expire after December 31, 2002. VA supports this proposal.

* * * * * * *

S. 2043

S. 2043 would extend by five years (through December 31, 2008) VA's authority to provide non-institutional extended care services as part of the medical benefits package furnished to veterans. The bill would also extend through December 31, 2008, mandatory eligibility for nursing home care for veterans with a service-connected disability rated 70% or greater. Finally, S. 2043 would extend by five years the date by which the Secretary must report to Congress on the operation of its long-term care programs established under the Millennium Act. VA supports S. 2043 and the continuation of the Millennium Act non-institutional long-term care provisions.

* * * * * * *

S. 2044

S. 2044 would amend section 116 of the Millennium Act to direct that we increase funding for specialized mental health services for veterans. The measure directs that we expend $25 million for these programs, but it is not clear whether it would require $25 million for each of three successive years, or over a three-year period. The additional $25 million must also be over and above the baseline amount now being expended for these programs. However, it is unclear if we must expend an additional $25 million over the baseline each year for three successive years, or only over a three-year period. Finally, the measure directs that we consider these funds to be special-purpose funds that we must allocate outside the VERA allocation system.

Although VA appreciates the need to ensure adequate funding for these highly valuable and essential health-care programs, we strongly oppose this bill. We do not believe any individual health service should be treated differently from other essential treatment programs for allocation of appropriated resources. We also believe it is inappropriate to direct that we allocate funds for programs like this outside of the VERA system.

* * * * * * *

S. 2227

S. 2227 would clarify the effective date of changes to the method of computing retirement annuities for certain VA health-care personnel. Last January the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107–135) became law. That bill changed the way part-time service performed before April 7, 1986, by certain VA health-care personnel is credited for annuity purposes. VA had recruitment and retention problems

based upon the prior methodology of the annuity computation for VA nurses. These difficulties were addressed by the enactment of section 132 of P.L. 107–135. S. 2227 would extend the benefits of section 132 of P.L. 107–135 to individuals who retired before the law's enactment. The Administration opposes legislation that modifies the retirement-benefit computations for employees who are already retired.

* * * * * * *

S. 2228

This bill would provide that the Secretary may establish not more than 15 Centers for Mental Illness Research, Education, and Clinical Activities under 38 U.S.C. § 7320. VA has no objection to this provision.

Additional Views of Chairman John D. Rockefeller IV

Section 212 of the Committee bill sets a precedent which is cause for concern. The State Veterans Home program—run by the Department of Veterans Affairs—is a partnership between the states and VA to meet the needs of veterans through the establishment and maintenance of custodial facilities, hospitals, and nursing homes. This partnership has existed for more than 60 years.

In order to gain access to VA funds, which total 65 percent of the construction or renovation of existing buildings, a state must certify the availability of the remaining 35 percent. This financial commitment allows VA's limited resources to benefit more states and ultimately more veterans, and it is the cornerstone of the State Veterans Home Program.

Section 212 of the Committee bill creates an exception for the State of Alaska and would allow the Secretary of VA to hand over $16 million to Alaska *without* any corresponding State appropriation.

Every state, save Alaska, Delaware and Hawaii, have previously enacted legislation to appropriate their share for participation in the program. Many states have done so multiple times, so that veterans could have access to more than one facility. Currently, both Alaska and Delaware legislatures have taken up the issue.

Most recently, the legislatures in West Virginia, Colorado, Texas, Pennsylvania, and Idaho, have each set aside funds totaling more than $25 million dollars. Had these States sought a route similar to the one taken by section 212 of the Committee bill, the cost to the Federal government would be more than $46 million. The chart below details the funding for each State Veterans Home project.

Construction Grants for State Extended Care Facilities

[dollars in thousands]

State Home	Total Cost	VA Share	State Appropriated Share
Alexander City, AL	7,629	4,959	2,670
Anderson, SC	12,520	7,516	5,004
Anna, IL	4,510	2,932	1,578
Armore, OK	9,501	6,176	3,325
Augusta, GA	1,956	978	978
Augusta, ME	4,472	2,907	1,565

Construction Grants for State Extended Care Facilities—Continued

[dollars in thousands]

