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Report RL32961

Veterans' Health Care Issues in the 109th Congress

Sidath Viranga Panangala, Domestic Social Policy Division

October 26, 2006

Abstract. This report provides an overview of major issues facing veterans' health care during the 109th Congress. The report's primary focus is on veterans and not military retirees. While any person who has served in the armed forces of the United States is regarded as a veteran, a military retiree is someone who has completed a full active duty military career (almost always at least 20 years of service), or who is disabled in the line of military duty and meets certain length of service and extent of disability criteria, and who is eligible for retired pay and a broad range of nonmonetary benefits from the Department of Defense (DOD) after retirement. A veteran is someone who has served in the armed forces (in most, but not all, cases for a few years in early adulthood), but may not have either sufficient service or disability to be entitled to post-service retired pay and nonmonetary benefits from DOD. Generally, all military retirees are veterans, but all veterans are not military retirees.

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Veterans' Health Care Issues in the 109th Congress

Updated October 26, 2006

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<http://wikileaks.org/wiki/CRS-RL32961>



Prepared for Members and
Committees of Congress

Veterans' Health Care Issues in the 109th Congress

Summary

The Department of Veterans Affairs (VA) provides services and benefits to veterans who meet certain eligibility criteria. VA carries out its programs nationwide through three administrations and the Board of Veterans Appeals (BVA). The Veterans Health Administration (VHA) is responsible for veterans health care programs. The Veterans Benefits Administration (VBA) is responsible for providing compensation, pensions, and education assistance among other things. The National Cemetery Administration's (NCA) responsibilities include maintaining national veterans cemeteries.

VHA operates the nation's largest integrated health care system. Unlike other federal health programs, VHA is a direct service provider rather than a health insurer or payer for health care. VA health care services are generally available to all honorably discharged veterans of the U.S. Armed Forces who are enrolled in VA's health care system. VA has a priority enrollment system that places veterans in priority groups based on various criteria. Under the priority system VA decides each year whether its appropriations are adequate to serve all enrolled veterans. If not, VA could stop enrolling those in the lowest-priority groups.

Congress continues to grapple with a number of issues facing current veterans and new veterans returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). They include trying to ensure a seamless transition process for veterans moving from active duty into the VA health care system, and improving mental health care services such as post-traumatic stress disorder (PTSD) treatment programs for returning veterans.

In recent years, VA has made an effort to realign its capital assets, primarily buildings, to better serve veterans' needs. VA established the Capital Asset Realignment for Enhanced Services (CARES) initiative to identify how well the geographic distribution of VA health care resources matches the projected needs of veterans. Given the tremendous interest in the implementation of the CARES initiative in the previous Congress, the 109th Congress would continue to monitor the CARES implementation.

Several veterans' health-care related bills have been passed by either the House or Senate. At present, these bills are pending action in the other chamber.

This report will be updated as events warrant.

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Veterans' Health Care Issues in the 109th Congress

Background

The history of the present-day Department of Veterans Affairs (VA) can be traced back to July 21, 1930, when President Hoover issued Executive Order 5398, creating an independent federal agency known as the Veterans Administration by consolidating many separate veterans' programs.¹ On October 25, 1988, President Reagan signed legislation (P.L. 100-527) creating a new federal cabinet-level Department of Veterans Affairs to replace the Veterans Administration, effective March 15, 1989. VA carries out its veterans' programs nationwide through three administrations and the Board of Veterans Appeals (BVA). The Veterans Health Administration (VHA) is responsible for veterans' health care programs. The Veterans Benefits Administration (VBA) is responsible for compensation, pension, vocational rehabilitation, education assistance, home loan guaranty and insurance among other things. The National Cemetery Administration's (NCA) responsibilities include maintaining 120 national cemeteries in 39 states and Puerto Rico. The Board of Veterans Appeals renders final decisions on appeals on veteran benefits claims.

This report provides an overview of major issues facing veterans' health care during the 109th Congress.² The report's primary focus is on *veterans* and not *military retirees*. While any person who has served in the armed forces of the United States is regarded as a veteran, a *military retiree* is someone who has completed a full active duty military career (almost always at least 20 years of service), or who is disabled in the line of military duty and meets certain length of service and extent of disability criteria, and who is eligible for retired pay and a broad range of nonmonetary benefits from the Department of Defense (DOD) after retirement. A *veteran* is someone who has served in the armed forces (in most, but not all, cases for a few years in early adulthood), but may not have either sufficient service or disability to be entitled to post-service retired pay and nonmonetary benefits from DOD. Generally, all military retirees are veterans, but all veterans are not military retirees.

Currently, VA health care services are generally available to all honorably discharged veterans of the U.S. Armed Forces who are enrolled in VA's health care system. In general, veterans have to enroll in the VA's health care system to receive

¹ In the 1920s three federal agencies, the Veterans Bureau, the Bureau of Pension in the Department of the Interior, and the National Home for Disabled Volunteer Soldiers, administered various benefits for the nation's veterans.

² For detailed information on veterans benefits issues see CRS Report RL33216, *Veterans Benefits Issues in the 109th Congress*, by Paul J. Graney.

care from VA. Typically veterans are enrolled in priority enrollment groups based on service-connectedness and income (described later in this report). Persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned after October 16, 1981 must have completed two years of active duty or the full period of their initial service obligation to be eligible for benefits. Veterans discharged at any time because of service-connected disabilities are not held to this requirement.³ Also eligible on a more limited basis are members of the armed forces Reserve components called to active duty and who serve the length of time for which they were activated, and National Guard personnel who are called to active duty by a federal declaration and serve the full period for which they were called. These servicemembers can receive care from VA for an initial two-year period for conditions presumably related to military service and for proven service-connected conditions thereafter.⁴

To provide some context on veterans' health care issues, the first part of this report provides a brief history of the Veterans Health Administration (VHA) and an overview of the evolution of eligibility for VA health care.⁵ The second part of the report discusses major issues facing veterans' health care and provides a summary of major legislation enacted into law and bills that have been passed by either the House or Senate.⁶

Veterans Health Administration (VHA)

History. VA's largest and most visible operating unit is the Veterans Health Administration (VHA). Established in 1946 as the Department of Medicine and Surgery, it was succeeded in 1989 by the Veterans Health Services and Research Administration, and renamed the Veterans Health Administration (VHA) in 1991.⁷ The veterans' medical system was first developed to provide needed care to veterans injured or sick as a result of service during wartime. When there was excess capacity in VA hospitals, Congress gave wartime veterans without service-connected

³ A service-connected disability is one that results from an injury or disease or physical or mental impairment incurred or aggravated during military service. VA determines if veterans have service-connected disabilities and, for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability.

⁴ For an overview of eligibility for disability benefit programs, and information on benefits for service-connected disabilities see CRS Report RL33113, *Veterans Affairs: Basic Eligibility for Disability Benefit Programs*, by Douglas Reid Weimer and CRS Report RL33323, *Veterans Affairs: Benefits for Service-Connected Disabilities*, by Douglas Reid Weimer.

⁵ This report will use VA and VHA interchangeably to describe the Veterans Health Administration.

⁶ For a summary of veterans' benefits legislation, see CRS Report RL33216, *Veterans Benefits Issues in the 109th Congress*, by Paul J. Graney.

⁷ Prior to the establishment of VHA, Public Health Service (PHS) hospitals treated veterans. In 1921 these PHS hospitals treating veterans were transferred to the newly established Veterans Bureau.

conditions access to VA hospitals, provided space was available and the veterans signed an oath indicating they were unable to pay for their care.⁸ At the end of World War II, the federal government undertook the task of increasing the number of VA medical facilities to meet the expected demand for health care for veterans returning with injuries or illnesses sustained during hostilities. The primary focus of the expansion was to immediately tend to the medical needs of returning combatants for acute care and then to address the long-term rehabilitation needs of more seriously injured veterans. Within a few years after the cessation of hostilities, the initial demand for acute care services for service-connected conditions diminished and VA initiated what was later to become its specialized services mission, in part because services such as spinal cord injury care, blind rehabilitation, and prosthetics were almost non-existent in the private medical market during the late 1940s.

The VA system has evolved and expanded since World War II. Congress has enlarged the scope of the VA's health care mission and has enacted legislation requiring the establishment of new programs and services. Through numerous laws, some narrowly focused, others more comprehensive, Congress has also extended to additional categories of veterans' eligibility for the many levels of care the VA now provides. No longer a health care system focused only on service-connected veterans, the VA has also become a "safety net" for the many lower-income veterans who have come to depend upon it.

Transformation of VHA. Over the past decade, VA has transformed its health care system through structural and organizational changes. In the early 1990s VA recognized that its system might want to respond to certain changes taking place in the private health care market and began a process of restructuring and rationalizing services. VA established regional networks and decentralized certain budgetary authority to these networks. Furthermore, advances in medical technology, such as laser and other minimally invasive surgical techniques, allowed care previously provided in hospitals to be provided on an outpatient basis. Similarly, development of psychotherapeutic drugs to treat mental illness have led to fewer and shorter hospital admissions for psychiatric patients, as well as the deinstitutionalization of many long-term psychiatric patients. With the passage of eligibility reform legislation in 1996 (P.L. 104-262) and in response to changing trends in medical practice, VA began to shift its focus from primarily inpatient hospital care to outpatient care in order to provide more accessible and efficient delivery of health care to veterans.

Today, VA operates the nation's largest integrated health care system. VHA is divided into 21 Veterans Integrated Service Networks (VISNs, see **Appendix 1** for a map of VISNs). Each network includes a management office responsible for making basic budgetary, planning and operating decisions. Each office oversees between five and 11 hospitals as well as community-based outpatient clinics (CBOCs), nursing homes and readjustment counseling centers (Vet Centers) located

⁸ World War Veterans Act of 1924 (P.L. 68-242).

within each VISN. In FY2005, VA operated 157 hospitals, 750 CBOCs, 134 nursing homes and 42 domiciliary care facilities.^{9,10}

Unlike other federal health programs (such as Medicaid and Medicare), the VA is a direct service provider rather than a health insurer or payer for health care services. VHA offers a standardized medical benefits package that includes a full range of outpatient and inpatient services with an emphasis on preventive and primary care. As defined in regulations, VA medical benefits include among other things, preventive services, including immunizations, screening tests, and health education and training classes, primary health care diagnosis and treatment, prescription drugs, comprehensive rehabilitative services, mental health services including professional counseling, home health care, respite (inpatient), hospice, and palliative care, and emergency care.¹¹ Some veterans are also eligible to receive long-term care including nursing home care, domiciliary care, adult day care, and limited dental care.

In FY2005, there were 7.7 million enrolled veterans, and 4.8 million unique veteran patients received care from VA.¹² That same fiscal year, VA treated 768,651 inpatients, 89,961 veterans in nursing home care units or in community nursing home facilities, and 30,118 veterans in home and community-based facilities. The VHA's outpatient clinics registered more than 52 million visits by veterans in FY2005.¹³

In addition to providing direct health care to veterans, since 1946 VA has been authorized to enter into agreements with medical schools and their teaching hospitals. Under these agreements, VA hospitals provide training for medical residents and students and appoint medical school faculty as VA staff physicians to supervise resident education and patient care. Across the nation, VA is currently affiliated with 107 medical schools, 54 dental schools, and over 1,000 other schools offering students allied and associated education degrees or certificates in 40 health profession disciplines. More than one-half of all practicing physicians in the U.S. received at least part of their clinical educational experiences in the VA health care system. In

⁹ A domiciliary is a facility that provides rehabilitative and long-term health care for veterans who require minimal medical care. VA now refers to these as Residential Rehabilitation Treatment Facilities.

¹⁰ Department of Veterans Affairs, *FY2006 Budget Submission, Medical Programs*, vol. 2 of 4, pp. 4-21. (Hereafter cited as VA, *FY2006 Budget Submission*.)

¹¹ 38 C.F.R. § 17.38.

¹² Under current law, most veterans have to enroll to receive health care from VHA. However, in any given year, some enrollees do not seek any medical care, either because they do not become ill or because they rely on other sources of care. In some cases, VHA provides care to non-enrolled veterans in the following classes: veterans who need treatment for a VA rated service-connected disability; veterans who are VA rated as 50% or more service-connected disabled; and veterans who were released from active duty within the previous 12 months for a disability incurred or aggravated in the line of duty. In addition, VA provides care to certain eligible dependents of veterans through a program called the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and to VA employees. These users of VA do not enroll for VA care.

¹³ VA, *FY2006 Budget Submission*.

