Calendar No. 284

109TH CONGRESS, *1st Session* | SENATE | REPORT 109–177

VETERANS' HEALTH CARE ACT OF 2005

NOVEMBER 10, 2005.—Ordered to be printed

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

R E P O R T

together with

MINORITY VIEWS

[To accompany S. 1182]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (S. 1182) to amend title 38, United States Code, to improve and enhance the health care for veterans, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute, and recommends that the bill, as amended, do pass.

INTRODUCTION

On June 9, 2005, Committee Chairman Larry E. Craig introduced S. 1182, the Veterans Health Care Act of 2005. The bill, as introduced, would have: eliminated copayments for hospice care provided to veterans; repealed the requirement that the Department of Veterans Affairs (hereinafter "VA") maintain long-term care bed capacity at 1998 levels; exempted former POWs from certain long-term care copayments; authorized VA to reimburse insured veterans for emergency care provided at non-VA facilities; authorized VA to provide, or pay for, up to 14 days of care for a newborn child of a female VA patient; allowed providers of care to Spina Bifida-afflicted children of Vietnam Veterans to balance bill private insurers; permanently authorized grant and per diem payments to homeless assistance providers; authorized Senior Execu-

tive Service compensation to VA's national Director, Nursing Services; repealed the ban on the use of appropriated funds to conduct cost-comparison studies; and required the expansion and improvement of mental health services and care for veterans suffering from Post-traumatic Stress Disorder (hereinafter "PTSD"). The bill was referred to the Committee on Veterans' Affairs.

On June 7, 2005, Committee Ranking Member, Daniel K. Akaka, introduced S. 1177. The bill, as introduced, would have: required the VA to adjust funding for mental health services by adding inflation to the amount appropriated for such services each year starting in 1996; required VA's Under Secretary for Health to ensure that 90 percent of VA's community-based outpatient clinics (hereinafter "CBOCs") have the capacity to provide mental health services onsite, via contract referral, or through tele-health services; required that each VA primary medical facility have the capacity to provide not less than five days of inpatient detoxification services; required VA and the Department of Defense (hereinafter "DoD") to develop a standardized pre-separation mental health and sexual trauma examination; required VA national guidelines for screening primary care patients for mental illness; and required a joint working group between VA and DoD to develop methods for combating the stigma of mental illness, improving the availability of treatment for mental illnesses, and advance family education for transition. Committee Members John D. Rockefeller, Patty Murray, and Ken Salazar along with Senator Richard Durbin were added as cosponsors. The bill was referred to the Committee on Veterans' Affairs.

On June 7, 2005, Senator Barack Obama introduced S. 1180. The bill as introduced would have: specified that per diem payments to providers of services to homeless veterans should be paid at the same as per diem payments to state veterans homes; expanded VA's homeless reintegration program; extended to 2011 VA's authorization to treat seriously mentally ill homeless veterans; made permanent VA's program to transfer acquired properties to homelessness service providers; extended VA's special needs homeless grant program through 2011; removed the 60 day limitation on homeless veterans' dental care eligibility; authorized appropriations for VA's technical assistance program for applicants for grants to assist homeless veterans; extended through 2011 VA's Advisory Committee on Homeless Veterans; and required a study by VA on relationships between military sexual trauma and homelessness. Committee Member Patty Murray along with Senators Richard Durbin, Tim Johnson, and Byron Dorgan were added as cosponsors. The bill was referred to the Committee on Veterans' Affairs.

On June 7, 2005, Senator Ken Salazar introduced S. 1189, a bill to require the Secretary to develop a strategic plan for the provision of long-term care services to veterans and submit that plan to Congress. The bill was referred to the Committee on Veterans' Affairs.

On June 7, 2005, Senator Ken Salazar introduced S. 1190, a bill that would have: required the Secretary to establish the position of Blind Rehabilitation Outpatient Specialist (hereinafter "BROS") at each VA facility that treats more than 150 blind veterans; and authorized $5 million per year through 2010 to hire such specialists.

Senators Rick Santorum and Tim Johnson were added as cosponsors. The bill was referred to the Committee on Veterans' Affairs.

COMMITTEE HEARINGS

On June 9, 2005, the Committee held hearings on, among other bills: S. 716, S. 1177, S. 1180, S. 1189, and S. 1190. Testimony was heard from: The Honorable R. James Nicholson, Secretary of Veterans Affairs; The Honorable Jonathan B. Perlin, VA's Under Secretary for Health; The Honorable Tim McClain, VA's General Counsel; Mr. Donald Mooney, Assistant Director, The American Legion; Mr. Dennis Cullinan, Director of National Legislative Service, Disabled American Veterans; Mr. Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans; Mr. Carl Blake, Associate National Legislative Director, Paralyzed Veterans of America; and Mr. Richard Jones, AMVETS.

COMMITTEE MEETING

After carefully reviewing the testimony from the foregoing hearing, the Committee met in open session on September 15, 2005 to consider, among other legislation, S. 1182. The Committee voted by voice vote to report favorably S. 1182, as amended to incorporate provisions derived from S. 1177, S. 1180, S. 1189, and S. 1190 as well as an amendment offered by Committee Ranking Member Daniel K. Akaka and an amendment from Committee Ranking Member Daniel K. Akaka as amended by Committee Chairman Larry E. Craig.

SUMMARY OF THE COMMITTEE BILL AS REPORTED

S. 1182, as reported (hereinafter the "Committee bill"), consists of changes to current law that would:

1. Authorize VA to provide up to 14 days of care for newborn children of female veterans who are receiving maternity care furnished by VA (section 2);
2. Permit private sector providers of care to certain disabled children of Vietnam Veterans to balance bill private insurers for costs of that care not paid by the Secretary (section 3);
3. Permanently authorize VA's Homeless Grant and Per Diem Program, provide an authorization for $130,000,000 in funding for Fiscal Year 2006 and each year thereafter for the program, and re-authorize $1,000,000 for each of Fiscal Years 2006—2011 for the Homeless Service Provider Technical Assistance Program (section 4);
4. Authorize VA to employ licensed and credentialed Marriage and Family Therapists and Licensed Professional Mental Health Counselors (section 5);
5. Authorize VA to pay the Chief Nursing Officer of the department at the Senior Executive Schedule rate of pay (section 6);
6. Repeal the statutory prohibition on VA spending any funds comparing the costs and efficiency of services provided by government employees with similar services provided in the private sector (section 7);
7. Authorize $95,000,000 to: expand the number of clinical treatment teams principally dedicated to the treatment of

PTSD in VA facilities; expand and improve services available to diagnose and treat substance abuse; expand and improve tele-health initiatives to provide better access to mental health services in areas of the country that are determined to be underserved; improve educational programs for primary care clinicians to allow them to better recognize and treat mental illness in veterans; expand the number of VA CBOCs capable of providing on-site mental health services; and expand the number of Mental Health Intensive Case Management Teams to provide services to veterans with Serious Chronic Mental Illness (section 8(b));

8. Require the Under Secretary for Health to take appropriate steps and provide incentives to encourage Regional Directors of the Veterans Health Administration (hereinafter "VHA") to: prioritize the provision of mental health services; foster collaborative working environments among clinicians for the provision of mental health services; and conduct mental health consultations during primary care appointments (section 8(c));

9. Require the Secretary to ensure that VA CBOCs have the capacity to provide, or monitor the provision of, mental health services to veterans through: a contract-provider, referral to another facility of the department, or an employee of the department (section 8(c));

10. Require the Secretaries of Defense and VA to enter into a Memorandum of Understanding to ensure that separating service-members receive standardized mental health and sexual trauma assessments and that the two Secretaries share guidelines on how to conduct such assessments (section 8(d));

11. Establish a Joint Working Group within DoD and VA to analyze the feasibility of initiatives related to: combating stigma associated with service-members who suffer from mental illness; VA making its expertise in the treatment of mental illness more readily available to DoD providers; the education of family members of veterans to assist them in recognizing and coping with readjustment issues; and the seamless transition of service-members who have been diagnosed with mental illness. The Joint Working Group would report on its findings and recommendations not later than June 30, 2007 (section 8(d));

12. Require the Under Secretary for Health to establish system-wide guidelines for screening primary care patients for mental illness and ensure that VA clinicians are trained in the use of such guidelines (section 8(e));