State Home	Total Cost	VA Share	State Appropriated Share
Aurora, CO	23,843	15,498	8,345
Bangor, ME	10,154	6,600	3,554
Barstow, CA	30,500	19,825	10,675
Batavia, NY	15,000	8,633	6,367
Bay Minette, AL	10,035	6,523	3,512
Bennington, VT	11,960	7,006	4,954
Big Springs, TX	11,770	7,650	4,120
Boise, ID	6,795	4,292	2,503
Bonham, TX	11,770	7,650	4,120
Boulder City, NV	20,930	13,604	7,326
Bristol, RI	8,377	5,264	3,113
Buffalo, NY	3,633	2,254	1,379
Cape Girardeau, MO	8,364	5,436	2,928
Cameron, MO	20,356	13,604	6,752
Caribou, ME	1,850	1,187	663
Charlotte Hall, MD	33,885	20,432	13,453
Chelsea, MA	7,999	4,593	3,406
Chula Vista, CA	34,803	22,100	12,703
Claremore, OK	22,769	14,364	8,405
Clarksburg, WV	13,500	8,775	4,725
Clinton, OK	10,223	6,568	3,655
Collins, MS	9,451	6,143	3,308
Columbia Falls, MT	1,711	1,040	671
Columbia, SC	1,982	687	1,295
Daytona Beach, FL	11,646	7,764	3,882
Erie, PA	6,862	3,550	3,312
Fayetteville, NC	8,801	692	8,109
Fergus Falls, MN	8,000	5,200	2,800
Florence, CO	1,410	894	516
Floresville, TX	11,746	7,635	4,111
Ft. Dodge, KS	830	415	415
Glendive, MT	5,691	3,699	1,992
Grand Island, NB	3,299	1,333	1,966
Grand Rapids, MI	22,005	12,993	9,012
Hanson, KY	13,635	8,863	4,772
Hastings, MN	4,888	3,292	1,596
Hazard, KY	15,457	10,047	5,410
Hollidaysburg, PA	26,569	16,567	10,002
Holyoke, MA	4,062	2,130	1,932
Homelake, CO	2,822	1,864	958
Hot Springs, SD	1,330	829	501
Humboldt, TN	7,538	4,900	2,638
Huntsville, AL	10,308	6,701	3,607
Jackson, LA	8,675	5,000	3,675
Jackson, MS	6,198	3,931	2,267
Juana Diaz, PR	13,667	8,884	4,783
King, WI	34,801	20,385	14,416
Kosciusko, MS	9,172	5,962	3,210
Lafayette, IN	12,532	6,126	6,406
Lake City, FL	6,739	4,376	2,363
Land O'Lakes, FL	11,944	7,764	4,180
LaSalle, IL	7,200	4,643	2,557
Lawson, OK	38,226	24,847	13,379
Lewiston, ID	6,012	3,908	2,104
Lisbon, ND	5,381	3,498	1,883
Little Rock, AR	2,182	1,418	764
Luverne, MN	7,457	4,847	2,610
Manteno, IL	18,094	11,761	6,333
Marquette, MI	10,639	6,915	3,724
Marshalltown, IA	42,557	27,205	15,352
Menlo Park, NJ	47,284	30,058	17,226
Mexico, MO	8,027	5,204	2,823
Milledgeville, GA	12,284	6,808	5,476

Construction Grants for State Extended Care Facilities—Continued

[dollars in thousands]

State Home	Total Cost	VA Share	State Appropriated Share
Minneapolis, MN	43,831	28,358	15,473
Monroe, LA	11,849	7,279	4,570
Montrose, NY	43,856	28,506	15,350
Murfreesboro, TN	5,126	3,226	1,900
Norman, OK	29,737	19,255	10,482
Norfolk, NB	16,516	10,527	5,989
Omaha, NB	1,913	1,243	670
Orting, WA	4,382	2,805	1,577
Oxford, MS	9,537	6,199	3,338
Paramus, NJ	28,677	18,251	10,426
Pembroke Pines, FL	15,344	9,924	5,420
Philadelphia, PA	20,930	13,605	7,325
Phoenix, AZ	14,189	9,223	4,966
Pittsburgh, PA	27,339	17,770	9,569
Pocatello, ID	5,277	3,430	1,847
Quincy, IL	3,976	2,772	1,204
Retsil, WA	5,989	3,871	2,118
Rifle, CO	3,571	2,321	1,250
Roanoke, VA	17,846	9,161	8,685
Rocky Hill, CT	4,656	2,843	1,813
Salisbury, NC	3,371	2,191	1,180
Salt Lake City, UT	6,792	4,415	2,377
St. Albans, NY	28,919	18,798	10,121
St. James, MO	27,754	16,829	10,925
Sandusky, OH	47,762	30,008	17,754
Scarborough, ME	11,226	6,858	4,368
Scotts Bluff, NB	4,520	2,854	1,666
Scranton, PA	23,143	13,477	9,666
Silver Bay, MN	2,481	1,613	868
South Paris, ME	7,619	4,953	2,666
Spring City, PA	17,936	11,653	6,283
Stony Brook, NY	25,400	16,510	8,890
Sulfur, OK	5,077	3,300	1,777
Talihina, OK	9,438	5,999	3,439
Temple, TX	11,770	7,650	4,120
The DIlas, OR	14,218	9,242	4,976
Tilton, NH	7,022	4,414	2,608
Truth or Consequence, NM	5,662	3,636	2,026
Union Grove, WI	2,857	1,857	1,000
Vineland, NJ	16,432	8,663	7,769
Walsenburg, CO	7,741	5,404	2,337
Warrensburg, CO	20,960	13,624	7,336
Wilmore, KY	14,923	10,315	4,609
Winfield, KS	17,171	10,641	6,530
Yountville, CA	94,694	61,384	33,310