FY2005, more than 87,000 health care professionals received training in VA medical centers.¹⁴ VA is also the largest employer of registered nurses in the United States, with 32,582 nurses on its payroll in FY2005.¹⁵

Evolution of Veterans' Eligibility for VA Health Care

To understand some of the issues facing veterans' health care programs discussed later in this report, it is important to get a sense of how veterans' eligibility for health care has evolved over time. While a full description of this evolution is beyond the scope of this report, this report will provide a brief overview. Generally, veterans' eligibility for VA health care services has evolved from treating veterans with service-connected conditions or veterans with low incomes to veterans with nonservice-connected conditions and higher incomes. Moreover, VA's health care coverage has changed from not having a well-defined medical benefits package to a standardized benefits package.

Eligibility criteria used to determine which veterans must be served by VA and what type of medical care that they can be provided has undergone many changes since the establishment of VA. Congress has made several major changes throughout the years concerning the provision of hospital care, outpatient care and nursing home care. Initially veterans could receive care only for treatment of service-connected conditions that were incurred or aggravated during wartime service. In 1924, Congress gave access to hospital care to World War I veterans with nonservice-connected conditions on a space available basis who signed an oath of poverty. In 1943, hospital care was extended to World War II veterans with nonservice-connected conditions and outpatient care was limited to those with service-connected conditions. However, with the passage of P.L. 86-639 in 1960, Congress authorized VA to provide outpatient treatment for nonservice-connected conditions in preparation for or to complete treatment of hospital care. In 1973, with the passage of the Veterans Health Care Expansion Act (P.L. 93-82), Congress further extended outpatient treatment for nonservice-connected veterans to "obviate the need of hospital admission."¹⁶

By 1985, VA was authorized to provide most categories of veterans with hospital, nursing home, and domiciliary care. However, VA was not required or obligated to do so. This is evidenced by the use of the phrase "may provide" in the statutes. In 1986, with passage of P.L. 99-272, Congress established three categories of eligibility for VA health care. The law provided that hospital care *shall* be provided, free of direct charge, to veterans within Category A. The term "shall" was interpreted by many as meaning "entitled" to hospital care. These Category A veterans were defined to include those with service-connected disabilities, low-income veterans without such disabilities, and certain "exempt" veterans, including (for example) former prisoners of war, those exposed to Agent Orange,

¹⁴ Ibid., pp. 8-9.

¹⁵ Ibid., pp. 2-26.

¹⁶ U.S. General Accounting Office, *VA Health Care: Issues Affecting Eligibility Reform*, GAO/T-HEHS-95-213, p. 6.

recipients of VA pensions, and those eligible for Medicaid. Moreover, P.L. 99-272 provided that Category A veterans *may* be provided outpatient and nursing home care. The term “may” was interpreted by many as meaning “eligible” for outpatient and nursing home care. Veterans not in Category A were assigned to either Category B or Category C on the basis of current income and net worth; VA could furnish care to these veterans on a resources-available basis. Veterans not eligible for Category B on the basis of either income or net worth were placed in Category C.¹⁷ Veterans in Categories B and C were eligible to receive care but were not entitled to care.

It should be noted that the terms eligibility and entitlement had different meanings under the VA health care system than under other public health care programs such as Medicare. For instance, all beneficiaries who meet the basic eligibility requirements for Medicare are entitled to all medically necessary care under the Medicare benefits package. Under the VA health care system, the term “eligible” meant that VA “may” provide care, and the term “entitled” meant that VA was required or “must” provide care.¹⁸ However, neither being eligible for nor being entitled to health care services guaranteed the availability of health services. Since funding for VA health care was, and still is, based on fixed annual appropriations, once the funds were expended VA could no longer provide care, even to veterans who were entitled to care. Being entitled to care essentially gave veterans a higher priority for care than being eligible for VA health care.

Eligibility Reform. Although from time to time Congress expanded access to VA health care, certain criteria that accompanied these expansions were an apparent source of frustration not only for veterans, but also for VA physicians and VA administrative staff who applied and enforced these provisions. As mentioned earlier, some veterans were entitled to outpatient care only if it was for pre- and post-hospitalization and to obviate the need for hospital care. As illustrated in **Figure 1**, for most categories of veterans, eligibility for outpatient care was subject to the obviate the need for hospitalization criterion. Only two categories of veterans were not subject to this criterion: they were veterans with a service-connected disability rated 50% or more who were entitled to care, and nonservice-connected veterans with special status, such as former prisoners of war, who were only eligible for care.

However, the obviate the need statutory authority was interpreted by VA medical centers in several different ways. Some medical centers interpreted it as care for any medical condition, whereas other medical centers interpreted this statutory authority as care for only certain medical conditions.¹⁹ Similarly, since there was no defined health benefits package prior to eligibility reform, veterans were often uncertain about whether they were entitled to certain services or were merely eligible to receive some services. Likewise, VA health care providers complained that when

¹⁷ For a comprehensive history of eligibility for VA health care, see U.S. General Accounting Office, *VA Health Care: Issues Affecting Eligibility Reform Efforts*, GAO/HEHS-96-160. Much of the history described in this section was drawn from this GAO report.

¹⁸ This is evidenced by the use of words “shall” and “may” throughout 38 U.S.C. §1710.

¹⁹ U.S. General Accounting Office, *VA Health Care: Issues Affecting Eligibility Reform Efforts*, GAO/HEHS-96-160, p. 44.

treating certain veterans, they could only treat the service-connected conditions and not the entire patient, although the nonservice-connected condition could affect the veteran's overall health.

These limitations were addressed by Congress with the passage of the Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262). This act required VA to establish priority categories and operate a patient enrollment system to manage access to VA health care if sufficient resources were not available to serve all veterans seeking care. It also substantially revised statutes governing care for veterans, putting inpatient and outpatient care on the same statutory footing so that VA can provide care the patient needs in the most medically appropriate setting.²⁰ The intent of these changes was to expand the services VHA could provide to veterans while eliminating statutory barriers to providing care in the most economical manner, and to lower the expenses associated with providing care to veterans.²¹

VHA began enrolling veterans beginning October 1, 1998.²² A detailed list of priority enrollment groups is provided in **Appendix 2**.^{23 24} **Table 1** provides details on eligibility for VA health care prior to the enactment of P.L. 104-262, as it relates to the current priority enrollment groups. For example, as illustrated in **Table 1**, veterans with service-connected conditions rated 50%-100% currently are correlated to Priority Group 1 veterans. Veterans with service-connected conditions rated 0%-40% may either be Priority Group 2 or Priority Group 3 depending upon their disability rating. These veterans, along with other veterans discharged for disability, would have had the clearest entitlement to VA services prior to eligibility reform.

²⁰ Kenneth W. Kizer et al., "Reinventing VA Health Care, Systematizing Quality Improvement and Quality Innovation," *Medical Care*, vol. 28, no. 6, pp. 1-8.

²¹ U.S. Congress, House Committee on Veterans' Affairs, *Veterans Eligibility Reform Act of 1996*, report to accompany H.R. 3118, 104th Cong., 2nd sess., H.Rept. 104-690, pp. 5, 8, 25.

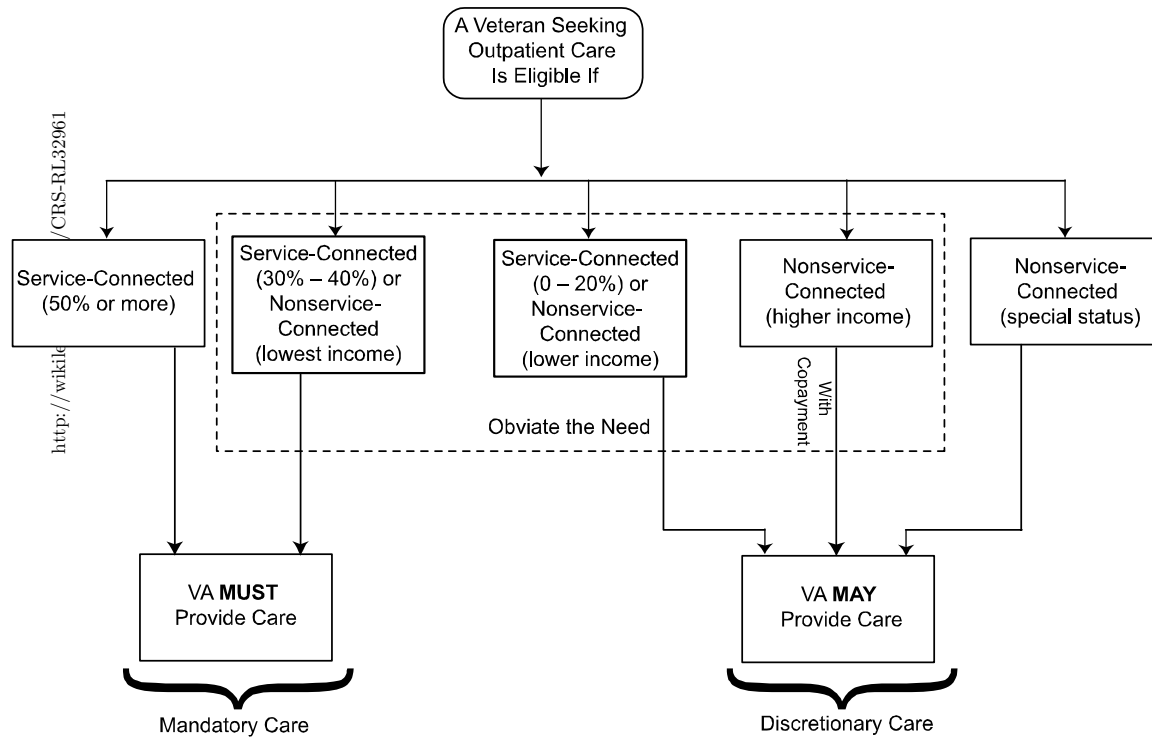
²² VA has eight priority enrollment groups, with Priority 1 veterans — those with service-connected disabilities rated 50% or more — having the highest priority for enrollment. By contrast, Priority 8 veterans are primarily veterans with no service-connected disabilities and higher incomes.

²³ For a detailed description of the current VA enrollment process, see CRS Report RL33409, *Veterans' Medical Care: FY2007 Appropriations*, by Sidath Viranga Panangala.

²⁴ Under current law, most veterans have to enroll to receive health care from VHA. However, in any given year, some enrollees do not seek any medical care, either because they do not become ill or because they rely on other sources of care. In some cases, VHA provides care to non-enrolled veterans in the following classes: veterans who need treatment for a VA rated service-connected disability; veterans who are VA rated as 50% or more service-connected disabled; and veterans who were released from active duty within the previous 12 months for a disability incurred or aggravated in the line of duty. In addition, VA provides care to certain eligible dependents of veterans through a program called the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and to VA employees. These users of VA do not enroll for VA care.

Although the prior eligibility criteria have no **direct** correlation to today's enrollment priority groups, in general, Category A correlated with Priority Groups 1 through 6, and Category C correlated with Priority Groups 7 and 8. Category B (not shown in **Table 1**) included veterans with nonservice-connected disabilities who may have received hospital and nursing home care if they were unable to defray the cost of the said care based on a defined income threshold. Category B most closely correlated with veterans in Priority Group 4 and certain veterans classified in Priority Group 5. Former Category B veterans cannot be isolated in **Table 1** because it is spread among multiple priority groups.

Figure 1. Eligibility Criteria for Outpatient Care Prior to Eligibility Reform



Source: Chart prepared by CRS based on U.S. General Accounting Office (now the Government Accountability Office, or GAO), *Variabilities in VA Outpatient Care*, GAO-HRD-93-106, p. 27.