13. Require the National Center on Post Traumatic Stress Disorder to collaborate with the Secretary of Defense to enhance the clinical skills of military clinicians and promote predeployment resilience and post-deployment re-adjustment for veterans of Operations Iraqi Freedom and Enduring Freedom (section 8(f));

14. Permit the exchange of certain health information between VA and DoD (section 9);

15. Require the expansion of VA's Global War on Terrorism Outreach Program (hereinafter "GWOT") and ensure the coordination with appropriate State officials to ensure members

of the National Guard receive accurate and timely information about VA's benefits and services (section 10);

16. Require the Secretary to expand the number of Veterans Readjustment Counseling Service facilities capable of providing services to veterans through tele-health linkages and to submit a report on accomplishing this expansion in Fiscal Years 2006 and 2007 (section 11);

17. Require the Secretary to submit a report to the Committees on Veterans' Affairs of the Senate and House of Representatives containing: a description of the mental health data maintained by VA; an analysis as to whether the current method of collecting and storing the data is efficient and effective, and any recommendations for improving the collection, storage, and use of mental health data (section 12);

18. Require the Secretary to publish a strategic plan for the provision of long-term care services to veterans (section 13);

19. Require the establishment of Blind Rehabilitation Outpatient Specialist positions at not fewer than fifty facilities of VA that do not currently have such a position (section 14);

20. Extend through 2006 the requirement that the Secretary submit a report to the Committees on Veterans' Affairs of the Senate and House of Representatives detailing VA's compliance with the specialized services capacity requirement (section 15);

21. Authorize the Secretary to provide health care services to any veteran who lived in the catchments region of VA's medical center in Gulfport or Biloxi, Mississippi or New Orleans, Louisiana and prohibit the Secretary from collecting any out-of-pocket fees associated with that care until January 31, 2006 (section 16);

22. Allow the Secretary to cover out-of-pockets costs for certain insured veterans when such costs are related to care or treatment provided for an emergency health condition in a non-VA medical facility (section 17).

BACKGROUND AND DISCUSSION

Section 2. Care for Newborn Children of Women Receiving Maternity Care

Under current law, VA provides what it believes to be a "comprehensive package of health benefits for eligible veterans". Unfortunately, while a veteran's care extends to maternity, prenatal, and postnatal care for female veterans, it does not permit the provision of, or payment for, any care for the newborn child of a female veteran-patient. In other words, for the increasing number of female veterans enrolling for VA care, the word "comprehensive" is not exactly accurate.

VA has advised the Committee that newborn care is not provided because VA is only authorized to provide medical care and treatment to veterans. While that is true, it is also a disservice to our growing female veteran population and an inequity that must be addressed.

As such, Section 2 of the Committee bill would authorize VA to provide, or pay for, up to the first 14 days of care for a newborn child of an enrolled, female veteran who delivers her baby under

VA provided, or VA financed, care. The Committee hopes that this limited but important step will help equalize the health care benefits package and ensure that it addresses the health needs of all veterans.

Section 3. Enhancement of Payer Provisions for Health Care Furnished To Certain Children of Vietnam Veterans

Under current law, VA provides, or pays for, care for certain children of Vietnam veterans. Generally, the payment provided by VA is considered payment in full for all services provided to the patient. However, it has come to the Committee's attention that in rare circumstances it may be perfectly appropriate for a care provider to seek reimbursement for certain services not otherwise covered by VA. Yet, that action is not permitted.

Section 3 of the Committee bill would designate VA as the primary payer for care or services furnished to certain children of Vietnam veterans under Title 38 U.S.C. § 1803. In so designating VA, the language expressly permits a provider (or his agent) who furnishes care to children under this program to seek payment for the difference between the amount billed and the amount paid by the Secretary from a third party payer if the beneficiary has a health care plan that would otherwise be responsible for payment.

The Committee is concerned that express authority for so-called "balance billing" would permit providers to send such bills to veterans and their family members. In an effort to ensure that does not occur, Section 3 would prohibit the health care provider (or the provider's agent) from imposing any additional charges on the beneficiary who received the care, or the beneficiary's family, for any service or item for which the Secretary has made payment under this section.

In addition, it would limit the total amount a provider could receive for furnishing care or services under this section from all payer sources to the amount billed to VA. Finally, under this section, VA would be required, upon request, to provide a third party with information concerning claims under this section.

The Committee intends for this provision to encourage providers to work with VA to provide care to this very deserving and limited beneficiary population.

Section 4. Improvements to Homeless Veterans Service Providers Programs

VA operates a Homeless Providers Grant and Per Diem Program to fund community agencies providing services to homeless veterans. The program aims to help homeless veterans achieve residential stability, improve skill levels, and increase personal income. Only programs that offer supportive housing or service centers for case management, education, crisis intervention, and counseling are eligible for funds. In addition, VA maintains a small program to assist grant applicants in their efforts to submit in a timely fashion all of the complex paperwork associated with grants under this program.

Since 1992, when this program was established, VA has been able to spur development of increased levels of assistance at the local level for homeless veterans living throughout the country. Indeed, grantees' programs often fill existing gaps in the continuum

of VA care and services, thus serving as an effective complement to VA's own efforts.

VA has been successful at leveraging new resources to increase the overall supply of transitional housing and other effective assistance for homeless veterans throughout the country. In fact, the only programmatic shortcoming the Committee can identify is that there is more interest on the part of participating providers than there is grant money to support those efforts.

As such, Section 4 of the Committee bill would permanently authorize the Homeless Grant and Per Diem Program and would increase the amount of money authorized for these efforts to $130,000,000 in each fiscal year. Further, the grantee assistance program would be authorized though 2011 with an authorized funding level of $1,000,000 for each fiscal year.

Section 5. Additional Mental Health Providers

Chapter 74 of Title 38, United States Code authorizes VA to hire a wide range of clinical care personnel to provide treatment to veterans who seek health services from the department. These include, but are not limited to: physicians, nurses, psychologists, and, social workers. Because the hiring authority is specific to listed medical professionals, VA is not permitted to employ any professional not mentioned in statute.

Section 5 would add the professions of "Marriage and Family Therapist" and "Licensed Mental Health Counselor" to the list of clinical care providers VA is authorized to hire. This section does not require VA to hire any of the new clinicians. That decision is best left to the medical administrative professionals who operate VA's medical centers and CBOCs across the United States.

Still, the Committee believes that VA officials should have as much latitude as possible to hire the clinical professionals needed to ensure that the Nation's veterans are provided with the right clinical care in the most cost-effective manner. The military is already offering Marriage and Family Therapy and Licensed Mental Health Counseling to those who are returning from overseas. And their programs are receiving good reviews from those in the mental health and counseling professions. It seems only logical that we extend successful ideas from the military experience to our veterans.

Section 6. Pay Comparability for Chief Nursing Officer, Office of Nursing Services

Section 6 would correct a long-time pay inequity for the VA's Chief Nursing Officer. Under current law, this official is compensated at an annual salary far below that of all other VA service chiefs.

Section 6 would ensure that any future holder of this important position is compensated as a salary level equal to the executive responsibilities of the job and equal to his or her other service chief counterparts.

Section 7. Repeal of Cost Comparison Studies Prohibition

Under current law, VA is prohibited from using any appropriated funds to carry out a study comparing the costs of a service provided by VHA with the same service provided under contract through a

private sector company. The Committee finds continuation of this strict prohibition to be unreasonable.

America's taxpayers have a right to expect that services offered by the Federal Government will be provided in the most cost efficient and effective manner possible. In order to provide that assurance to taxpayers, VA must be permitted to compare its performance with the experience of those conducting a similar business in the private sector. Section 7 would allow those comparison studies to be undertaken.

It is important to note that the Committee does not believe that comparison studies will inevitably result in the reduction of government employment. Nor does the Committee believe that an increase in outside contracts is the only outcome possible. Rather, the Committee expects that such studies will, in many cases, verify the good work being done by VA's employees. In cases where positive results are not shown, the Committee expects that appropriate changes, both inside and outside of VHA, will be implemented.

Section 8. Improvement and Expansion of Mental Health Services

The Committee has followed closely the studies which suggest that a number of men and women serving in Operations Enduring Freedom and Iraqi Freedom (hereinafter "OIF/OEF") will need assistance coping with the mental and physical scars war leaves. The Committee held a hearing on March 17, 2005 on this topic specifically as it relates to the transition from active duty to civilian life.