On June 6, 2002, John Johnson, President of the National Association of State Veterans Homes wrote:

> We feel giving one state preference would be unjust to all other states. We have worked long and hard with the Department of Veterans Affairs and members of both Houses to create a fair and equitable program. If any changes are made, they should not favor one state over another, but should be equally applied to all states and veterans. Forty-seven states have had to use the process that has been in place, and to waive rules and regulations for one state would be an injustice to all other states who have followed the process.

Joseph A. Violante, National Legislative Director, Disabled American Veterans, expressed similar reservations. In his letter of

June 6, 2002, Mr. Violante argued that section 212 "bypasses the Department of Veterans Affairs State Home authority currently in place."

The proponent of this provision, Senator Murkowski, made the case that the uniqueness of Alaska mandates a different approach, and that may well be true. Alaska has six Pioneers' Homes, in which the elderly reside. Of the current 500 residents, 97 are veterans. Rather than building one new home, it was argued that renovation of these existing homes would be more practical. Not only does the statute allow for the renovation of multiple facilities, but it actually favors these types of projects over new construction. Through the normal course—appropriation of funds by the Alaskan legislature, certification of the funds, and applications made to VA—Alaska could have multiple State Veterans Homes. Each stage of the process, including submitting a basic application, was disregarded.

Applying this type of change equally to all states would unfortunately mean a total erosion of the partnership which has made the State Home Program a success. Allowing an exception for only one State is unfair to all others.

CHANGES IN EXISTING LAW MADE BY THE COMMITTEE BILL, AS REPORTED

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

* * * * * * *

§ 1701. Definitions

For the purposes of this chapter—

* * * * * * *

(10)(A) During the period beginning on [the date of the enactment of the Veterans Millennium Health Care and Benefits Act and ending on December 31, 2003,] *November 30, 1999, and ending on December 31, 2008,* the term "medical services" includes non-institutional extended care services.

* * * * * * *

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

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(e)(1)(A) " * *

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(3) * * *

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(B) in the case of care for a veteran described in paragraph (1)(C), after [December 31, 2002] *December 31, 2012*; and

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§ 1710A. Required nursing home care

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(c) The provisions of subsection (a) shall terminate on [December 31, 2003] *December 31, 2008*.

* * * * * * *

§ 1720D. Counseling and treatment for sexual trauma

(a)(1) [During the period through December 31, 2004, the Secretary] *The Secretary* 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) In furnishing counseling to a veteran under this subsection, the Secretary may[, during the period through December 31, 2004,] 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.

(b)(1) The Secretary shall give priority to the [establishment and] operation of the program to provide counseling and care and services under subsection (a). In the case of a veteran eligible for counseling and care and services under subsection (a), the Secretary shall ensure that the veteran is furnished counseling and care and services under this section in a way that is coordinated with the furnishing of such care and services under this chapter.

(2) In [establishing a program] *operating a program* to provide counseling under subsection (a), the Secretary shall—

* * * * * * *

§ 1722A. Copayment for medications

(a)(1) * * *

* * * * * * *

(3) Paragraph (1) does not apply—

* * * * * * *

[(B) to a veteran whose annual income (as determined under section 1503 of this title) does not exceed the maximum annual rate of pension which would be payable to such veteran if such

veteran were eligible for pension under section 1521 of this title.]

(B) to a veteran whose attributable income is not greater than the amount provided for in subsection (b) of section 1722 of this title, as adjusted from time to time under subsection (c) of that section.

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§ 7320. Centers for mental illness research, education, and clinical activities

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(b)(1) * * *

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(3) Not more than [five centers] *15 centers* may be designated under this section.