**Table 1. Access to VA Health Care Services
Prior to the 1996 Eligibility Reform**

Veteran category prior to eligibility reform	New enrollment priority groups after eligibility reform	Inpatient hospital care	Outpatient care	Nursing home care
Category A				
Service-connected rated 50%-100% obtaining care for any condition	Priority Group 1	Entitled	Entitled	Eligible
Service-connected rated 0%-40% obtaining care for service-connected conditions only	Priority Group 2 Priority Group 3		Entitled, limited to pre- and post-hospitalization and to obviate the need for hospital care	
Veterans discharged for disability	Priority Group 3			
Service-connected rated 30%-40% obtaining care for a nonservice-connected condition	Priority Group 2	Entitled	Entitled, limited to pre- and post-hospitalization and to obviate the need for hospital care	Eligible
Veterans receiving VA pension benefits or income under VA means test threshold	Priority Group 5			
Disabled due to treatment by VA	Priority Group 3			
Prisoner of War (POW)	Priority Group 3	Entitled	Eligible	Eligible
World War I and Mexican Border War veterans	Priority Group 6			
Veterans receiving a pension with aid and attendance payments	Priority Group 4			

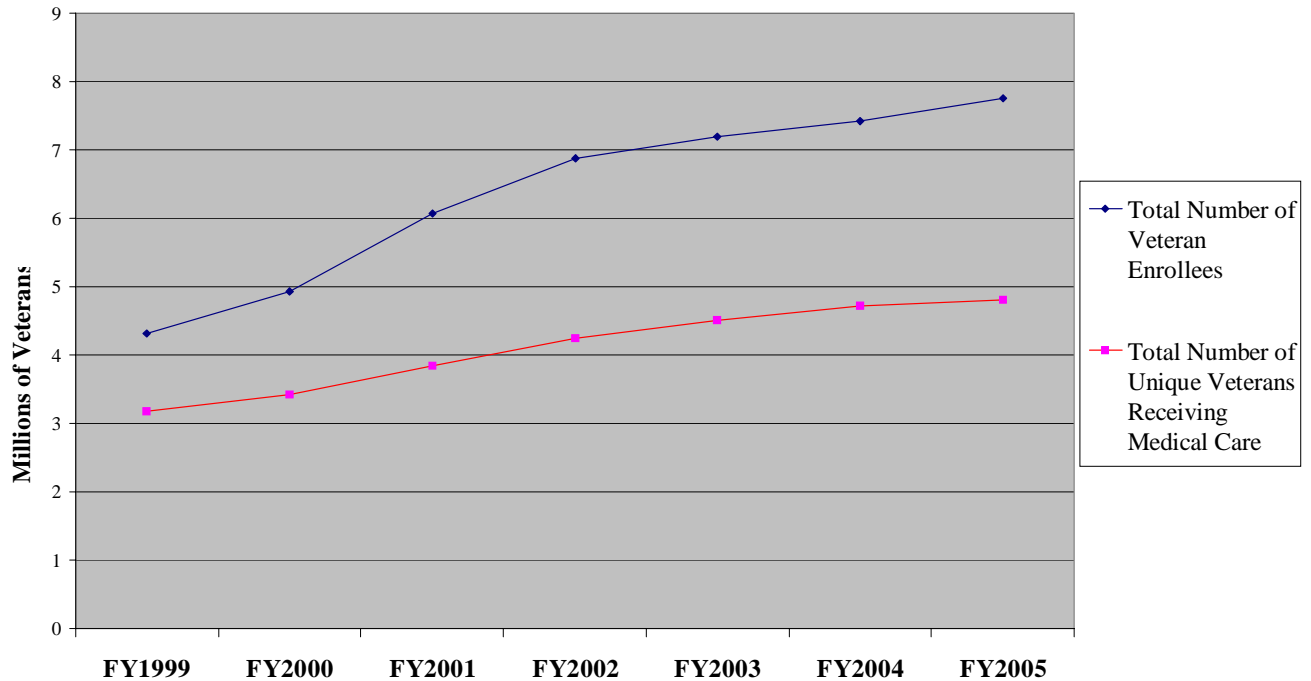
Veteran category prior to eligibility reform	New enrollment priority groups after eligibility reform	Inpatient hospital care	Outpatient care	Nursing home care
Service-connected rated 0-20% obtaining care for a nonservice-connected condition	Priority Group 3	Entitled	Eligible, limited to pre- and post-hospitalization and to obviate the need for hospital care	Eligible
Nonservice-connected with an income below VA means test threshold (no dependents)	Priority Group 5			
Veterans exposed to agent orange, radiation or Medicaid eligible	Priority Group 5 Priority Group 6			
Category C				
Nonservice-connected with income above VA means test threshold (no dependents)	Priority Group 7 Priority Group 8	Eligible with copayments	Eligible with copayments, limited to pre- and post-hospitalization and to obviate the need for hospital care	Eligible with copayments

Source: Table prepared by CRS based on U.S. General Accounting Office, *VA Health Care, Issues Affecting Eligibility Reform*, GAO/T-HEHS-95-213, p. 8.

Today, 10 years after the passage of the Veterans Health Care Eligibility Reform Act of 1996, when Congress dramatically restructured the VA health care system, VA has experienced unprecedented growth in demand for medical care. The total number of veteran enrollees has grown by 79.5% from FY1999, the first year of enrollment, to FY2005 (**Figure 2**). During this same period the number of unique veterans receiving medical care has grown by 49.2% — from 3.2 million veteran patients in FY1999 to 4.8 million veteran patients in FY2005 (**Figure 2**). This growth in demand for care, and the budgetary constraints placed on the federal budget has once again opened the debate in Congress as to what categories of veterans should have priority to receive care. Some in Congress are concerned about the growing costs, question the current eligibility for VA medical care, and suggest that it should be narrowed. They believe that VA’s primary responsibility is to care for veterans with service-connected medical problems and that the system should not be providing care to veterans with nonservice-connected conditions with incomes above certain mean-tests. However, most of the veterans currently enrolled in VA were eligible for, if not entitled to, certain care from VA prior to the 1996 reforms. The reform act clarified and expanded veterans’ access to outpatient care. It also

built in mechanisms to limit enrollment in the event that VA funding was insufficient to meet the demand for care. Most of the issues discussed in the next section are linked to these fundamental concerns.

Figure 2. Total Number of Veteran Enrollees and Number of Veterans Receiving Medical Care, FY1999-FY2005



Source: Graph prepared by CRS. Data provided by the Office of Actuary, Office of Policy, Planning, and Preparedness, U.S. Department of Veterans Affairs (VA).

Health Care Issues in the 109th Congress

Introduction

Shortly after the terrorist attacks on the U.S. on September 11, 2001, military personnel began deploying to Afghanistan. Beginning in late 2002 and early 2003, additional military personnel were deployed to Iraq. Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) produced a new generation of war veterans. The return of thousands of these veterans from the Iraq and Afghanistan theaters in need of medical services has put considerable pressure on both VHA personnel and budgets. During the 109th Congress, policymakers will face a number of issues affecting these and other veterans. Among other things, Congress will continue to focus on attempting to ensure a “seamless transition” process for veterans moving from active duty into the VA health care system, improving mental health care services for veterans, funding the growing demand for veterans’ health care services, and overseeing improvements to the effectiveness and efficiency of VA’s provision of health care services. Moreover, in recent years, some in Congress

have shown a keen interest in using VA as a model to inform changes in certain aspects of private and public health care delivery systems; that intent is likely to continue in this Congress as well. The discussion below focuses on these major issues facing VA's health care programs.

Seamless Transition of Returning Servicemembers

Congress and veterans' advocates are concerned that returning servicemembers from OIF and OEF do not have a smooth transition from DOD health care to VA health care. This holds especially true for Reserve and National Guard OEF and OIF veterans. At a congressional hearing held in October 2003, some witnesses testified about the lack of an integrated medical information system between DOD hospitals and the VA. The VA Undersecretary for Health testified that "too often Reservists and National Guard personnel have not received timely information about the benefits and access to health care they have earned."²⁵ The President's Taskforce to Improve Health Care Delivery for Our Nation's Veterans has also discussed the importance of providing a seamless transition from military to veteran status, including the coordination and sharing of electronic health information between VA and DOD. In March 2005, the Government Accountability Office (GAO) testified that VA still does not have systematic access to DOD data about returning servicemembers who may need its services.²⁶ Again, in September 2005, GAO testified that while VA has developed policies and procedures to provide OEF and OIF servicemembers and veterans with timely access to care, the sharing of health information between DOD and VA is limited.²⁷

Data and Trends. Since the beginning of conflicts in Afghanistan and Iraq, approximately 1.4 million troops have served in the two theaters of operation.²⁸ As of May 31, 2006, 588,923 OEF and OIF veterans had separated from active duty. Of this amount, 262,061, or 45%, were active duty troops, while 326,862, or 56%, were separated National Guard members. Approximately 31%, or 184,524, of these separated veterans have sought care from VA. About 97% of these veterans have received outpatient care, while 3%, or 5,762, have been hospitalized at least once in a VHA facility. Reservists and National Guard members make up the majority of

²⁵ Testimony of Undersecretary for Health, Department of Veterans Affairs, Robert H. Roswell, in U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, "*Handoffs or Fumbles?*" *Are DOD and VA Providing Seamless Health Care Coverage to Transitioning Veterans?*, 108th Cong., 2nd sess., Oct. 16, 2003.

²⁶ U.S. Government Accountability Office, *VA Disability Benefits and Health Care, Providing Certain Services to the Seriously Injured Poses Challenges*, GAO-05-444T, p. 5.

²⁷ U.S. Government Accountability Office, *VA and DOD Health Care: VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited*, GAO-05-1052T.

²⁸ Since October 2003, DOD's Defense Manpower Data Center (DMDC) has periodically (every 60 days) sent VA an updated personnel roster of troops who participated in OEF and OIF, and who have separated from active duty and become eligible for VA benefits. The roster was originally prepared based on pay records of individuals. However, in more recent months it has been based on a combination of pay records and operational records provided by each service branch.

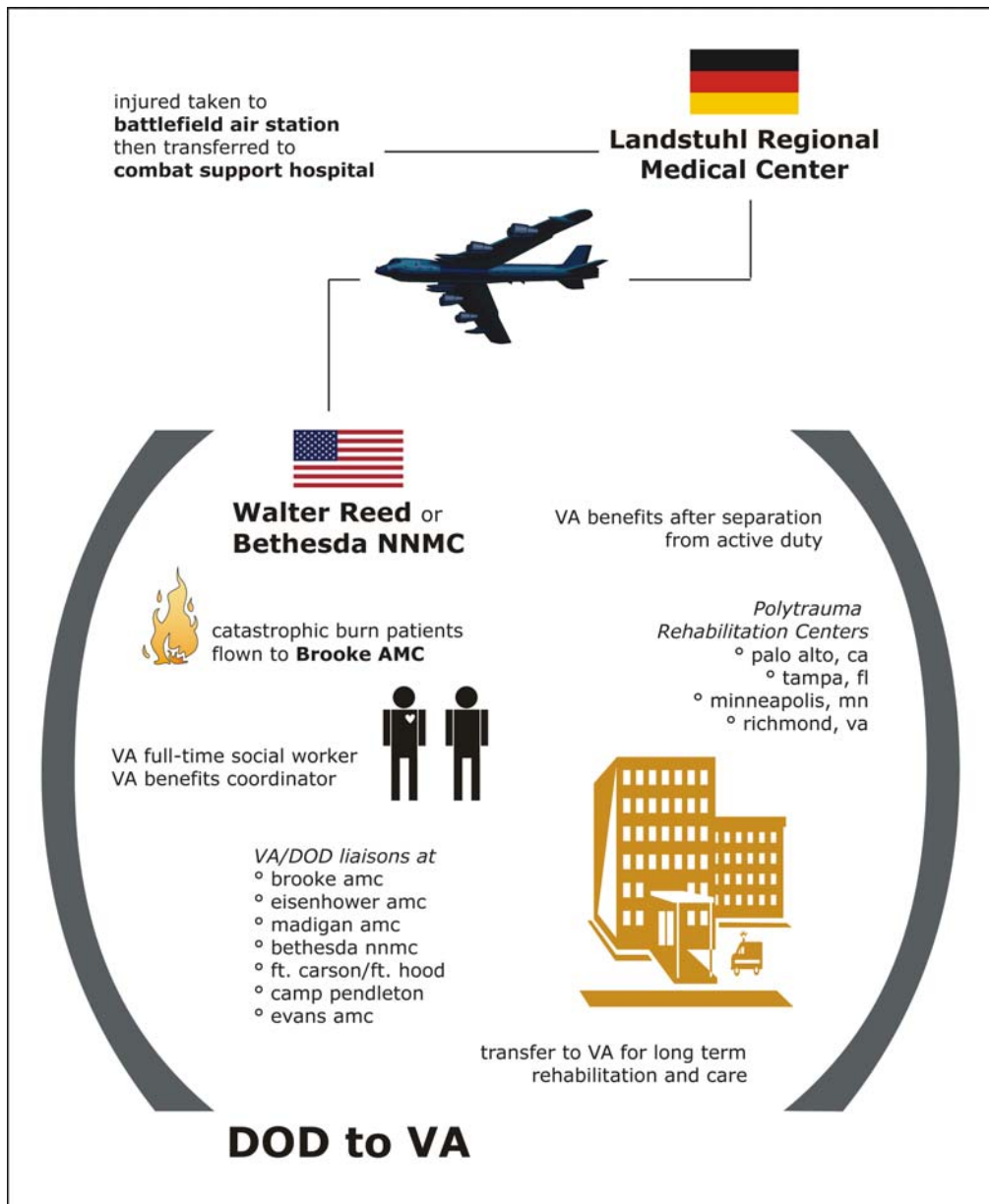
those who have sought VA health care, accounting for approximately 95,041, or 51.5%, of those who received care. Those who separated from regular active duty have accounted for approximately 48%, or 89,483, veterans.

Transitioning of Seriously Injured OEF and OIF Veterans into the VA Health Care System. In general, when a soldier is injured on the battlefield, he or she is stabilized in theater by a combat medic/lifesaver and then moved to a battalion aid station. If the servicemember has serious injuries, he or she is transferred to a forward surgical team to be stabilized, and then moved to a combat support hospital and further stabilized for a period of about two days. If the servicemember needs more specialized care, he or she is evacuated from OEF and OIF conflict theaters and brought to Landstuhl Regional Medical Center (LRMC) in Germany for treatment. Most patients arrive at LRMC 12 to 48 hours after injury. In general, servicemembers remain in Germany for a period of about four to five days.²⁹ Length of stay at in-theater medical facilities is determined by the stability of the patient and the availability of medical evacuation aircraft.