In order to ensure that VA can adequately address the mental health needs of returning servicemen and women, Section 8 directs VA to expand and improve programs and services in a number of settings.

Specifically, VA is directed to: expand the number of clinical treatment teams principally dedicated to the treatment of PTSD; expand treatment and diagnosis services for substance abuse; expand tele-health initiatives principally dedicated to mental health care in communities located great distances from current VA facilities; improve programs that provide education in mental health treatment to primary care clinicians; and expand the number of community based outpatient clinics capable of providing treatment for mental illness.

The Committee bill would authorize $95 million to be dedicated to the implementation of this section. It is the Committee's expectation that VA will take this opportunity to ensure that the treatment teams and the tools to provide care are in place before returning OIF/OEF veterans present themselves at VHA facilities.

Section 8 also requires VA to ensure that it has the capacity to provide mental health services at every Community-Based Outpatient Clinic (CBOC) in the system. As part of this, VA is directed to establish performance standards and working environments that give appropriate recognition to the importance of mental health care. Based on the recommendations of VA's Mental Health Strategic Plan, the Committee seeks to encourage greater collaboration among primary and mental health care providers.

Additionally, the Committee is concerned that a provision of P.L. 107–95 has yet to be properly implemented. The provision required VA to have a plan to meet the needs of any veteran who entered a VA health care facility seeking mental health or substance abuse

treatment. As such, Section 8 reiterates and expands on these requirements, by giving the option of using tele-mental health services or contracting.

Another provision in this section seeks to address the transition of returning servicemembers from active duty to civilian life. The Committee found that there is currently no real collaborative body examining or developing ways for VA and the Department of Defense (DOD) to work together to provide for a smoother transition out of the military for those that may require mental health services. Section 8 establishes a joint VA–DOD workgroup that will consist of 7 experts in the fields of mental health and readjustment counseling from each Department. The workgroup will look at ways to combat stigmas associated with mental health, to better educate families of servicemembers on how to deal with such issues, and will report to Congress on their findings.

Section 8 also requires the two Departments to enter into a Memorandum of Understanding to ensure that all separating servicemembers receive mental health and sexual trauma screening. The Committee believes that this will ensure that no servicemember who may require treatment or counseling leaves their military service without that being discovered, and ultimately going untreated.

As part of the effort to encourage improved coordination of mental and primary health care, Section 8 directs the Secretary to establish systemwide guidelines for screening primary care patients for potential mental health issues or disorders, as well as properly training physicians to conduct the screening.

Finally, Section 8 requires VA's National Center on Post-Traumatic Stress Disorder (PTSD) to collaborate with the Secretary of Defense for the purposes of enabling DOD mental health care providers and clinicians to benefit from the unique and comprehensive expertise that VA has in the area of PTSD diagnosis and treatment. It also directs the two entities to develop joint training and protocols to ensure consistency. This is yet another facet of this Committee's encouragement of the two Departments to collaborate on the mental health treatment of servicemembers. The Committee has authorized $2 million for the purpose of carrying out these requirements.

Section 9. Data Sharing Improvements

Each year, approximately 200,000 active duty personnel leave the Armed Forces and become veterans. A good portion of those men and women, approximately 20% by historical standards, will seek care or services from the Department of Veterans Affairs at some point during their lifetime.

Unfortunately, due to requirements under the Health Insurance Portability and Accountability Act (hereinafter "HIPAA"), VA must wait until the veteran actually enrolls for care at a VA facility before requesting that DoD send the veteran's medical records from active duty service. This small delay in records processing seriously hinders the seamless transition from active duty to civilian life that many servicemembers have come to expect and this Committee demands.

Section 9 of the Committee bill would ensure that DoD would not violate HIPAA regulation by providing VA with access to certain

medical records of servicemembers while the future VA beneficiary is still on active duty. The Committee does not intend this action to be a license for VA to request access to all active duty records maintained by DoD. Records transfer costs, privacy expectations, and basic fairness should guide the use of this authority.

Section 10. Expansion of Global War on Terrorism Outreach Program

On February 3, 2004, then-Secretary of Veterans Affairs, Anthony Principi, authorized the Veterans Readjustment Counseling Service to hire 50 veterans of OIF/OEF to conduct outreach to returning servicemembers and help ensure a smooth transition back to civilian life. Since that time, it is estimated that the Global War on Terrorism Outreach Program (hereinafter "GWOT") has served 20,000 combat veterans from OIF/OEF.

On March 17, 2005, the Committee held a hearing on the activities of this program and learned of its importance to ensuring that our new veterans obtain the benefits to which they are entitled and the help and services they and their families need. Especially noteworthy is the outreach done to our returning Guardsmen and Reservists at reserve and state guard facilities.

Unlike active duty personnel, most members of the Guard and Reserves quickly begin rebuilding a private, civilian life after returning stateside. GWOT Outreach employees are taking their important message directly to Guardsmen and Reservists by speaking during weekend drilling periods and at special gatherings of Guard and Reserve troops.

The Committee was truly impressed by the dedication of the GWOT staff and the passion with which each of them approached this important mission.

As such, Section 10 directs the Secretary to expand the total number of persons employed by the GWOT program and to ensure that VA is collaborating to the maximum extent practicable with appropriate State officials in their outreach efforts.

Section 11. Expansion of Tele-health Services

As has been noted, the Veterans Readjustment Counseling Service has made great efforts to improve its outreach and services to combat veterans and their families to ensure a smooth and seamless transition from active duty to civilian life. However, Readjustment Counseling Centers (hereinafter "VET Centers") are often located only in the most urban settings around the country. As such, critically important transition assistance can be unavailable to veterans who reside in rural communities.

Section 11 of the Committee bill would direct VA to expand the number of VET Center facilities capable of providing health services and counseling through tele-health linkages. It is the Committee's belief that this important step will allow VA to reach more veterans in rural areas and provide more services in a setting closer to the veterans' homes.

Section 12. Mental Health Data Sources Report

VA is one of the largest integrated providers of mental health care services in the United States. As a consequence, VA collects

and maintains extraordinary amounts of data and statistics on veterans who seek mental health treatment.

Unfortunately, the Committee has little information on how much data is maintained by VA, where it is held, and at what cost. Therefore, Section 12 of the Committee bill requires VA to submit a report, not later than 180 days after the date of enactment of the Committee bill detailing the information needed by the Committee to better monitor VA's data collection in this sensitive area.

Section 13. Strategic Plan for Long-Term Care

In 1999, Congress passed and the President signed Public Law 106–117, the Veterans Millennium Health Care and Benefits Act of 1999 (hereinafter the "Millennium Act"). The Millennium Act, among other things, required VA to develop a program of non-institutional long-term care services and mandated that VA maintain the institutional staffing and level of extended care services at, or above, the level of staffing and services during Fiscal Year 1998. These two actions were taken simultaneously because, at the time, some felt that the development of a non-institutional care program would cause VA to discontinue a large portion of its institutional care capacity.

Since that time, VA has increased the number of veterans it treats by nearly two million. Yet, VA reports that it does not have a need to maintain the number of nursing home beds it is required to maintain under the current law. VA asserts that this is because they have paralleled the progress of medicine and offered tens-of-thousands of veterans the non-institutional care services that will keep them at home rather than in a VA long-term care bed.

S. 1182, as introduced, contained a provision that would have struck the institutional capacity requirement from current law. However, discussion at the Committee's hearing of June 9, 2005, coupled with legislation introduced by Senator Ken Salazar and testimony from the Veterans Service Organizations convinced the Committee that a more measured approach would serve the interests of the veterans VA serves as well as VA itself.

As such, Section 13 requires the Under Secretary for Health to publish a strategic plan for long-term care. The plan should address policies and strategies for: care delivery in institutional, non-institutional, and domiciliary settings; maximizing the use of the State Home Program; identification of free-standing nursing homes for care; data collection on catastrophically disabled veterans and their geographic location; and providing a full spectrum of non-institutional care services.

It is the Committee's hope that this strategic plan will provide a clearer focus for the future of VA long-term care as well as a roadmap for veterans who rely on VA's services.

Section 14. Blind Rehabilitation Outpatient Specialists

VA operates a robust program to provide medical and social assistance to visually impaired veterans. Typically, care is provided at one of VA's ten residential Blind Rehabilitation facilities. These facilities provide intensive inpatient care services designed to allow blinded veterans to live, work, and socialize independently of outside assistance.