* * * * * * *

§ 7802. Duties of Secretary with respect to Service

The Secretary shall—

* * * * * * *

(5) employ such persons as are necessary for the establishment, maintenance, and operation of the Service, and pay the salaries, wages, and expenses of all such employees from the funds of the Service. Personnel necessary for the transaction of the business of the Service at canteens, warehouses, and storage depots shall be appointed, compensated from funds of the Service, and removed by the Secretary without regard to the provisions of title 5 governing appointments in the competitive service and chapter 51 and subchapter III of chapter 53 of title 5. Those employees are subject to the provisions of title 5 relating to a preference eligible described in section 2108(3) of title 5, subchapter I of chapter 81 of title 5, and subchapter III of chapter 83 of title 5. *Employees and personnel under this clause may be considered for appointment in Department positions in the competitive service in the same manner that Department employees in the competitive service are considered for transfer to such positions. An employee or individual appointed as personnel under this clause who is appointed to a Department position under the authority of the preceding sentence shall be treated as having a career appointment in such position once such employee or individual meets the three-year requirement for career tenure (with any previous period of employment or appointment in the Service being counted toward satisfaction of such requirement)*;

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§ 8104. Congressional approval of certain medical facility acquisitions

(a)(1) * * *

* * * * * * *

(3) For the purpose of this subsection:

(A) The term *major medical facility project" means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than [$4,000,000] *$9,000,000*, but such term does not include an acquisition by exchange.

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VETERANS MILLENNIUM HEALTH CARE AND BENEFITS ACT

* * * * * * *

TITLE I—ACCESS TO CARE

Subtitle A—Long-Term Care

SEC. 101. REQUIREMENT TO PROVIDE EXTENDED CARE SERVICES.

* * * * * * *

(i) REPORT.—Not later than [January 1, 2003,] *January 1, 2008,* the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the operation of this section (including the amendments made by this section). The Secretary shall include in the report—

* * * * * * *

SEC. 116. SPECIALIZED MENTAL HEALTH SERVICES.

* * * * * * *

(c) FUNDING.—(1) In carrying out the program described in subsection (a), the Secretary shall identify, from funds available to the Department for medical care, an amount of not less than [$15,000,000] *$25,000,000 in each of fiscal years 2003, 2004, and 2005* to be available to carry out the program and to be allocated to facilities of the Department pursuant to subsection (d).

(2) In identifying available amounts pursuant to paragraph (1), the Secretary shall ensure that, after the allocation of those funds under subsection (d), the total expenditure for programs relating to (A) the treatment of post-traumatic stress disorder, and (B) substance use disorders is not less than [$15,000,000] *$25,000,000* in excess of the baseline amount.

(3)*(A)* For purposes of paragraph (2), the baseline amount is the amount of the total expenditures on such programs for the most recent fiscal year for which final expenditure amounts are known, adjusted to reflect any subsequent increase in applicable costs to deliver such services in the Veterans Health Administration, as determined by the Committee on Care of Severely Chronically Mentally Ill Veterans.

(B) For purposes of this paragraph, in fiscal years 2003, 2004, and 2005, the fiscal year utilized to determine the baseline amount shall be fiscal year 2002.

* * * * * * *

(d) ALLOCATION OF FUNDS TO DEPARTMENT FACILITIES.—[The Secretary] *(1) In each of fiscal years 2003, 2004, and 2005, the Secretary* shall allocate funds identified pursuant to subsection (c)(1) to individual medical facilities of the Department as the Secretary determines appropriate based upon proposals submitted by those facilities for the use of those funds for improvements to specialized mental health services.

(2) In allocating funds to facilities in a fiscal year under paragraph (1), the Secretary shall ensure that—

(A) not less than $10,000,000 is allocated by direct grants to programs that are identified by the Mental Health Strategic Health Care Group and the Committee on Care of Severely Chronically Mentally Ill Veterans;

(B) not less than $5,000,000 is allocated for programs on post-traumatic stress disorder; and

(C) not less than $5,000,000 is allocated for programs on substance abuse disorder.

(3) The Secretary shall provide that the funds to be allocated under this section during each of fiscal years 2003, 2004, and 2005 are funds for a special purpose program for which funds are not allocated through the Veterans Equitable Resource Allocation system.

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VETERANS BENEFITS AND HEALTH CARE IMPROVEMENT ACT OF 2000

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TITLE II—HEALTH PROVISIONS

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Subtitle D—Construction Authorization

SEC. 231. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS.

(a) FISCAL YEAR 2001 PROJECTS.—The Secretary of Veterans Affairs may carry out the following major medical facility projects, with each project to be carried out in an amount not to exceed the amount specified for that project:

* * * * * * *

(2) Construction of a nursing home at the Department of Veterans Affairs Medical Center, Beckley, West Virginia, [$9,500,000] *$18,200,000*.

* * * * * * *

SEC. 232. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to the Secretary of Veterans Affairs for the Construction, Major Projects, account—

(1) for fiscal years 2001 and 2002, a total of **[**$87,800,000**]** *$96,500,000* for the projects authorized in paragraphs (1), (2), and (3) of section 231(a);

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