After further stabilization at LRMC, soldiers are evacuated to the United States. They arrive at an echelon V Military Treatment Facility (MTF) such as Walter Reed Army Medical Center (WRAMC) in Washington, DC, or the National Naval Medical Center in Bethesda, Maryland. All catastrophic burn patients are flown to the Brooke Army Medical Center (BAMC) at Fort Sam Houston, Texas. BAMC has also established a specialized amputee rehabilitation center. **Figure 3** provides a very simplified version of the transition process from DOD to VA.

²⁹ Joachim J. Tenuta, "From the Battlefields to the States: The Road to Recovery. The Role of Landstuhl Regional Medical Center in US Military Casualty Care," *Journal of the American Academy of Orthopedic Surgeons*, vol 14, (2006), S45-S47.

Figure 3. Transition of Seriously Injured Servicemembers



Source: Based on information provided by the Department of Veterans Affairs, Office of Seamless Transition.

As seen in **Figure 3**, once a seriously injured servicemember enters a major MTF, DOD can elect to send those with traumatic brain injuries (TBI) and other complex polytrauma cases to one of the four VA Polytrauma Rehabilitation Centers (PRCs) at the following locations: James A. Haley Veterans Affairs Medical Center (VAMC), Tampa, Florida; Minneapolis VAMC, Minneapolis, Minnesota; Veterans Affairs Palo Alto Health Care System, Palo Alto, California; and Hunter Holmes McGuire VAMC, Richmond, Virginia.³⁰ These Level 1 polytrauma centers have

³⁰ The Veterans Health Programs Improvement Act of 2004 (P.L. 108-422) required VA to (continued...)

resources and clinical expertise to provide care for complex patterns of injuries, including TBI, traumatic or partial limb amputation, nerve damage, burns, wounds, fractures, vestibular damage, vision and hearing loss, pain, mental health, and adjustment problems.

VA has stationed its employees at Army and Navy hospitals to act as VHA/DOD liaisons.³¹ These VA/DOD liaisons assist with the transfer of patients as they move from MTFs to VHA hospitals and clinics. In general, once the MTF decides to transfer a patient to a PRC, it refers the patient to a VA/DOD liaison. The VA/DOD liaison then contacts the liaison at the PRC. The PRC completes a medical screening and initiates the transfer process. Video teleconferencing between the MTFs and PRCs provides an opportunity for families to meet the VA interdisciplinary team and facilitate the transition-of-care process. VA/DOD liaisons also collaborate closely with case managers at VA hospitals, and work with patients and families to assist them in applying for VA benefits.

In addition, the Army has assigned liaison personnel to each of the VA's four PRCs to assist servicemembers and their families with issues such as pay, lodging, and travel. As severely injured servicemembers progress from an acute care setting through various stages of rehabilitation back into their communities, VHA has set up a polytrauma system of care to provide the appropriate services throughout the continuum of care (see **Table 2**).

³⁰ (...continued)

establish centers for research, education, and clinical activities related to complex trauma due to combat injuries, and the Department of Veterans Affairs, and Housing and Urban Development, and Independent Agencies Appropriations Act, 2005 (P.L. 108-447), required VA to establish a new prosthetics and integrative health care initiative. These sites were designated as a response to these mandates.

³¹ There are nine VA/DOD liaisons located at Walter Reed Army Medical Center, Washington, DC (two VA/DOD liaisons); National Naval Medical Center, Bethesda, MD; Brooke Army Medical Center, Fort Sam Houston, TX ; Eisenhower Army Medical Center, Fort Gordon, GA; Fort Hood Army Medical Center, Fort Hood, TX; Madigan Army Medical Center, Tacoma, WA (two VA/DOD liaisons); Evans Army Medical Center Fort Carson, CO; and Camp Pendleton, San Diego, CA.

Table 2. VHA's Polytrauma System of Care**Level I. Comprehensive Polytrauma Rehabilitation Centers (PRCs)**

- provide acute comprehensive medical, surgical, and rehabilitation care for complex and severe polytraumatic injuries
- serve as a resource to other facilities in the system via the development of telerehabilitation for consultation, best practices in polytrauma care, educational programs, and evaluation of new technology
- provide all clinical services and serve concurrently as Level II sites within their respective Veterans Integrated Service Networks (VISNs)

Level II. Polytrauma Network Sites (PNSs)

- there are 21 PNSs, one in each of VHA's 21 VISNs
- these sites manage veterans with complex injuries requiring specialized expertise as they return to their VISNs
- these sites provide a high level of expert care, with a full range of clinical and ancillary resources
- these sites provide specialized outpatient care to polytrauma patients not requiring inpatient services
- these sites develop a referral network within their VISN, and identify VISN resources for TBI/polytrauma services

Level III. Polytrauma Facility Teams (PFTs)

- these facilities have more limited resources than Level I and Level II centers
- Level III PFTs include a core polytrauma clinic team that could deliver a continuum of follow-up services in consultation with Level I and II centers
- these facilities are more likely to be closer to a veterans home and to provide day-to-day care, contact and support

Level IV. Polytrauma Care Coordination Points of Contact (POCs)

- these sites are smaller facilities with limited resources
- these sites serve as coordinators of referrals and consultations of polytrauma patients to Level I, II, or III facilities
- Level IV coordinators are knowledgeable about the services available within the system of care and the avenues for access to care

Source: Department of Veterans Affairs, Office of Inspector General, *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*, (Report No. 05-01818-165), July 12, 2006.

VA Activities to Assist the Transitioning of OEF and OIF Service Members. VA has stated that it has taken numerous steps to ease the transition of seriously injured servicemembers between DOD and VA medical facilities. VA has conducted several thousand briefings to servicemembers and their families about VA benefits and services, and about where to obtain VA health care services. VA also sends “thank-you” letters together with information brochures to each OEF and OIF veteran identified by DOD as having separated from active duty. These letters provide information on health care and other VA benefits, toll-free numbers for obtaining information, and appropriate VA websites for accessing additional information. Letters and educational “tool kits” explaining VA services and benefits are also sent to each of the National Guard Adjutants General and the Reserve Chiefs.

In April 2004, VA signed an Memorandum of Understanding (MOU) with DOD to provide health care and rehabilitation services to servicemembers who sustain spinal cord injury, TBI, or visual impairment. The MOU established referral procedures for transferring active duty inpatient servicemembers from MTFs to VA medical facilities. On January 3, 2005, VA established the National Veterans Affairs Office of Seamless Transition to ensure that there is no interruption of care as a person moves from being a DOD patient to a VA patient, that whatever kinds of treatment are being delivered in the MTF are continued, and that treatment plans are shared. The office also facilitates priority access to care by enrolling patients in the VA system before they leave an MTF.

Vet Centers. The department has emphasized that it has enhanced its outreach efforts through the Vet Center program. This program was originally established by Congress in 1979 to meet the readjustment needs of veterans returning from the Vietnam War.³² From their inception, Vet Centers were designed to be community-based, non-medical facilities that offered easy access to care for Vietnam veterans who were experiencing difficulty in resuming a normal life.

Today, VHA’s Vet Center program consists of 207 community-based centers located across the country, and in Puerto Rico, the Virgin Islands, and Guam. VHA plans to open two new Vet Centers in 2007 in Atlanta, Georgia, and Phoenix, Arizona, bringing the total number of centers to 209. All combat veterans are eligible for Vet Center readjustment counseling services.³³ The Vet Center program also provides bereavement counseling services to family members of those servicemembers killed while on active duty. In addition, the Vet Centers provide counseling to veterans who have experienced sexual trauma while on active duty.

In FY2005, Vet Centers hired and trained up to 50 new outreach workers from among the ranks of recently separated OIF and OEF veterans at targeted Vet Centers, and planned to hire another 50 outreach staff in FY2006. Vet Center outreach is primarily for the purpose of providing information that will facilitate a seamless transition and the early provision of VA services to newly returning veterans and

³² Established by the Veterans’ Health Care Amendments of 1979 (P.L.96-22).

³³ For a list of who is eligible for Vet Center services, see [<http://www.va.gov/RCS/Eligibility.asp>].

their family members upon separation from the military. These positions are being located on or near active military out-processing stations, as well as National Guard and Reserve facilities. New veteran hires are providing briefing services to transitioning servicemen and women regarding military-related readjustment needs, as well as the complete spectrum of VA services and benefits available to them and their family members.

Furthermore, on April 30, 2004, the Army, at the direction of the Acting Secretary of the Army, introduced the Disabled Soldier Support System (DS3), and later renamed it the U.S. Army Wounded Warrior (AW2), to serve as a program advocate for severely disabled soldiers and their families. AW2 is available to all active and Reserve component soldiers who have been classified as a Special Category as a result of war-related injuries or illness incurred after September 10, 2001, and who have been awarded an Army disability rating of 30% or greater.³⁴

Exchange of Health Information. Another issue that faces both VA and DOD when transferring patients between DOD and VA medical facilities is the requirement that medical information be exchanged between the two departments. Since the late 1990s, VA and DOD have been working toward an interoperable medical record. In June 2005, VA and DOD signed an MOU to share appropriate protected health information. The issues that hinder a formal agreement between DOD and VA include their differing understanding of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), particularly the HIPAA privacy provisions that govern the sharing of individually identifiable health data.³⁵ According to GAO, VA believes that HIPAA allows DOD to share servicemembers' health data with VA because the departments serve the same or similar populations — active duty servicemembers who transition to veteran status. In contrast, DOD believes that serving the same or similar populations would mean that servicemembers have a dual eligibility for both DOD and VA services. Although DOD acknowledges that some former servicemembers are dually eligible for DOD and VA services, not all qualify for both services simultaneously. Furthermore, according to VA, HIPAA allows DOD to share data sooner than the decision by DOD that the servicemember will separate from active duty. However, DOD is reluctant to provide individually identifiable health data to VA until DOD is certain that a servicemember will separate from the military. Furthermore, DOD is concerned that VA's outreach to servicemembers who are still on active duty could work at cross-purposes to the military's retention goals.³⁶

³⁴ A patient is Special Category when one of the following conditions exist: (a) Has a severe injury, such as loss of sight or limb, (b) Has a permanent and unsightly disfigurement of a portion of the body normally exposed to view, (c) Has an incurable and fatal disease and has limited life expectancy, (d) Has an established psychiatric condition, (e) May require extensive medical treatment and hospitalization, (f) Has been released from the Service for a psychiatric condition, (g) Is paralyzed, Army Regulation 40-400, 12 March 2001. For further information on AW2 see, CRS Report RS22366, *Military Support to the Severely Disabled: Overview of Service Programs*, by Charles A. Henning.

³⁵ P.L. 104-191, § 264; 110 Stat. 1936, 2033-34; 45 C.F.R. Part 164.

³⁶ U.S. Government Accountability Office, *DOD and VA: Systematic Data Sharing Would* (continued...)

However, according to a GAO report issued in June 2006, “none of the PRCs had real-time access to the injured servicemembers’ DOD electronic medical records from transferring MTFs. Instead, the MTF faxed copies of some of the medical information, such as the servicemember’s medical history and physical and doctor’s progress notes, to the PRC.”³⁷

At present, both VA and DOD are engaged in a joint effort to share selected health information between the two departments. Known as the Bidirectional Health Information Exchange (BHIE), this project permits the transfer of data between the VA’s Computerized Patient Record System (CPRS) and the DOD’s Composite Health Care System (CHCS). According to VA, data will be shared in real time, and include computable data for use by both VA and DOD health care providers.

Two-Year Eligibility for Veterans Returning from Iraq and Afghanistan. Veterans who have served or are now serving in Iraq and Afghanistan may, following separation from active duty, enroll in the VA health care system and, for a two-year period following the date of their separation, receive VA health care without copayment requirements for conditions that are or may be related to their combat service. Following this initial two-year period, they may continue their enrollment in the VA health care system but may become subject to any applicable copayment requirements.³⁸

There were several legislative proposals (H.R. 1588, S. 481) in the first session of this Congress to extend the period of eligibility for health care for combat service in the Persian Gulf War or future hostilities from two years to five years after discharge or release. During a hearing in June 2005, the Administration voiced opposition to this proposal. According to VA, the current two-year post-combat eligibility period provides ample opportunity for a veteran to apply for enrollment into the VA health care system.³⁹

³⁶ (...continued)

Help Expedite Servicemember’s Transition to VA Services, GAO-05-722T, p. 7.

³⁷ U.S. Government Accountability Office, *VA and DOD Health Care: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans*, GAO-06-794R, p. 10.