Often, following a stay at a residential program, follow-up care will occur through care coordination provided by a Visual Impairment Service Team (hereinafter "VIST") coordinator at a local VA medical facility. Care coordinators ensure that veterans' prosthetics are properly maintained, benefits are explained, and specialized health care services are provided to visually impaired veterans. In FY 2006, VA will employ over 150 part-time and full-time VIST coordinators. Total VA expenditures on blind rehabilitation services will exceed $62 million.

Recently, a new model of care has been developed known as BROS. BROS are well-trained, blind rehabilitation specialists who can provide many of the services on an outpatient basis that are normally reserved for the inpatient treatment program. This allows VA to treat a greater number of visually impaired veterans, closer to home, at a lower cost.

Further, because travel to one of the ten inpatient facilities is often a limitation to participation in rehabilitation, many advocates suggest that more veterans will become self-sufficient and enjoy greater opportunities for independent living through the BROS program.

Unfortunately, VA has not focused as much as the Committee would like on the expansion of the BROS program. As such, Section 14 directs VA to employ 35 new BROS at facilities of the department over the next three years. It is the Committee's belief that by expanding the total number of BROS to over 50 VA can make a true, meaningful improvement in the lives of blinded veterans and do so closer to their homes.

Section 15. Extension of Compliance Reporting Requirement

Under current law, 38 U.S.C. §1706(b)(5), VA is required to submit to the Committees on Veterans' Affairs of the House and Senate a report on its compliance with the so-called "specialized services capacity requirement". The capacity requirement dictates that VA must maintain within each Veterans Integrated Service Network (hereinafter "VISN") the capacity to provide specialized services to veterans. VA's specialized services include: spinal cord injury programs; blind rehabilitation programs; traumatic brain injury programs, and amputation rehabilitation programs.

Clearly, the Committee believes that VA must continue to devote significant resources to these important efforts. Renewing the reporting requirement will ensure that the Committee can appropriately monitor VA's efforts in this area and hold officials accountable.

Section 16. Health Care and Services for Veterans Affected by Hurricane Katrina

Hurricane Katrina had devastating effects on the citizens and infrastructure in the States of Mississippi, Louisiana, Alabama, and Texas. Facilities of the Department of Veterans Affairs and the veterans served by these facilities were not immune to the results of this destruction.

Over one million veterans reside in Louisiana, Mississippi, and Alabama. Hundreds-of-thousands of them were significantly affected by Katrina. They were forced to relocate (in many cases to Texas and Florida), lost their homes, jobs, and unfortunately health

insurance coverage. To address some of these concerns, Section 16 of the Committee bill seeks to ensure that those veterans who lost health insurance and primary income can be assured of health coverage in any facility of the department as they attempt to put their lives back together and recover from this historical storm.

The bill would authorize VA to treat any veteran from one of the affected states in any facility of the department regardless of whether the veteran is enrolled in the VA health care system, or even eligible to enroll. This authority, which also waives any applicable copayments or fees, extends through the end of January 2006.

There were views expressed in Committee about extending the cost-free access to all veterans for a longer period of time than January 31, 2006. The Committee is prepared to consider an extension of the timeline if VA officials believe that a longer access period is needed. However, the Committee believes that the bill contains a reasonable period of time for recovery of the affected veterans. Any efforts to extend the time must be mindful of the fact that special geographically-based eligibility cannot continue in perpetuity without being unfair to similarly situated veterans who reside in states not affected by Hurricane Katrina.

Section 17. Reimbursement for Certain Veterans' Outstanding Emergency Treatment Expenses

Under current law, VA is authorized to pay for emergency care services provided to veterans in non-VA facilities if the veteran seeking the services is an enrolled patient and has seen a VA care provider in the past two years. However, the payment is also contingent on the veteran not having any other health insurance coverage for the service.

As a result of the "payor of last resort" contingency, privately insured veterans are often paying more out-of-pocket costs than those with no insurance. VA has some evidence to suggest that the out-of-pocket expenditures are causing some veterans to attempt to "make it" to a VA facility where only VA copayments would apply.

A recent study undertaken for VA showed that the additional travel time to a VA facility for emergency care was having deleterious health affects on VA patients. Clearly, that is not the kind of behavior the Committee seeks to encourage in our veterans. Nor is it good medicine.

The Committee bill clarifies that veterans will be treated equally regardless of where emergency care treatment is sought.

COMMITTEE BILL 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 the CBO, estimates that enactment of the Committee bill would, relative to current law, increase spending by $193 million in 2006 and by $1.2 billion over the 2006–2010 period. Enactment of the Committee bill would not affect direct spending or receipts, and would not affect the budget of state, local or tribal governments.

The cost estimate provided by CBO, setting forth a detailed breakdown of costs, follows:

OCTOBER 14, 2005.

Hon. LARRY E. CRAIG,
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. 1182, the Veterans Health Care Act of 2005.

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

Sincerely,

DOUGLAS HOLTZ-EAKIN,
Director.

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

S. 1182—Veterans Health Care Act of 2005

S. 1182 would expand or establish a number of health care benefits for veterans. In particular, the bill would authorize the Secretary of the Department of Veterans Affairs (VA) to provide medical care to infants born in VA hospitals, to reimburse certain veterans who seek emergency care from non-VA medical facilities, and to hire additional specialists who provide care for blind veterans. The bill also would allow veterans in areas affected by Hurricane Katrina who otherwise would not be eligible for such care to obtain medical care from VA and would prohibit the collection of co-payments and third-party reimbursements for medical care given to veterans from these areas.

CBO estimates that implementing this bill would cost $193 million in 2006 and about $1.2 billion over the 2006–2010 period, assuming appropriation of the authorized and estimated amounts. Enacting this bill would not affect direct spending or receipts.

S. 1182 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.

The estimated budgetary impact of S. 1182 is shown in Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

TABLE 1.—ESTIMATED BUDGETARY IMPACT OF S. 1182

	By fiscal year, in millions of dollars—				
	2006	2007	2008	2009	2010
CHANGES IN SPENDING SUBJECT TO APPROPRIATION [1]					
Estimated authorization level	297	319	228	234	238
Estimated outlays	193	303	236	236	237

[1] These amounts do not include the costs of implementing section 7 because CBO cannot estimate such costs at this time.

S. 1182 would affect discretionary spending for veterans' medical care and would decrease the amount of offsetting collections deposited to the Medical Care Collections Fund (MCCF). CBO estimates that implementing S. 1182 would cost $193 million in 2006 and about $1.2 billion over the 2006–2010 period (see Table 2), assuming appropriation of the authorized and estimated amounts. These amounts do not include the costs of implementing section 7, which

would allow VA to conduct cost-comparison studies, because CBO cannot estimate the costs at this time. For this estimate, CBO assumes the bill will be enacted before the end of calendar year 2005.

Section 4 would reinstate and make permanent VA's authority to provide grants to organizations that furnish services to homeless veterans. That authority expired on October 1, 2005. The provision also would authorize the appropriation of $130 million in fiscal year 2006 and each subsequent year for these grants. Finally, the provision would authorize the appropriation of $1 million a year over the 2006–2011 period for grants to organizations that give technical assistance to entities or organizations that assist nonprofit, community-based groups in applying for grants to furnish services to homeless veterans.

In 2005, the Congress appropriated $75 million for grants to organizations that furnish services to homeless veterans and $750,000 for grants to provide technical assistance. Based on information from VA, CBO assumes that it would take the department about three years to expand the grant programs to the levels authorized for 2006. Thus, CBO estimates that implementing section 4 would cost $67 million in 2006 and $565 million over the 2006–2010 period, assuming appropriations of the authorized amounts.

TABLE 1.—ESTIMATED CHANGES IN SPENDING SUBJECT TO APPROPRIATION UNDER S. 1182 [1]

Provision	By fiscal year, in millions of dollars—				
	2006	2007	2008	2009	2010
Grants for Helping Homeless Veterans:					
Authorization level	131	131	131	131	131
Estimated outlays	67	105	131	131	131
Expansion of Mental Health Services					
Authorization level	97	95	0	0	0
Estimated outlays	65	112	9	4	0
Reimbursement for Emergency Treatment at Non-VA Medical Facilities:					
Estimated authorization level	52	73	76	80	83
Estimated outlays	47	69	75	79	82
Medical Care for Veterans Affected by Hurricane Katrina:					
Estimated authorization level	6	9	9	10	10
Estimated outlays	6	8	9	9	10
Forgone Offsetting Collections:					
Estimated authorization level	3	0	0	0	0
Estimated outlays	2	*	*	0	0
Care for Newborns:					
Estimated authorization level	4	7	8	9	10
Estimated outlays	4	6	8	9	10
Outpatient Specialists for Blind Rehabilitation:					
Authorization level	4	4	4	4	4
Estimated outlays	2	3	4	4	4
Total Changes: [2]					
Estimated authorization level	297	319	228	234	238
Estimated outlays	193	303	236	236	237

[1] Five-year costs in the text differ slightly from a summation of the annual costs shown here because of rounding.
[2] These amounts do not include the costs of implementing section 7 because CBO cannot estimate such costs at this time.
Note: * = less than $500,000.

Section 8 would direct VA to improve and expand mental health services offered by the department and would authorize the appropriation of $95 million in 2006 and 2007 for these purposes. The provision would direct VA to increase the number of clinical treatment teams dedicated to the treatment of post-traumatic stress disorder (PTSD), to expand the services available to diagnose and treat substance abuse, and to improve tele-health initiatives in

areas of the country that are far from VA facilities. The provision also would require the Department of Defense (DoD) to work with the National Center on Post Traumatic Stress Disorder to provide training medical care providers within DoD on PTSD and would authorize the appropriation of $2 million in 2006 to carry out this authority. Assuming outlays follow historical patterns, CBO estimates that implementing section 8 would cost $65 million in 2006 and about $190 million over the 2006–2009 period, assuming appropriation of the authorized amounts.

Section 17 would allow VA to reimburse certain veterans who seek emergency treatment from a non-VA medical facility. Under current law, a veteran who receives emergency care in the private sector for a nonservice-connected condition can only be reimbursed if he or she has no other insurance coverage. This provision would authorize VA to reimburse veterans who receive emergency treatment from a non-VA medical facility for costs that the veteran remains personally liable for if the veteran is enrolled in VA's health care system, received medical care from VA during the 24-month period preceding emergency treatment, has health insurance that partially reimburses the cost of emergency treatment, is financially liable for the cost of treatment that is not reimbursed by his or her health insurance, and is not eligible for reimbursement under current law.

According to VA, it expects about 250,000 veterans would qualify each year for reimbursement under this provision and that, on average, such veterans would be paid about $280 in 2006 to cover nonreimbursed treatment costs including net co-pays and deductibles. (VA indicates that it would deduct the co-payment a veteran would have paid if the treatment had been provided at a VA facility from any request for reimbursement.) Based on this information and adjusting for inflation, CBO estimates that implementing section 17 would cost $47 million in 2006 (accounting for a partial-year effect) and about $350 million over the 2006–2010 period, assuming appropriation of the necessary amounts.

Section 16 would require VA to treat certain veterans affected by Hurricane Katrina who would otherwise not be allowed to receive care from the agency's medical system. Since January 2003, VA has not accepted new enrollments from priority 8 veterans, who are veterans without a service-connected disability and with income above certain thresholds. This provision would allow those priority 8 veterans in the New Orleans, Louisiana, and Gulfport or Biloxi, Mississippi, regions who were previously excluded to receive care at VA medical facilities through January 31, 2006.

Based on data from VA about the number of veterans in these regions and the projected population of potential priority 8 enrollees in each state, CBO estimates that there are about 5,700 veterans from the affected areas who would seek care from VA at an average annual cost of about $1,500 in 2006. Although the provision would limit such care to the period before January 31, 2006, CBO expects that VA would allow these veterans to continue to receive medical care beyond that date since it has grandfathered such priority 8 veterans in the past. Thus, after adjusting for expected inflation, CBO estimates that implementing this provision would cost $6 million in 2006 and almost $45 million over the 2006–2010 period, assuming appropriation of the necessary amounts.

Section 16 also would prohibit VA from collecting co-payments and third-party co-payments and third-party reimbursements for medical care given to veterans from these areas until January 31, 2006. Under current law, certain veterans must make co-payments when receiving health care from VA. In addition, VA can bill a veteran's third-party insurance when the veteran is treated for non-service-connected conditions. These payments are deposited into the MCCF and, under current law, are treated as offsets to discretionary spending. Spending from the MCCF is subject to appropriation.

VA estimates that it will collect nationwide more than $2.1 billion in co-payments and reimbursements in 2006. Because the population for the affected area comprises less than 1 percent of all veterans using VA's medical system and CBO expects that VA would waive co-payments and third-party reimbursements for only one month, CBO estimates that implementing this provision would reduce collections by about $3 million in 2006.

Section 2 would allow VA to provide medical care for up to 14 days to newborns of female veterans who are delivered in a VA facility. Under current law, VA may only provide medical benefits to the mother. VA estimates that about 1,000 newborns would receive medical care in the first year and that this number would grow to about 2,000 infants by 2011. Based on data from VA, CBO estimates that the cost of providing neonatal care to those infants would be about $5,900 per infant in 2006. (Providing neonatal care for most infants would cost much less; the high average cost is driven by those infants who require extensive care for longer periods of time.) After adjusting for expected inflation, CBO estimates that implementing this provision would cost $4 million in 2006 and $36 million over the 2006–2010 period, assuming appropriation of the necessary amounts.

Section 14 would require VA to employ outpatient specialists for blind rehabilitation at no fewer than 35 of its facilities and would authorize the appropriation of $3.5 million a year over the 2006–2011 period to carry out this provision. CBO estimates that implementing this provision would cost $2 million in 2006 and just over $16 million over the 2006–2010 period, assuming appropriation of the necessary amounts.

Section 7 would repeal a provision in law that prohibits VA from using appropriated funds to conduct studies comparing the costs of allowing certain functions to be performed by private contractors instead of using VA personnel. CBO cannot estimate the budgetary impact of implementing this provision since VA has not provided information on the number of studies it would conduct or the potential cost per study. It is likely, however, that the costs of implementing section 7 would be small compared to the total cost of this bill.

The following provisions would have an insignificant budgetary impact on spending subject to appropriation:

- Section 6 would exempt the Chief Nursing Officer with the Office of Nursing Services from current-law restrictions to nurse pay and allow that officer to be paid at a rate up to the maximum rate established by the Senior Executive Service. Based on information provided by VA, CBO estimates that implementing this provision would cost less than $50,000 a year.

- Section 3 would allow medical care providers to collect payment for services from a third-party insurance company when they provide care to certain children of Vietnam veterans. Under current law, medical care providers who treat children of Vietnam veterans with spina bifida or birth defects can only receive payment from VA. This provision would allow providers to seek payment from a responsible third-party for the difference between the amount billed and the amount paid by VA. CBO estimates that implementing this provision would not affect VA payments to these providers.
- Section 10 would direct VA to increase the number of personnel employed by VA as part of its Readjustment Counseling Service outreach program. Section 11 would direct VA to increase the number of Veterans Readjustment Counseling Service facilities that can provide tele-health linkages with other VA facilities. VA indicates that it is already implementing such increases. As such, CBO estimates that implementing these provisions would result in no additional costs.

S. 1182 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

The CBO staff contacts are Michelle Patterson, Melissa Merrell, and Allison Percy. This estimate was 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 September 15, 2005 meeting.

On that date, the Committee, by voice vote, ordered S. 1182 reported favorably to the Senate, with related measures included from the following: provisions of S. 1177, a bill by Committee Ranking Member Daniel K. Akaka; provisions of S. 1189, a bill by Committee Member Senator Ken Salazar; and provisions of S. 1190, a bill by Committee Member Senator Salazar.

In addition, the Committee adopted two amendments to S. 1182. One amendment by Committee Ranking Member Akaka concerning the provision of emergency care services to veterans was adopted by unanimous consent. A second amendment offered by Committee Ranking Member Akaka concerning health care services for veterans affected by Hurricane Katrina was adopted by voice vote after a second degree amendment to the Akaka amendment, offered

by Chairman Larry E. Craig, was adopted by a vote of 8 yeas and 6 nays.