³⁸ The Veterans Programs Enhancement Act of 1998 (P.L. 108-368) [38 U.S.C. § 1710(e)(1)(D) and § 1710(e)(3)(C)] authorized VA to provide health care for an initial two-year period after discharge from service for veterans (including National Guard and Reserve components) in combat during any period of war after the first Gulf War or during any other future period of hostilities after Nov. 11, 1998, even if there is insufficient medical evidence to conclude that such illnesses are attributable to such service. For combat veterans who do not enroll with VA during the two-year post-discharge period, eligibility for enrollment and subsequent health care is subject to such factors as a service-connected disability rating, VA pension status, catastrophic disability determination, or financial circumstances. If their financial circumstances place them in Priority Group 8, they will be “grandfathered” into a Priority Group 8a or Priority Group 8c, and their enrollment in VA will be continued, regardless of the date of their original VA application.

³⁹ U.S. Congress, Senate Committee on Veterans Affairs, hearing on legislation related to (continued...)

However, some proponents of this proposal are concerned that restricting enrollment eligibility for only a two-year period may prevent veterans from enrolling in VHA when health conditions manifest, especially for conditions such as PTSD that may not manifest until years after veterans return from combat. The Administration's response to this concern has been that "if PTSD appears in a non-enrolled combat veteran following the end of his or her two-year period of eligibility, and is subsequently determined to be service-connected, that veteran would then become eligible for enrollment in Priority Group 1, 2, or 3, and thus they would be able to receive needed care."⁴⁰

Mental Health and Post-Traumatic Stress Disorder (PTSD)

With the ongoing conflicts in Iraq and Afghanistan, Congress is greatly concerned about VA's current and future capacity to treat mental health issues of these new veterans. Among the mental health issues that could affect veterans, post-traumatic stress disorder (PTSD) has attracted the most attention. This a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged; these symptoms can be severe enough and last long enough to significantly impair the person's daily life.⁴¹ While there is no cure for PTSD, mental health experts believe that early identification and treatment of PTSD symptoms may lessen the their severity and improve the overall quality of life for individuals with PTSD.

According to DOD, only 3% of soldiers report serious mental health issues in post-deployment assessments given as they prepare to return home.⁴² Early in the Iraq War, the Army surveyed 3,671 returning veterans and found that up to 17% of the soldiers were already suffering from depression, anxiety and symptoms of PTSD.⁴³ Other studies have indicated that protracted warfare in Iraq — with its intense urban street fighting, civilian combatants and terrorism — could drive PTSD

³⁹ (...continued)
veterans' health care, 109th Cong., 1st sess., June 9, 2005.

⁴⁰ U.S. Congress, Senate Committee on Veterans Affairs, hearing on the *Proposed FY2006 Budget for the Department of Veterans Affairs Programs*, 109th Cong., 1st sess., Feb. 15, 2005, p. 36.

⁴¹ National Center for PTSD Fact Sheet, available at [http://www.ncptsd.org/facts/general/fs_what_is_ptsd.html].

⁴² Scott Shane, "Military Plans a Delayed Test for Mental Issues," *New York Times*, Jan. 30, 2005. Many returning servicemembers do not disclose mental health concerns at the time of discharge in order to avoid being held up at their bases. Therefore, there is concern among health care professionals about underreporting of mental health issues.

⁴³ Charles W. Hoge, et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *New England Journal of Medicine*, vol. 351, no. 1 (July 1, 2004), p. 16.

rates even higher.⁴⁴ According to VHA, of the 184,524 OEF and OIF veterans who have sought care from VA, 29,041 have been diagnosed as having probable symptoms of PTSD.⁴⁵

Among the challenges faced by DOD and VA in treating returning servicemembers with mental health issues is the apparent stigma associated with disclosing PTSD symptoms to DOD clinicians. Reportedly, there is less stigma associated with disclosing PTSD symptoms in VA settings, but there are perceived risks associated with disclosure within military settings.⁴⁶ Nondisclosure could result in servicemembers not receiving early intervention and an underestimation of the future demand for VA mental health services.

For more than two decades, Congress has highlighted the importance of PTSD services for veterans. In 1984 Congress established the Special Committee on Post-Traumatic Stress Disorder (Special Committee) to determine VA's capacity to provide assessment and treatment for Post-Traumatic Stress Disorder and to guide VA's educational, research and benefits activities with regard to PTSD.⁴⁷ The Special Committee is composed of PTSD experts from across a broad spectrum of VA's Mental Health and Readjustment Counseling Services (RCS). The Special Committee issued its first report on ways to improve VA's PTSD services in 1985 and its latest report, which includes 37 recommendations for VA, in 2004.⁴⁸

The Special Committee's 2004 report indicates that combat veterans of OEF and OIF are at high risk for PTSD and related problems. According to the Special Committee, the suicide rate for soldiers in Iraq is higher than the Army's base rate and higher than suicide rates during the first Gulf War or the Vietnam War. It estimates that an estimated 40% of OEF and OIF casualties returning by the way of

⁴⁴ Brett T. Litz, *The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq (Information for Professionals)*, Department of Veterans Affairs, National Center for PTSD, available at [http://www.ncptsd.va.gov/facts/veterans/fs_Iraq-Afghanistan_wars.html].

⁴⁵ Testimony of Acting Principal Deputy Undersecretary for Health, Department of Veterans Affairs, Gerald Cross, in U.S. Congress, House Committee of Veterans Affairs, Subcommittee on Health, hearing on *Post Traumatic Stress Disorder and Traumatic Brain Injury: Emerging Trends in Force and Veteran Health*, 109th Cong., 2nd sess., Sept. 28, 2006. Data current as of August 2006.

⁴⁶ Matthew Friedman, "Veterans' Mental Health in the Wake of War," *New England Journal of Medicine*, vol. 352, no. 13 (Mar. 31, 2005), p. 1288.

⁴⁷ Section 110 of Veterans Health Care Act of 1984 (P.L. 98-528), as amended by Section 206 of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117).

⁴⁸ Department of Veterans Affairs Undersecretary for Health's Special Committee on Post-Traumatic Stress Disorder, *Fourth Annual Report of the Department of Veterans Affairs: Under secretary for Health's Special Committee on Post-Traumatic Stress Disorder*, 2004. The Special Committee has issued 15 reports since its establishment, but did not issue a report in every year.

Walter Reed Army Medical Center report symptoms consistent with PTSD.⁴⁹ Moreover, the Special Committee in its 2004 report concluded that “VA must meet the needs of new combat veterans while still providing for veterans of past wars. Unfortunately, VA does not have sufficient capacity to do this.”⁵⁰

GAO reported in September 2004 that VA does not have a reliable estimate of the total number of veterans it currently treats for PTSD and lacks the information it needs to determine whether it can meet an increased demand for PTSD services.⁵¹ In February 2005, GAO reviewed 24 of the Special Committee’s 37 recommendations and reported that VA has not fully met any of the 24 recommendations.⁵² Specifically, GAO determined that VA has not met 10 recommendations and has partially met 14 of these 24 recommendations.⁵³

According to VA, it has undertaken many efforts to improve PTSD care delivered to veterans. VA points out that it has developed an Iraqi War guide for clinicians; implemented a national clinical reminder to prompt clinicians to assess OEF and OIF veterans for PTSD, depression, and substance abuse; implemented a national system of 144 specialized PTSD programs in all states;⁵⁴ required all VA outpatient clinics to either have a psychiatrist or psychologist on staff full-time or ensure that veterans can consult a mental health provider in their community; elevated the VHA’s chief psychiatrist to the agency’s National Leadership Board (a key policymaking group that includes VHA’s other top executives and medical personnel); and established uniform budgets for mental health care at VA’s 21 VISNs.⁵⁵ In June 2004, the VA instituted the “Afghan and Iraq Post-Deployment Screen” as a mandatory electronic clinical reminder to conduct brief, post-deployment screening of OEF/OIF veterans. The screening consists of brief, validated screening measures to assess alcohol use, PTSD, and depression.

VA has also stated that it has enhanced its Vet Center program. The department has staffed its Vet Centers with interdisciplinary teams that include psychologists, nurses, and social workers. Vet Centers address the psychological and social

⁴⁹ Department of Veterans Affairs, Undersecretary for Health’s Special Committee on Post-Traumatic Stress Disorder, *Fourth Annual Report*, p. 4.

⁵⁰ *Ibid.*, p. 5.

⁵¹ U.S. Government Accountability Office, *VA and Defense Health Care: More Information Needed to Determine if VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services*, GAO-04-109, Sept. 20, 2004.

⁵² U.S. Government Accountability Office, *VA Health Care, VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services*, GAO-05-287. Of the 37 recommendations proposed by the Special Committee, GAO examined only 24 recommendations related to clinical care. The full list of 24 recommendations is listed on pp. 41-43.

⁵³ *Ibid.*, p. 3.

⁵⁴ Statement of Jonathan B. Perlin, Mar. 17, 2005.

⁵⁵ George Cahlink, “VA to Boost Mental-Health Services for Returning Troops,” *Government Executive*, Sept. 28, 2004, available at [<http://www.govexec.com/dailyfed/0904/092804g1.htm>].

readjustment and rehabilitation process for veterans with TBI or PTSD, and are instituting new programs to enhance outreach, counseling, treatment, and rehabilitation.⁵⁶

In 2004, a new Mental Illness Research, Education and Clinical Center (MIRECC) was established at the VAMC in Durham, North Carolina, to focus on issues of post-deployment health for returning OIF and OEF veterans. This center will collaborate with the National Center for Post-Traumatic Stress Disorder (NCPTSD) and nine other MIRECCs spread throughout the country.⁵⁷ VHA also established a new MIRECC in Denver, Colorado, to focus on suicide and its prevention, which is a growing concern in the OIF and OEF veteran population.

VA and DOD are also studying the use of psychotherapy for treatment of PTSD in female veterans and active duty personnel. A randomized clinical trial, part of VA's Cooperative Studies Program, has recently been completed; results are currently being analyzed, and a report is expected in 2007. Those results will inform additional research and implementation activities across VHA.

PTSD Claims Review Controversy. On May 19, 2005, VA's Inspector General (IG) reported on an examination of files from a sample of 2,100 randomly selected veterans with disability ratings for PTSD.⁵⁸ The IG cited insufficient documentation in the files and a dramatic increase in veterans filing for disability compensation for PTSD since 1999. The IG reported that about 25% of the 2,100 PTSD awards it reviewed were based on inadequate evidence of the occurrence of a traumatic event (stressor). VA conducted its own review of the 2,100 cases reviewed by the IG. VA's preliminary findings showed that some of the decisions on PTSD claims were premature. According to VA, it found that a large percentage of cases judged to have insufficient evidence were older cases in which VA statutes prohibit a change in the rating decision. According to statute, if a condition has been determined to be service-connected for a period of 10 years or more, service connection is protected and may not be severed except for a finding of fraud on the part of the veteran.⁵⁹ Following the IG's finding, VA proposed to review 72,000 individual cases of veterans who were rated at 100% disabled and unemployable within the last five years due to PTSD. After intense criticism by both Congress and veterans advocacy groups, on November 10, 2005, VA announced that it will not initiate a review of the 72,000 claims.

⁵⁶ Testimony of Acting Principal Deputy Undersecretary for Health, Department of Veterans Affairs, Gerald Cross, in U.S. Congress, House Committee of Veterans Affairs, Subcommittee on Health, hearing on *Post Traumatic Stress Disorder and Traumatic Brain Injury: Emerging Trends in Force and Veteran Health*, 109th Cong., 2nd sess., Sept. 28, 2006.

⁵⁷ The National Center for PTSD, promotes research, and education on PTSD within VA and in collaboration with DOD. The NCPTSD maintains a website [<http://www.ncptsd.org>] that describes the NCPTSD Divisions and their accomplishments and provides fact sheets for clinicians, veterans, their families and the general public.

⁵⁸ U.S. Department of Veterans Affairs, Office of Inspector General, *Review of State Variances in VA Disability Compensation Payments*, Report No: 05-00765-137, May 19, 2005.

⁵⁹ 38 U.S.C. 1159; 38 C.F.R. 3.957; 38 U.S.C. 110; 38 C.F.R. 3.951(b).

On November 16, 2005, VA announced that it had requested the Institute of Medicine (IOM) to conduct a review of PTSD. Under the agreement, IOM was tasked to review the scientific and medical literature related to the diagnosis and assessment of PTSD, and to review PTSD treatments (including psychotherapy and pharmacotherapy) and their efficacy. The department also asked the IOM to convene a committee of experts to examine issues surrounding VA's compensation program for veterans diagnosed with Post-Traumatic Stress Disorder (PTSD).