AGENCY REPORT

On June 9, 2005, Secretary of Veterans' Affairs, the Honorable R. James Nicholson, appeared before the Committee on Veterans' Affairs and submitted testimony on, among other things, a draft version of the Veterans Health Care Improvements Act of 2005. Excerpts from this statement are reprinted below:

STATEMENT OF THE VIEWS OF THE ADMINISTRATION

STATEMENT OF THE HONORABLE R. JAMES NICHOLSON

SECRETARY OF VETERANS' AFFAIRS

Good Afternoon Mr. Chairman and Members of the Committee:

I am pleased to be here this morning to present the Department's views on several different bills being considered by the Committee. They cover a wide range of subjects related to VA's provision of health care services to veterans.

VETERANS HEALTH CARE IMPROVEMENTS ACT OF 2005

Mr. Chairman, I will begin by commenting on your draft bill that includes an array of provisions, many of which would carry out proposals that were included in the President's budget submitted to Congress earlier this year. We strongly support enactment of this measure and we appreciate your inclusion of provisions to carry out the President's plans for assisting veterans and for assisting the Department to carry out its mission.

One major provision in the bill would expand VA's authority to assist with payment for emergency-care costs that veterans incur in private hospitals. As you may know, a major study found that veterans with cardiac emergencies, despite having health insurance, often deliberately forgo emergency treatment at the closest community hospital (where they might incur out-of-pocket expenses) in favor of receiving care from the nearest VA facility at no or minimal cost. Delaying needed emergency medical treatment can jeopardize their health status and hinder the Department's ability to timely and successfully manage their emergent medical conditions. Under current law, a veteran who obtains emergency care in the private sector for a nonservice-connected condition is not eligible for VA reimbursement for the related expenses if the veteran has any insurance or other coverage for the cost of the care, in whole or in part. Your proposal would amend the law to enable the Department to reimburse a veteran for out-of-pocket expenses not covered by insurance or other coverage, thereby ensuring that veterans, whether insured or not, have consistent access to optimal care for emergency health conditions.

Unfortunately, the stress of combat leaves scars on many veterans. Your bill contains several new authorities that will help assist us in caring for those returning from overseas who are suffering from PTSD and other mental health disorders. The bill also contains a provision to exempt former POWs from having to pay copayments in connection with the receipt of extended-care services, and a second provision to exempt veterans from copayments for hospice care in a hospital or at home. These provisions will be extremely beneficial to the affected veterans. The bill would also authorize time-limited care for newborn children when veterans deliver the children under VA auspices.

Finally, Mr. Chairman, your bill contains two provisions that would repeal laws that have seriously hindered our efforts at VA to provide veterans with high-quality care by the best and most cost-effective means. The bill would repeal a law that requires VA to maintain at least the same staffing and level of extended-care services in Department facilities as was provided in fiscal year 1998. That law has seriously limited our ability to provide or pay for extended care services for veterans in a variety of institutional and non-institutional settings outside VA, including private nursing homes in the community and State nursing home facilities. As you know, many veterans prefer to remain in their homes and communities, and it is often cost-effective to provide care in those settings. Your bill would also repeal an old law that generally bars the Department from using appropriated funds to compare the costs of providing services directly, or by contract, which impedes our ability to obtain the best possible value for veterans. On a government-wide basis, public-private competitions completed in FYs 2003 and 2004 are estimated to generate savings, or cost avoidances, for the taxpayer of more than $2.5 billion over the next three to five years. The tailored and responsible use of competitive sourcing at VA will help the Department free up resources that can be dedicated to our veterans.

MINORITY VIEWS OF RANKING MEMBER AKAKA

The underlying legislation is a step forward in improving care for veterans. I am especially pleased that the bill now includes my legislation to provide a measure of financial relief for those veterans affected by Hurricane Katrina.

Where this legislation falls short, however, is that it does not do enough to improve care for veterans living in rural areas. In addition, the legislation would eliminate the long-standing prohibition against the Veterans Health Administration conducting costly private-public cost comparison studies without a separate appropriation.

Let me present my concerns.

RURAL CARE IS NOT ADDRESSED

While the underlying legislation contains varying provisions on such subjects as mental health care, emergency care, and homeless veterans, none are specifically designed to help veterans living in rural areas.

The Committee rejected an amendment I offered that would have provided VA with a viable set of tools with which to address the unique needs of veterans living in rural areas. The amendment was partially based on legislation I introduced in June to improve things for rural veterans in Hawaii. In addition, provisions from worthy legislation introduced by Senators Thune and Salazar on rural health initiatives were also included in the amendment. This amendment received bipartisan support but failed on a tie vote.

Specific to Hawaii, we know that the level of care provided to those living on what we call the "Neighbor Islands"—Kauai, Molokai, Lanai, Maui, and the Big Island is not at the optimal level. My amendment called for a pilot program to test the operation of two satellite clinics, as well as expanding services at those already in existence.

This pilot would focus on the islands of Molokai and Lanai, which currently lack VA facilities altogether. A veteran living on either of these remote islands must either wait for a VA provider to visit—which is only nine to ten times a year for Molokai and four times a year for Lanai—or take it upon himself to get to Maui for clinical care or to Oahu for treatment for a more serious condition.

Filling up the car with a tank of gas and driving across the State is obviously not even an option. Inter-island airfare is more than $200. VA does not reimburse for this. Add in various other travel costs, such as rental car and lodging expenses, and a veteran may choose to forgo care rather than pay these sizeable out-of-pocket costs. Even when a VA provider finally comes to one of these remote islands, they have no computer or telemedicine equipment—

this from a Department which touts their computerized medical records and technologies.

At the Committee's legislative hearing in early June, VA couldn't comment on these Hawaii-specific rural access components. However, VA now has had four months to comment. And they have still not done so. One could assume that the needs of Hawaii's veterans do not rank high on the list of Department priorities.

Let us not be under the illusion that State-specific projects are not important and have not been moved upon by this Committee. For those who would argue that this amendment is too prescriptive, I would argue that it absolutely needs to be.

For example, clinic personnel have asked for home care nurses to fulfill the long-term mandate this Committee passed six years ago. Veterans on Molokai are literally rallying for better care. Even when the Network and the local VA sends up proposals to Headquarters they are not acted upon. In the meantime, veterans are suffering.

With respect to this bill including benefits for veterans in rural areas in my state, let me state that these are legitimate needs of Hawaii veterans and, if these demonstration projects are successful, could be used as models for other rural areas in our nation.

At times, Members need to write prescriptive legislation, when it is clear that an agency or Department is not doing what is required. Because of the distance to the mainland, and because of the view that Hawaii is a paradise—which it is—it is difficult for us to get policymakers to travel to Hawaii to actually witness firsthand the challenges faced by veterans living on these geographically remote islands. As a result, the needs of neighbor island veterans are being ignored.

This amendment seeks to fix some of the access problems, while giving VA another opportunity to work with veterans to see which approach is best for all.

Also included in this amendment was Senator Thune's rural pilot program which would give us more data about how best to treat veterans living in highly rural areas. In addition, again based on Senator Thune's bill, VA needs to revamp its beneficiary travel program. This benefit is one that is highly valued by many veterans, especially those on fixed incomes. Unfortunately, there has not been an increase in the benefit for some time. In 2001, VA found that the current allowances under this program were not sufficient to begin to deal with high gas prices. Yet, four years later, the increase was never put forward.

This beneficiary travel increase would go hand in hand with another provision—an innovative grant program to provide options for transportation that Senator Salazar originally introduced. Although some ad hoc veterans travel programs have community support, many suffer from underfunding. Relatively small investments in transportation services can result in significantly better care for our Nation's most vulnerable veterans.

While this legislation still does not contain any provisions aimed at rural health, I will be working to ensure that these provisions come to fruition. For example, the Committee will be holding field hearings in my State. The main focus of these hearings will be on the unique access issues.

BLANKET APPROVAL FOR COST COMPARISON STUDIES: UNPROVEN AND EXPENSIVE

The Committee Bill would eliminate the longstanding prohibition against the Veterans Health Administration (VHA) conducting private-public cost comparison studies without a separate appropriation. This is the wrong course for VA at this time.

VHA has experienced serious shortfalls this year in the funding account for veterans' health care. As the cost of health care continues to rise to adjust for medical inflation and burgeoning demand, VHA resources are stretched thin. Yet, the Committee would give VHA this authority without any idea of the costs of the studies and the expenses associated with implementing the findings.

VA has yet to provide detailed estimates on how much will be spent doing these studies. The annual report on President Bush's "competitive sourcing" initiative says that the government spent $110 million in 2004 on private-public cost comparison studies. These studies reviewed, in total, more than 12,000 positions throughout the Federal government. In the end, about 1,000 jobs were contracted out, at a cost to the taxpayer of close to $100,000 per position. VA has identified 36,000 positions which could be affected by cost-comparison studies. Given the results from the "competitive sourcing" initiative, it is unrealistic to expect that VA would spend hundreds of millions to conduct its own cost comparison studies. In reality, VA would likely spend much, much more.

At the Committee markup, the Chairman argued that this bill would generate, "$1.3 billion over five years, that this would be the opportunity for this Committee to reinvest that money in care services." Unfortunately, to date, VA has been unable to document any substantial savings through its previous outsourcing initiatives or the creation of any significant new hires of full-time employees (FTE) as a result.

The Committee Report above states, "It is important to note that the Committee does not believe that comparison studies will inevitably result in the reduction of government employment." In reality, VA's own estimates for FTE reinvestment are based upon the potential elimination or outsourcing of some or all of 36,000 jobs currently being performed by government workers.

The provision would likely have a disastrous effect on VA workers, many of whom are also veterans. VA's own plan calls for the first 12,000 VHA employees affected by these cost-comparison studies to be laundry, canteen, nutrition, and food service workers. According to VA's own figures, 75 percent of the laundry workers and 57 percent of the food service workers are veterans. In addition, there are 3,400 veterans participating in VA's compensated work therapy program working in these same fields. It makes no sense for the Committee to pursue legislation that disregards the unique characteristics of VHA's workforce and jeopardizes the employment of veterans currently employed in these wage-grade jobs.

The provision in the legislation also lacks any mechanism for effective oversight of these studies. If enacted, there would be no transparency, and ergo, no accountability to Congress on this issue.

Before we blindly proceed, we should have a clear idea of how and where these savings will occur and what impact they will have

on VA's existing workforce. A much more prudent course of action would allow VA to use its own internal management analyses. VA through its own internal program should first be given the opportunity to realize its goal for management efficiencies without the disruption and uncertainty to its workforce created by cost-comparison studies and without the unnecessary expenditure of millions of unappropriated dollars needed to conduct them.

In summary, given the current shortfalls in VHA funding, it is inappropriate for VHA to spend millions on cost-comparison studies without any evidence there are substantial savings to be gained from such an endeavor. The legislation would give VA blanket approval to spend millions on conducting these studies without any provisions for Congressional oversight.

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, changes in existing law made by the Committee bill, as reported, are shown as follows (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

* * * * * * *

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

* * * * * * *

Subchapter II—Hospital, Nursing Home, or Domiciliary and Medical Treatment

* * * * * * *

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

* * * * * * *

(f)(1) The Secretary may not furnish hospital care or nursing home care *other than hospice care* under this section to a veteran who is eligible for such care under subsection (a)(3) of this section unless the veteran agrees to pay to the United States the applicable amount determined under paragraph (2) of this subsection.

(g)(1) The Secretary may not furnish medical services *other than hospice care* 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 in the case of each outpatient visit the applicable amount or amounts established by the Secretary by regulation.

* * * * * * *

§ 1710B. Extended care services

* * * * * * *

(a) * * *

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

[(c)**]***(b)*(1) Except as provided in paragraph (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 compensable service-connected disability unless the veteran agrees to pay to the United States a copayment (determined in accordance with subsection (d)) for any period of such services in a year after the first 21 days of such services provided that veteran in that year.

(2) Paragraph (1) shall not apply—

(A) to a veteran whose annual income (determined under section 1503 of this title) is less than the amount in effect under section 1521(b) of this title;

(B) to a veteran who is a former prisoner of war;

[(B)**]***(C)* to a veteran being furnished hospice care under this section; or

[(C)**]***(D)* with respect to an episode of extended care services that a veteran is being furnished by the Department on November 30, 1999.

[(d)**]***(c)*(1) A veteran who is furnished extended care services under this chapter and who is required under subsection **[**(c)**]***(b)* 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)**]***(b)*, the Secretary shall develop a methodology for establishing the amount of the copayment for which a veteran described in subsection **[**(c)**]***(b)* 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)**]***(d)*(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.

* * * * * * *

Subchapter III—Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

* * * * * * *

§ 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] *expenses resulting from emergency* treatment furnished the veteran in a non-Department facility *for which the veteran remains personally liable.*

(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 the 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.]

(1) is enrolled in the health care system established under section 1705(a) of this title;

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

(A) the veteran is enrolled in the health care system established under section 1705(a) of this title; and

(B) the veteran received care under this chapter within the 24-month period preceding the furnishing of such emergency treatment.]

(2) received care under this chapter during the 24-month period preceding the furnishing of such emergency treatment;

[(3) 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 healthplan contract (determined, in the case of a health-plan contract as defined in subsection (f)(2)(B) or (f)(2)(C), without regard to any requirement or limitation relating to eligibility for care or services from any department or agency of the United States);

(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 of services under section 1728 of this title.]

(3) is entitled to care or services under a health-plan contract that partially reimburses the cost of the veteran's emergency treatment;

(4) is financially liable to the provider of emergency care treatment for costs not covered by the veteran's health-plan contract, including copayments and deductibles; and

(5) is not eligible for reimbursement for medical care or services under section 1725 or 1728 of this title.

(c) LIMITATIONS ON REIMBURSEMENT.—(1) [The Secretary, in accordance with regulations prescribed by the Secretary, shall—] *Any amount paid by the Secretary under subsection (a) shall exclude the amount of any payment the veteran would have been required to make to the United States under this chapter if the veteran had received the emergency treatment from the Department.*

[(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)] [t] *T*he Secretary may *not* provide reimbursement under this section *with respect to any item or service* [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.]—

(A) provided or for which payment has been made, or can reasonably be expected to be made, under the veteran's health-plan contract; or

(B) for which payment has been made or can reasonably be expected to be made by a third party.

(3) *(A)* Payment by the Secretary under this section on behalf of a veteran 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].

(B) The absence of a contract or agreement between the Secretary and the provider, any provision of a contract or agreement, or an assignment to the contrary shall not operate to modify, limit, or negate the requirement under subparagraph (A).

(4) In accordance with regulations prescribed by the Secretary, the Secretary shall (A) establish criteria for determining the amount of reimbursement (which may include a maximum amount) payable under this section; and

(B) delineate the circumstances under which such payment may be made, including requirements for requesting reimbursement.

(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] *if,* 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—

(A) 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] *(B)* immediately forward all documents relating to [such] *a* payment *described in subparagraph (A)*

(C) cooperate with the Secretary in the investigation of [such] *a payment described in subparagraph (A);* and

(D) 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 [:]—

[(2)] *(1)* The term ["] 'healthplan 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 that 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.) [.]*; and*

(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)] *(2)* 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[.]*;* and

[(D) An automobile accident reparations insurance carrier.]

[(E)] *(D)* A person or entity obligated to provide, or to pay the expenses of, [health services under a healthplan contract.] *such emergency treatment; and*

[(1)] *(3)* The term ["] 'emergency treatment["]' [means medical care or services furnished, in the judgment of the Secretary—] *has the meaning given such term in section 1725 of this title.*

[(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 a prudent layperson reasonably expects that delay in seeking immediate medical attention 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.]

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1725 the following:

Sec. 1725A. Reimbursement for emergency treatment expenses for which certain veterans remain personally liable

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Subchapter VIII—Health Care of Persons Other Than Veterans

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§ 1785. * * *

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§ 1786. Care for newborn children of women veterans receiving maternity care

(a) The Secretary may furnish care to a newborn child of a woman veteran, who is receiving maternity care furnished by the Department, for not more than 14 days after the birth of the child if the veteran delivered the child in a Department contract for the delivery services.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1785 the following:

SEC. 1786. Care for newborn children of women veterans receiving maternity care

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CHAPTER 18—BENEFITS FOR CHILDREN OF VIETNAM VETERANS

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§ 1803. Health care

* * * * * * *

(b) * * *

(c)(1) If a payment made by the Secretary for health care under this section is less than the amount billed for such health care, the health care provider or agent of the health care provider may, in accordance with paragraphs (2) through (4), seek payment for the difference between the amount billed and the amount paid by the Secretary from a responsible third party to the extent that the provider or agent would be eligible to receive payment for such health care from such third party.