IOM decided to prepare three reports. The first report, issued by the IOM on June 16, 2006, focused on diagnosis and assessment of PTSD. A second report will focus on treatment for PTSD; it is to be issued in December 2006. A separate committee, the Committee on Veterans' Compensation for Post Traumatic Stress Disorder, has been established to conduct the compensation study; its report is expected to be issued in December 2006 as well. According to IOM's initial report:

Although numerous instruments have been developed for the diagnosis and assessment of PTSD, the committee strongly concludes that the best way to determine whether a person is suffering from PTSD is with a thorough, face-to-face clinical interview by a health professional trained in diagnosing psychiatric disorders.⁶⁰

Setting Funding for VA Medical Care

Veterans' advocates say that the unpredictable timing, if not uncertain funding amounts, inherent in the yearly discretionary appropriations process is a major management problem for VA. Therefore, national veterans' organizations have been calling for "assured funding" for veterans' health care. This has also been called "mandatory funding" by other veterans' advocates. This discussion will use mandatory funding to refer to these policy proposals.

To understand mandatory funding proposals, it is essential to understand how VA programs are funded presently. Under current law, VA programs are funded through both mandatory and discretionary spending authorities. The following programs are among mandatory spending programs: cash benefit programs, i.e., compensation and pensions (and benefits for eligible survivors); readjustment benefits (education and training, special assistance for disabled veterans); home loan guarantees; and veterans' insurance and indemnities. Each of these programs is an appropriated entitlement program that is funded through annual appropriations. With any entitlement program, because of the underlying law, the government is required to provide eligible recipients with the benefits to which they are entitled, whatever the cost. With these mandatory veterans' programs, Congress must appropriate the money necessary to fund the obligation. If the amount Congress provides in the annual appropriations act is not enough, it must make up the difference in a supplemental appropriation. Like other entitlement programs, spending

⁶⁰ National Academy of Sciences, Institute of Medicine, .Subcommittee on Posttraumatic Stress Disorder of the Committee on Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress, *Posttraumatic Stress Disorder: Diagnosis and Assessment*, p. 5. A free executive summary is available at [http://newton.nap.edu/execsumm_pdf/11674].

automatically increases or decreases over time as the number of recipients eligible for benefits varies. Certain of these VA entitlement benefits are indexed for inflation; the benefit amount will increase automatically based on the measured increase in the cost-of-living adjustment.

The remaining programs, primarily VA health care programs, medical facility construction, medical research, and VA administration, are funded through annual discretionary appropriations. Congress must act each year to provide budget authority for discretionary programs. As a discretionary program, the amount of funds VHA can spend on health care programs for veterans is limited by the amount of its appropriation.

Generally the mandatory funding proposals that have been suggested by veterans' advocates are based on a formula that takes into account the number of enrolled and nonenrolled veterans eligible for VA medical care, and the rate of medical care inflation. Proponents believe that mandatory funding will eliminate the year-to-year uncertainty about funding levels and close the gap between funding and demand for veterans' health care. Opponents believe that with these proposals spending for VHA will increase significantly as enrollment in the VA health care system soars; in most of the proposed funding formulas, automatic funding increases are primarily based on enrollment figures. Furthermore, critics believe that a static funding formula cannot adequately take into consideration the changing needs of veterans, which could affect the funding level necessary to provide a different mix of services, and that Congress is better able to evaluate the funding needs through the current appropriation process. At a recent hearing, Chairman Buyer of the House Veterans' Affairs Committee stated that "According to the Congressional Budget Office [CBO], mandatory funding would cost nearly half-a-trillion dollars over ten years. That would be a costly experiment. In contrast, the strong discretionary budgets of the past decade have proven responsive to change."⁶¹

As highlighted by some budget analysts, changing veterans' medical care into a mandatory budget authority will not solve the issue of closing the gap between funding and demand for veterans' health care, since Congress could place caps on spending for mandatory programs through budget reconciliation language which could limit spending on veterans' health programs.⁶² Since Congress can act to change the formula or cap the spending amounts, the issue of uncertainty in funding amounts may not be resolved either.

Assured Funding for Veterans Health Care Act, 2005 (H.R. 515) was introduced during the first session. This proposal would require the Secretary of the Treasury to make mandatory appropriations for VA health care based on the following formula: the amount of funds available for VA medical care in FY2007 would equal 130% of the total obligations made by VA for medical care programs in FY2005.

⁶¹ House Committee on Veterans' Affairs, "Committee Hears Legislative Views of Millions of Veterans," press release, Sep. 20, 2006.

⁶² Testimony of Richard Kogan, of the Center on Budget and Policy Priorities at the Alternative Processes for Funding Veterans Health Care Forum, Thurs., June 3, 2004. Transcript available at [http://www.dav.org/voters/mandatory_funding.html].

The amounts in succeeding years would be adjusted for medical inflation and growth in the number of veterans enrolled in VA's health care system and other non-veterans eligible for care from VA. CBO estimates that enacting H.R. 515 would result in a net increase in direct spending totaling about \$179 billion over the 2007-2010 period, and \$518 billion over the 2007-2015 period.⁶³ A companion measure, S. 331, was introduced in the Senate. Another measure introduced in the Senate, S. 13, uses a similar formula for determining funding available for VA health care and adjusts spending for changes in the veteran population and inflation.. Neither measure has yet seen any legislative action.

Continued Suspension of Priority Group 8 Veterans

Veterans' advocates want the suspension of Priority Group 8 veterans from enrolling in VA's health care system lifted, since they believe that all veterans must be able to receive care from VA. It should be noted that some of these veterans may have other types of health care coverage. The Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262) included language that stipulated that medical care to veterans will be furnished to the extent appropriations were made available by Congress on an annual basis. Based on this statutory authority, the Secretary of Veterans Affairs announced on January 17, 2003 that VA would temporarily suspend enrolling Priority Group 8 veterans.⁶⁴ Those who enrolled prior to January 17, 2003 in VA's health care system were not to be affected by this suspension. VA claims that, despite its funding increases, it cannot provide all enrolled veterans with timely access to medical services because of the tremendous increase in the number of veterans seeking care from VA.

Effect of the Enrollment Freeze. VA estimates that if the enrollment freeze was lifted, approximately 273,000 veterans who would be classified as Priority Group 8 would have been eligible to receive medical care from VA in FY2006, and 242,000 Priority Group 8 veterans would be eligible in FY2007. **Figure 4** provides a breakdown by state and territory of the estimated number of new Priority Group 8 veterans who would be unable to receive care in FY2007 due to the enrollment freeze.

Moreover, the number of Priority Group 8 veterans already enrolled in VA's health care system is expected to decline from 1.27 million in FY2005 to 1.22 million in FY2006; this will be mostly due to projected death rates for these veterans as well as the continued suspension of new enrollments.⁶⁵ In 2004, VA estimated that resumption of enrollment for Priority Group 8 veterans would require an

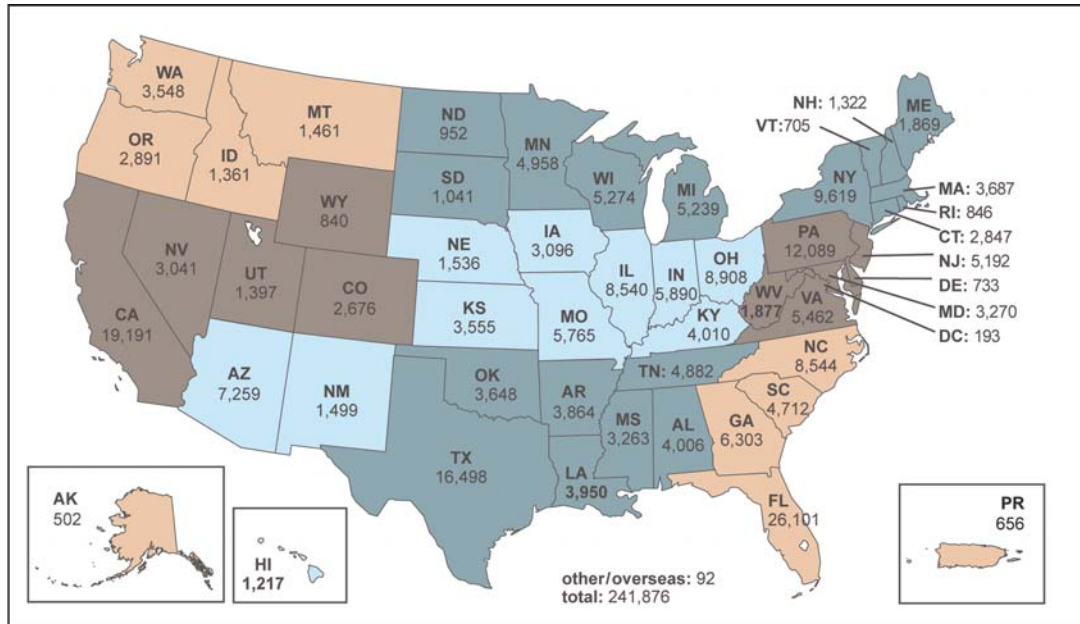
⁶³ U.S. Congressional Budget Office, Cost Estimate, H.R. 515, Assured Funding for Veterans Health Care Act of 2005, July 25, 2005. p.1.

⁶⁴ Department of Veterans Affairs, "Enrollment — Provision of Hospital and Outpatient Care to Veterans Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision; Final Rule," *68 Federal Register* 2670, Jan 17, 2003.

⁶⁵ Department of Veterans Affairs, *FY2006 Budget Submission, Medical Programs*, vol. 2 of 4, pp. 2-4.

additional \$519 million over the FY2005 requested VHA budget and an estimated \$2.3 billion in FY2012.⁶⁶

Figure 4. Estimated Number of New Priority 8 Veterans Unable to Receive Health Care, FY2007



Source: Information based on VA data. Map Resources. Adapted by CRS. (K. Yancey 9/06)

Congress has shown a keen interest in access to care for Priority Group 8 veterans. However, since enrollment of lower-priority veterans is tied to available resources, there are doubts that any measures introduced to lift the freeze on enrollment will be enacted into law during the remainder of this Congress.

VA's Cost Recoveries from Medicare

In general, VA is statutorily prohibited from receiving Medicare payments for services provided to Medicare-covered veterans.⁶⁷ Many veterans' advocates have suggested that VA should receive Medicare payments for nonservice-connected disability care that VA provides for veterans who are also covered by Medicare. However, there has been opposition to these proposals because authorizing VA recoveries from Medicare could further jeopardize the solvency of the Medicare trust fund and increase overall federal health care costs, since Medicare is an entitlement program without a cap on its total spending. GAO suggested that allowing VA to bill

⁶⁶ U.S. Congress, Senate Committee on Appropriations, *Department Veterans Affairs, and Housing and Urban Development and Independent Agencies Appropriations for FY2005*, hearings on H.R. 5041/S. 2825, 108th Cong., 2nd sess., Apr. 6, 2004, S.Hrg. 108-776, p. 379.

⁶⁷ 42 U.S.C § 1395f(c).

and retain recoveries from Medicare would create strong incentives for VA facilities to shift their priorities towards providing care to veterans with Medicare coverage.⁶⁸

In past Congresses proposals have been introduced to authorize VA recoveries from Medicare either for all Medicare-eligible veterans or for those with higher incomes. In the 106th and 107th Congresses this issue was known as Medicare Subvention, meaning a transfer of money from the Medicare trust funds to VA to pay for Medicare-covered services provided to veterans who are Medicare beneficiaries.

The Balanced Budget Act of 1997 (P.L. 105-33) authorized the DOD to implement a Medicare subvention pilot program in their MTFs. The Medicare subvention demonstration permitted DOD to create managed care organizations that participated in the Medicare+Choice program (now Medicare Advantage) and enroll Medicare-eligible retirees. In this demonstration, Medicare payments were structured on a capitation basis, with DOD receiving monies after meeting its level of effort to ensure that it sustained its prior level of spending on its Medicare beneficiaries. Under the demonstration, enrolled retirees received their Medicare-covered benefits and additional TRICARE benefits (notably prescription drugs) through TRICARE Senior Prime, the DOD-run managed care organizations set up by the demonstration. To be eligible for Senior Prime, retirees had to reside in one of the six geographic areas covered by the demonstration, be enrolled in both Medicare Part A and Part B, and had to be eligible for military health care benefits. They also had to have either (1) used an MTF before July 1, 1997, or (2) turned age 65 on or after July 1, 1997. While the demonstration had positive results for enrollees, the three-year pilot program was judged not to be cost-effective for DOD and it expired at the end of 2001.⁶⁹

VA was not authorized to establish a similar Medicare subvention demonstration. However, with its decision to no longer accept applications for enrollment of Priority Group 8 veterans, VA and the Centers for Medicare and Medicaid Services (CMS) began discussions to form a VA Advantage proposal in 2004. According to VA, it had planned to offer Medicare-eligible Priority 8 veterans who were unable to enroll for VA health care the option of receiving their Medicare benefits through VA. To accomplish this, VA would have contracted with an existing Medicare Advantage organization with the stipulations that VA would define the benefit package to be offered, and enrollees in VA Advantage would receive the majority of their health care benefits through VA facilities. Other benefits under the VA Advantage plan that are not provided in VA facilities would have been provided via arrangements with providers and facilities that contract with VA. It is likely that out-of-plan-area emergency and urgent care services would have fallen into this last category. Under the VA Advantage proposal, Medicare would have borne the full cost of care for veterans enrolled in the program.

⁶⁸ U.S. Government Accountability Office, *VA Health Care, Issues Affecting Eligibility Reform Efforts*, GAO/HEHS-96-160, Sept. 1996, p. 85.

⁶⁹ U.S. General Accounting Office, *Medicare Subvention Demonstration: Pilot Satisfies Enrollees, Raises Costs and Management Issues for DOD Health Care*, GA0-02-284, Feb. 2002, pp. 3-4.

Although VA had made plans to implement this program in September 2004, VA's General Counsel determined that legislation authorizing the implementation of the program was necessary. Moreover, it was not clear how attractive this option would have been to Medicare-eligible veterans. As mentioned earlier, only Medicare-eligible Priority 8 veterans who were unable to enroll for VA health care would have been offered the option of enrolling in VA Advantage. The veteran's spouse or other Medicare-eligible dependents of the veteran would not have been eligible for the VA Advantage plan. It is unclear at this time if Congress may introduce legislation to implement the VA Advantage program.

Filling of Privately Written Prescriptions at VA

As part of VA's comprehensive medical care benefits package, VA provides all veterans who are enrolled for VA care appropriate prescription medications, at the nominal charge of \$8 for a 30-day supply. In general, the copayments are waived if the prescription is for a service-connected condition, if the veteran is severely disabled or indigent, or if the veteran was a former Prisoner of War (POW). VA dispenses medications, however, only to those veterans who are enrolled for, and who actually receive VA-provided care. Generally, VA does not provide medications to veterans unless those medications are prescribed by a physician who is employed by or under contract with VA.

VHA dispenses medications only to those veterans who are enrolled for, and who actually receive, VA-provided care. Generally, VHA does not provide medications to veterans unless those medications are prescribed by a physician employed by or under contract with VHA.

However, there are two exceptions to this general requirement: VHA is required to provide medications, upon the order of any licensed physician, to 1) veterans receiving additional disability compensation under Chapter 11 of Title 38 of the United States Code (U.S.C.), as a result of being permanently housebound or in need of regular aid and attendance due to a service-connected condition, or veterans who were previous recipients of such compensation and in need of regular aid and attendance; and 2) veterans receiving nonservice-connected pensions under Chapter 15 of Title 38 U.S.C. as a result of being permanently and totally disabled from a nonservice-connected disability, and who are permanently housebound or in need of regular aid and attendance.⁷⁰

To address the growing waiting lists for primary care and specialty care appointments and to reduce the waiting times for a first appointment, VA implemented a program in September 2003 to provide access to VA prescription drugs for veterans experiencing long waits for their initial primary care appointment. This temporary program was known as the Transitional Pharmacy Benefit (TPB). Under this program, VA pharmacies and VA's Consolidated Mail Outpatient Pharmacies (CMOPs) were authorized to fill prescriptions written by non-VA (private) physicians until a VA physician could examine the veteran and determine an appropriate course of treatment. The TPB included most, but not all, of the drugs

⁷⁰ 38 U.S.C. § 1712(d); 38 C.F.R. § 17.96.

listed on the VA National Formulary (VANF). To be eligible for the program, veterans had to be enrolled in the VA health care system prior to July 25, 2003, and had to have requested their initial primary care appointment prior to July 25, 2003. To qualify for this program, veterans also must have been waiting more than 30 days for the initial primary care appointment as of September 22, 2003.

Although VA anticipated that around 200,000 veterans would be eligible to participate in the program, only about 41,000 veterans were finally eligible to enroll in the program; of those veterans about 8,300 veterans participated in the program. VA attributes low participation to the fact that many veterans had already received VA services by the start of the program. According to the VA, the TPB program increased the administrative prescription processing costs due to the increased labor requirements associated with contacting private physicians to suggest formulary alternatives because many private physicians had prescribed medications that were not on VA's formulary. At present VA has discontinued this pilot program.

There was considerable interest in the 108th Congress to provide a prescription-only health care benefit for veterans. While several bills were introduced none of them were enacted into law. Furthermore, in FY2004 and FY2005 the House and Senate Committees on Appropriations, and the conference committee, included bill language authorizing the dispensing of prescription drugs from VHA pharmacies to enrolled veterans with privately written prescriptions based on requirements established by VHA.^{71,72} The following bills were introduced during the first session of the 109th Congress: H.R. 693, H.R. 1585, H.R. 2379, S. 13, and S. 614. These measures would, among other things, require VA pharmacies to dispense medications on prescriptions written by private medical practitioners. Of these measures, a hearing was held on S. 614 by the Senate Veterans Affairs Committee on June 9, 2005. At this hearing, both the Administration and several Veterans Service Organizations (VSO's) expressed concerns about the legislation. Many believed that opening up the VA pharmacy system, as proposed in S. 614, would ultimately change the basic, primary mission of the entire VA. The Administration testified that "enactment of this measure could encourage situations where a veteran is receiving care and prescriptions from VA, and from outside sources, yielding increased costs, increased confusion, and decreased patient safety."⁷³

Capital Asset Realignment for Enhanced Services (CARES)

VA holds a substantial inventory of real property and facilities throughout the country. A majority of these buildings and property support VHA's mission. Much

⁷¹ U.S. Congress, Conference Committees, *Making Appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies for the Fiscal Year Ending September 30, 2004*, Conference Report to accompany H.R. 2673, 108th Cong., 1st sess., H.Rept. 108-401, p. 365.

⁷² Department of Veterans Affairs, *FY2006 Budget Submission, Medical Programs*, vol. 2 of 4, pp. 4-21. (Hereafter cited as VA, *FY2006 Budget Submission*.)

⁷³ Testimony of Secretary of Veterans Affairs R. James Nicholson, in U.S. Congress, Senate Committee on Veterans Affairs, *Veterans' Health Care Legislation*, hearings, 109th Congress 1st sess., June 9, 2005.

of VA's medical infrastructure was built decades ago when its focus was inpatient care. In the past several years VA has been shifting from a hospital-based system and, today, more than 80% of the treatment VA provides is on an outpatient basis through Community Based Outpatient Clinics (CBOCs). GAO projected that one in four medical care dollars is spent on maintaining and operating VA's buildings and land, and estimated that VA has over 5 million square feet of vacant space which can cost as much as \$35 million a year to maintain.⁷⁴

In October 2000, VA established the CARES program with the goal of evaluating the projected health care needs of veterans over the next 20 years and of realigning VA's infrastructure to better meet those needs. In August 2003, VA's Undersecretary for Health issued a preliminary *Draft National CARES Plan* (DNCP). The DNCP, among other things, recommended that seven VA health care facilities close and duplicative clinical and administrative services delivered at over 30 other VHA facilities be eliminated. The sites slated to be closed were in the following locations: Canandaigua, New York; Pittsburgh, Pennsylvania (Highland Drive Division); Lexington, Kentucky (Leestown Division); Cleveland, Ohio (Brecksville Unit); Gulfport, Mississippi; Waco, Texas; and Livermore, California. Patients currently provided services at these VHA facilities would have been provided care at other nearby sites. The DNCP recommended that new major medical facilities be built in Las Vegas, Nevada and East Central Florida. Furthermore, the DNCP recommended significant infrastructure upgrades at numerous sites including, at or near locations where VA proposed to close facilities. In addition, the draft plan called for the establishment of 48 new high-priority CBOCs.

Following the release of the DNCP, the VA Secretary appointed a 16-member independent commission to study the draft plan. The commission was composed of individuals from a wide variety of backgrounds outside of the federal government. The CARES Commission developed and applied six factors in the review of each proposal in the DNCP: (1) impact on veterans' access to health care; (2) impact on health care quality; (3) veteran and stakeholder views; (4) economic impact on the community; (5) impact on VA missions and goals; and (6) cost to the government. The commission conducted 38 public hearings and 81 site visits throughout 2003, and submitted its recommendations to the Secretary in February 2004. After reviewing the recommendations, the Secretary announced the final details of the CARES plan in May 2004 (Secretary's CARES Decision).

The final plan includes consolidating the following facilities: (1) Highland Drive campus in Pennsylvania with University Drive and Heinz campuses in Pennsylvania; (2) Brecksville campus in Ohio with Wade Park campus in Cleveland, Ohio; and (3) Gulfport campus with Biloxi campus in Mississippi. The following facilities will be partially realigned: (1) Knoxville campus in Iowa; (2) Canandaigua campus in New York; (3) Dublin campus in Georgia; (4) Livermore campus in California; (5) Montrose campus in New York; (6) Butler campus in Pennsylvania;

⁷⁴ U.S. General Accounting Office, *VA Health Care: Capital Asset Planning and Budgeting Need Improvement*, GAO/T-HEHS-99-83, Mar. 10, 1999, pp. 1-6.

(7) Saginaw campus in Michigan; (8) Ft. Wayne campus in Indiana, and (9) Kerrville campus in Texas.⁷⁵

The final plan also calls for building new hospitals in Orlando and Las Vegas; adding 156 new CBOCs, four new spinal cord injury centers, and two blind rehabilitation centers; and expanding mental health outpatient services nationwide. By opening health care access to more veterans, VA expects to increase the percentage of enrolled veterans from 28% of the veterans' population today, to 30% in 2012 and 33% in 2022. This percentage increase can be attributed in part to a projected decline in the veteran population. Nationally, the number of veteran enrollees is projected to increase 6% by 2012 and decrease 5% by 2022 from the number of veteran enrollees reported in 2001. VA asserts that the CARES plan will reduce the cost of maintaining vacant space over the period 2006 to 2022 from an estimated \$3.4 billion to \$750 million and allow VA to redirect those funds to patient care.⁷⁶

Critics of the CARES plan contend that closures are being considered without assessing what kind of facilities will be needed for long-term care and mental health care in the future. For instance, at the time of the release of the DNCP, projections for outpatient and acute psychiatric inpatient care contained data inconsistencies on future needs. VA asserted that it would improve its forecasting models to ensure that projections adequately reflect future need. Also, some believe that the CARES plan does not focus enough on future nursing home needs, would leave VA short of beds in a few decades, and thus VA would not have any choice but to privatize some parts of the health care system. Moreover, some veterans' groups believe that CARES is only about closing "surplus" hospitals and do not believe that CARES will result in the building of new and modern facilities. Finally, the closure of some VA medical facilities raised serious concern among some Members of Congress who felt that they had little control over the CARES process.⁷⁷

In December 2003, the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (P.L.108-170) was signed into law. Section 222 of this act requires a 60-day notice and a waiting period before VA could close any facilities under the final CARES plan. In addition, Section 221 of this act requires VA to wait 45 days after reporting to the Veterans' and Appropriations Committees before carrying out major construction projects as specified in the final CARES report. The Veterans Health Programs Improvement Act of 2004 (P.L.108-422) signed in to law on November 30, 2004 requires VA to notify Congress of the impact of actions that may result in a facility closure, consolidation, or administrative reorganization. The law also prohibits such actions from occurring until 60 days following the

⁷⁵ The Draft National CARES Plan (DNCP) defines realignment as: moving services from one facility to another, contracting for care to ensure inpatient access to care is available when needed, and in all cases maintaining outpatient services in the community.

⁷⁶ Department of Veterans Affairs, Office of the Secretary, Secretary of Veterans Affairs, *CARES Decision*, May 2004, pp. 1-8.

⁷⁷ Honorable Bob Graham, "Statements on Introduced Bill and Joint Resolutions," remarks in the Senate, *Congressional Record*, 108th Congress, vol. 149 (June 18, 2003), p. S8135.

notification or 30 days of continuous session of Congress as specified. This law superseded Section 221 of P.L.108-170.

The Secretary's CARES Decision identified implementation issues that required further study, including additional stakeholder input at selected sites. On September 29, 2004, the Secretary of VA established an Advisory Committee for CARES Business Plan Studies. The committee and its subcommittees generally consists of representatives from veterans' service organizations, governmental agencies, health care providers, planning agencies, and community organizations with a direct interest in the CARES process. This committee will consult with stakeholders during implementation of the Secretary's CARES Decision. The committee will ensure that the full range of stakeholder interests and concerns are assembled, publicly articulated, accurately documented, and considered in the development of site-level business plans. In January 2005, VA awarded a contract to PriceWaterhouseCoopers to complete studies at 18 sites throughout the country during a 13-month period, as required by the Secretary's CARES Decision.⁷⁸ Local Advisory Panels (LAPs) gathered views of stakeholders regarding the range of potential options provided by the contractor and made recommendations to the Secretary. Throughout 2006, VA plans to announce the Secretary's decision for each of the 18 sites. Given below in **Table 3** is a summary of the final decisions announced thus far.