(2) The health care provider or agent may not impose any additional charge on the beneficiary who received the health care, or the family of such beneficiary, for any service or item for which the Secretary has made payment under this section;

(3) The total amount of payment a health care provider or agent may receive for health care furnished under this section may not exceed the amount billed to the Secretary.

(4) The Secretary, upon request, shall disclose to such third party information received for the purposes of carrying out this section..

[c**]** *(d)* For the purposes of this section—

(1) The term "health care"—

(A) means home care, hospital care, nursing home care, outpatient care, preventive care, habilitative and rehabilitative care, case management, and respite care; and

(B) includes—

(i) the training of appropriate members of a child's family or household in the care of the child; and

(ii) the provision of such pharmaceuticals, supplies, equipment, devices, appliances, assistive technology, direct transportation costs to and from approved sources of health care, and other materials as the Secretary determines necessary.

(2) The term "health care provider" includes specialized spina bifida clinics, health care plans, insurers, organizations, institutions, and any other entity or individual furnishing health care services that the Secretary determines are authorized under this section.

(3) The term "home care" means outpatient care, habilitative and rehabilitative care, preventive health services, and health-related services furnished to an individual in the individual's home or other place of residence.

(4) The term "hospital care" means care and treatment for a disability furnished to an individual who has been admitted to a hospital as a patient.

(5) The term "nursing home care" means care and treatment for a disability furnished to an individual who has been admitted to a nursing home as a resident.

(6) The term "outpatient care" means care and treatment of a disability, and preventive health services, furnished to an individual other than hospital care or nursing home care.

(7) The term "preventive care" means care and treatment furnished to prevent disability or illness, including periodic examinations, immunizations, patient health education, and such other services as the Secretary determines necessary to provide effective and economical preventive health care.

(8) The term "habilitative and rehabilitative care" means such professional, counseling, and guidance services and treatment programs (other than vocational training under section 1804 of this title) as are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a disabled person.

(9) The term "respite care" means care furnished on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual to continue residing in such private residence.

* * * * * * *

§ 1813. Health care

(b) * * *

(c)(1) If payment made by the Secretary for health care under this section is less than the amount billed for such health care, the health care provider or agent of the health care provider may, in accordance with paragraphs (2) through (4), seek payment for the difference between the amount billed and the amount paid by the Secretary from a responsible third party to the extent that the provider or agent would be eligible to receive payment for such health care from such third party.

(2) The health care provider or agent may not impose any additional charge on the beneficiary who received health care, or the family of such beneficiary, for any service or item for which the Secretary has made payment under this section;

(3) The total amount of payment a health care provider or agent may receive for health care furnished under this section may not exceed the amount billed to the Secretary; and

(4) The Secretary, upon request, shall disclose to such third party information received for the purposes of carrying out this section.

[(c)**]** *(d)* DEFINITIONS.—For purposes of this section, the definitions in section 1803(c) of this title shall apply with respect to the provision of health care under this section, except that for such purposes—

(1) the reference to "specialized spina bifida clinic" in paragraph (2) of that section shall be treated as a reference to a specialized clinic treating the birth defect concerned under this section; and

(2) the reference to "vocational training under section 1804 of this title" in paragraph (8) of that section shall be treated as a reference to vocational training under section 1814 of this title.

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CHAPTER 20—BENEFITS FOR HOMELESS VETERANS

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Subchapter II—Comprehensive Service Programs

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§ 2011. Grants

(a) AUTHORITY TO MAKE GRANTS.—**[**(1)**]** Subject to the availability of appropriations provided for such purpose, the Secretary shall make grants to assist eligible entities in establishing programs to furnish, and expanding or modifying existing programs for furnishing, the following to homeless veterans:

(A) Outreach.

(B) Rehabilitative services.

(C) Vocational counseling and training

(D) Transitional housing assistance.

[(2) The authority of the Secretary to make grants under this section expires on September 30, 2005.**]**

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§ 2013. Authorization of appropriations

There are authorized to be appropriated *$130,000,000 for fiscal year 2006 and each subsequent fiscal year* to carry out this subchapter **[**amounts as follows:**]**.

[(1) $60,000,000 for fiscal year 2002.

[(2) $75,000,000 for fiscal year 2003.

[(3) $75,000,000 for fiscal year 2004.

[(4) $75,000,000 for fiscal year 2005.**]**

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CHAPTER 74—VHA—PERSONNEL

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Subchapter I—Appointments

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§ 7402. Qualifications of appointees

(b)(9) * * *

(b)(10) *Marriage and family therapist—To be eligible to be appointed to a marriage and family therapist position, a person must—*

(A) hold a master's degree in marriage and family therapy, or a comparable degree in mental health, from a college or university approved by the Secretary; and

(B) be licensed or certified to independently practice marriage and family therapy in a State, except that the Secretary may waive the requirement of licensure or certification for an individual marriage and family therapist for a reasonable period of time recommended by the Under Secretary for Health.

(b)**[**10**]***(11)* CHIROPRACTOR.—To be eligible to be appointed to a chiropractor position, a person must—

(A) hold the degree of doctor of chiropractic, or its equivalent, from a college of chiropractic approved by the Secretary; and

(B) be licensed to practice chiropractic in a State.

(b)**[**11**]***(12)* OTHER HEALTHCARE POSITIONS.—To be appointed as a physician assistant, expanded-function dental auxiliary, certified or registered respiratory therapist, licensed physical therapist, licensed practical or vocational nurse, occupational therapist, dieti-

tian, microbiologist, chemist, biostatistician, medical technologist, dental technologist, or other position, a person must have such medical, dental, scientific, or technical qualifications as the Secretary shall prescribe.

(c) Except as provided in section 7407(a) of this title, a person may not be appointed in the Administration to a position listed in section 7401(1) of this title unless the person is a citizen of the United States.

(d) A person may not be appointed under section 7401(1) of this title to serve in the Administration in any direct patient-care capacity unless the Under Secretary for Health determines that the person possesses such basic proficiency in spoken and written English as will permit such degree of communication with patients and other healthcare personnel as will enable the person to carry out the person's healthcare responsibilities satisfactorily. Any determination by the Under Secretary for Health under this subsection shall be in accordance with regulations which the Secretary shall prescribe.

(e) A person may not serve as Chief of Staff of a Department healthcare facility if the person is not serving on a full-time basis.

(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.

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§ 7404. Grades and pay scales

(c) * * *

(d) Except as provided under **[**subchapter III**]** *paragraph (e), subchapter III* and in section 7457 of this title, pay may not be paid at a rate in excess of the rate of basic pay for an appropriate level authorized by section 5315 or 5316 of title 5 for positions in the Executive Schedule, as follows:

(1) Level IV for the Deputy Under Secretary for Health.

(2) Level V for all other positions for which such basic pay is paid under this section.

(e) The position of Chief Nursing Officer, Office of Nursing Services, shall be exempt from the provisions of section 7451 of this title and shall be paid at a rate not to exceed the maximum rate established for the Senior Executive Service under section 5382 of title 5 United States Code, as determined by the Secretary.

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED—USE LEASES OF REAL PROPERTY

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Subchapter I—Acquisition and Operation of Medical Facilities

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§ 8110. Operation of Medical Facilities

(a)(4) * * *

[(5) Notwithstanding any other provision of this title or of any other law, funds appropriated for the Department under the appropriation accounts for medical care, medical and prosthetic research, and medical administration and miscellaneous operating expenses may not be used for, and no employee compensated from such funds may carry out any activity in connection with, the conduct of any study comparing the cost of the provision by private contractors with the cost of the provision by the Department of commercial or industrial products and services for the Veterans Health Administration unless such funds have been specifically appropriated for that purpose.]

[(6)] *(5)* (A) Temporary research personnel of the Veterans Health Administration shall be excluded from any ceiling on full-time equivalent employees of the Department or any other personnel ceiling otherwise applicable to employees of the Department. (B) For purposes of subparagraph (A) of this paragraph, the term "temporary research personnel" means personnel who are employed in the Veterans Health Administration in other than a career appointment for work on a research activity and who are not paid by the Department or are paid from funds appropriated to the department to support such activity.

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