<http://wikileaks.org/wiki/CRS-RL32961>

⁷⁸ The 18 sites are Boston, MA (VISN1); Canandaigua, NY (VISN 2); Montrose, NY (VISN 3); New York City, NY (VISN 3); St. Albans, NY (VISN 3); Perry Point, MD (VISN 5); Montgomery, AL (VISN 7); Louisville, KY (VISN 9); Lexington, KY (VISN 9); Poplar Buff, MO (VISN15); Biloxi, MS (VSIN 16); Muskogee, OK (VISN 16); Waco, TX (VISN 17); Big Spring, TX (VISN 18); Walla Walla, WA (VISN 20); White City, OR (VISN 20) Livermore, CA (VISN 21); West LA, CA (VISN 22).

Table 3. CARES Decisions on the 18 Sites

Study Site	CARES Decision
Boston, MA (VISN1)	The contractor's final report proposed closing four Boston VAMCs and creating a single medical center for the metropolitan area. The Secretary rejected this proposal and has instructed the contractor to proceed to Stage 2 and provide more detailed analysis of several other options. The additional options include shifting inpatient psychiatry and long-term care from the Bedford VAMC facility to the Brockton VAMC, while retaining outpatient care at Bedford and consolidating services currently located at West Roxbury VAMC into the Jamaica Plain VAMC, or vice versa.
Canandaigua, NY (VISN 2)	After reviewing the contractor's final report, the Secretary rejected all proposals to move services to an off-site facility, and requested the contractor to proceed to Stage 2 and provide a more detailed analysis of the four options selected by the Secretary. Two of the options evaluate retaining the historic core of the campus with renovations and new construction. Two other options will require all new construction on vacant parcels of the campus and reuse of the historic buildings on the campus. The Military Quality of Life, Military Construction, Veterans Affairs, and Related Agencies Appropriations Act FY2006 (P.L.109-114, H.Rept. 109-305) required VA to designate Canandaigua VAMC as a mental health and post-traumatic stress disorder (PTSD) "Center of Excellence."
Montrose, NY (VISN 3)	No final decision has been made by the Secretary.
New York City, NY (VISN 3)	Based on the contractor's final report, the Secretary has decided to retain the existing VAMCs in both Brooklyn and Manhattan.
St. Albans, NY (VISN 3)	Based on the contractor's final report, the Secretary has decided that VA would replace existing facilities at St. Albans with a new nursing home, outpatient clinics, and a domiciliary consolidated on the north end of the campus.
Perry Point, MD (VISN 5)	No final decision has been made by the Secretary.
Montgomery, AL (VISN 7)	Based on the contractor's final report, the Secretary has decided to continue inpatient services at the Montgomery facility.
Louisville, KY (VISN 9)	Based on the contractor's final report, a new medical center will replace the current facility. VA's office of Facility Management has created a site selection board, and is in the process of selecting an architectural and engineering firm to support the analysis of site locations.
Lexington, KY (VISN 9)	After reviewing the contractor's final report, the Secretary requested the contractor to proceed to Stage 2 and provide a more detailed study of two options selected by the Secretary. The first option is to replace all facilities on the southeastern part of the Leestown facility; and the second option is to construct appropriately sized new clinical care buildings on the central portion of the Leestown facility.
Poplar Buff, MO (VISN15)	No final decision has been made by the Secretary.
Biloxi, MS (VSIN 16)	The aftermath of Hurricane Katrina alleviated a need for this study. Future construction requirements are being addressed through emergency appropriations in response to Hurricane Katrina.

Study Site	CARES Decision
Muskogee, OK (VISN 16)	No final decision has been made by the Secretary.
Waco, TX (VISN 17)	No final decision has been made. The Military Quality of Life, Military Construction, Veterans Affairs, and Related Agencies Appropriations Act FY2006 (P.L.109-114, H.Rept. 109-305) required VA to designate Waco VAMC as a mental health and post traumatic stress disorder (PTSD) "Center of Excellence."
Big Spring, TX (VISN 18)	The contractor's final report did not recommend the closure and transfer of inpatient care, stating that the Big Spring VAMC is in good condition, the quality is excellent, and change would result in no improvements to access. Therefore, the Secretary decided that inpatient services will remain at the Big Spring VAMC.
Walla Walla, WA (VISN 20)	After reviewing the contractor's final report, the Secretary rejected options to close the Walla Walla VAMC and move the services to the Tri-Cities market. VA would replace the current Walla Walla VAMC with a new multi-specialty outpatient facility and ensure that inpatient and nursing home services are available.
White City, OR (VISN 20)	After reviewing the contractor's final report, the Secretary has decided that VA will not transfer services from the White City Southern Oregon Rehabilitation Center and Clinic (SORCC). However, VA will continue to evaluate if it will renovate or replace the current facility.
Livermore, CA (VISN 21)	After reviewing the contractor's final report, the Secretary requested that the contractor proceed to Stage 2 and provide a more detailed study of three options selected by the Secretary. The first option is to construct a new nursing home on the current site, the second option is to relocate the current nursing home care unit to a new off-site stand-alone facility co-located with ambulatory care services. The third option is to renovate the current nursing home unit and consolidate all necessary logistics and support functions.
West LA, CA (VISN 22)	No final decision has been made by the Secretary.

Source: [<http://www.va.gov/cares>].

VA as a Model for Other Health Care Systems

For decades the VA health care system had a reputation for providing suboptimal care to veterans, at least in certain circumstances.⁷⁹ These quality problems were highlighted in the popular press at that time.⁸⁰ As described earlier, however, VA initiated a systemwide reengineering, among other things, to improve the quality of care.⁸¹ VA is seen by many as a leader in improving quality of care. One of the most highly regarded VA initiatives is the National Surgical Quality Improvement program (NSQIP). The initiative's key components are: periodic performance measurement and feedback, along with self-assessment tools, site visits, and best practices to improve the outcome of major surgeries performed by VA surgeons.

Recent studies have shown that VA's quality of care has improved dramatically when compared to the quality of care in the VA health care system before its reengineering.⁸² Moreover, studies done following VA's transformation have shown that some aspects of VA's quality of care are better than what is offered in the general health care system. For instance, researchers (affiliated with VA, the RAND Corporation, and several universities) found that patients in the VA health care system are more likely to receive better chronic and preventive care than the general population. This study also found that VA performed better across the entire spectrum of care: screening, diagnosis, treatment, and follow-up.⁸³

Moreover, certain attributes of VA's health care system may have relevance to improving the quality of care provided in the broader health care system. For instance, VHA's Barcode Medication Administration System for dispensing pharmaceuticals has been in place since 2000, before the Food and Drug Administration's (FDA) attempt to put a similar system in place in the broader health care system.⁸⁴ The Barcode Medication Administration System, which is in all VA

⁷⁹ Sheldon Greenfield, "Creating a Culture of Quality: The Remarkable Transformation of the Department of Veterans Affairs Health Care System," *Annals of Internal Medicine*, vol. 141, no. 4 (Aug. 17, 2004), p. 316.

⁸⁰ "Investigator Cites Poor Care at Veterans Hospitals," *New York Times*, Nov. 22, 1991, p. A26.

⁸¹ Ashish K. Jha, et al., "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine*, vol. 348, no. 22 (May 29, 2003), p. 2219.

⁸² *Ibid.*, p. 2222. See also E.A. Kerr, et al., "Diabetes Care Quality in the Veterans Affairs Health Care System and Commercial Managed Care: The TRIAD Study," *Annals of Internal Medicine*, vol. 141, no. 4 (Aug. 17, 2004), pp. 272-281.

⁸³ Steven M. Asch, et al., "Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample," *Annals of Internal Medicine*, vol. 141, no. 12, p. 942.

⁸⁴ FDA issued its final bar coding rule in Feb. 2004. It applies to medications used in hospitals, as well as blood and blood products used in transfusions. New medications covered by the rule will have to include bar codes within 60 days of their approval; most
(continued...)

hospitals now, lets doctors and nurses verify the time, dose and name of a patient receiving a medication. VA hospitals give patients a bar-coded wristband inscribed with patient information, and attaches a bar code to every medication. A nurse scans the patient's wristband for identity verification, and the system retrieves the medication record from VA's Electronic Healthcare Record System and displays it on the PC or handheld screen.

VA is also leading an effort to reduce medication errors with a wireless application designed to ensure that patients receive the correct medications. Industry press indicates that VA not only has outpaced private hospitals in implementing health care IT systems, but the department is leapfrogging its private-sector counterparts in using mobile and wireless devices and applications directly in patient care.⁸⁵

The VHA is also known for its Electronic Healthcare Record (EHR) technology. The Veterans Health Information Systems and Technology Architecture (VistA) system (VA's electronic health record system) is currently in more than 1,300 VA facilities to maintain the records of over 5 million veterans. CMS and VHA are collaborating to configure VistA technology so that it might be adopted for use in the private physician office setting nationwide. The new product will be known as "The VistA-Office EHR," and the targeted release date is July 2005.

Since the late 1990s, VA has been generally recognized as a leader in patient safety. In 1999, the VA established a National Center for Patient Safety (NCPS) to lead the agency's patient safety efforts and develop a culture of safety throughout the VA health care system. The NCPS developed an internal, confidential, non-punitive reporting and analysis system, the Patient Safety Information System (PSIS), which permits VA employees to report both adverse events and close calls without fear of punishment. Other countries such as Australia, Japan, Denmark, the United Kingdom have adopted strategies from portions of VA's patient safety program. Furthermore, the Joint Commission for the Accreditation of Health Care Organization's (JCAHO) patient safety goals have been influenced by VA's advances in this area. In May 2000, the VA signed an agreement with the National Aeronautics and Space Administration (NASA) to develop the Patient Safety Reporting System (PSRS), an independent, external reporting system. The PSRS, which was inaugurated in 2002 at VA hospitals nationwide, is operated by NASA. It is intended to provide VA employees with a "safety valve" that allows them confidentially to report close calls or adverse events that, for whatever reason, would otherwise go unreported.

In the area of pharmaceutical purchasing, VA has been able to obtain prescription drugs at competitive prices. VA has been successful in using a number of purchasing arrangements to obtain substantial discounts on prescription drugs.

⁸⁴ (...continued)

previously approved medicines and all blood and blood products will have to comply with the new requirements within two years.

⁸⁵ Mary Mosquera, "VA's Dose of WiFi," *Government Computer News*, vol. 24, no. 9 (Apr. 24, 2005).

For the bulk of its pharmaceutical purchases, VA obtains favorable prices through the Federal Supply Schedule (FSS).⁸⁶ By statute, in order to be able to obtain reimbursement for drugs for Medicaid beneficiaries, manufacturers must offer their drugs on the FSS.⁸⁷ FSS prices are intended to be no more than the prices manufacturers charge their most-favored non-federal customers under comparable terms and conditions. VA also buys some brand-name drugs for prices less than those listed under the FSS. For example, by statute VA can buy brand-name drugs at a price at least 24% lower than the non-federal average manufacturer price (NFAMP), which may be lower than the FSS price for many drugs.⁸⁸ In addition, VA has obtained some drugs at lower than FSS prices through national contracts with a single manufacturer based on a competitive-bid process. VA may solicit competitive bids for therapeutically equivalent drugs and may select one winner based on price alone for exclusive or preferred use on their formularies. Often VA and DOD consolidate their buying power and negotiate contracts together. In FY2003, the total cost avoidance was estimated to be \$376 million for VA and DOD contacts.^{89,90}

Several measures (H.R. 376, H.R. 563, H.R. 1626, H.R. 4610, H.R. 4652, S. 123, S. 563) were introduced in the first session of this Congress to allow the Department of Health and Human Services (DHHS) to negotiate contracts with manufacturers of covered Medicare Part D pharmaceuticals similar to VA. However, many veterans' advocates have voiced concerns that if prices offered to VA were extended to Medicare recipients or other entities, it would result in increased prices for VA, since pharmaceutical companies will not give the same price discounts that it presently offers VA.

Beneficiary Travel Program

In general, the beneficiary travel program reimburses certain veterans for the cost of travel to VA medical facilities when seeking health care. P.L. 76-432, passed by Congress on March 14, 1940, authorized VA to pay the actual travel expenses, or instead an allowance based upon the mileage traveled by any veteran traveling to or from a VA facility or other place for the purpose of examination, treatment, or care. P.L. 85-857, signed into law on September 2, 1958, authorized VA to pay necessary

⁸⁶ The pharmaceutical portion of the Federal Supply Schedule (FSS) contains over 17,000 products available to federal agencies and other entities.

⁸⁷ 38 U.S.C. § 8126(a)(4).

⁸⁸ The Veterans Health Care Act of 1992 (P.L. 102-585). The other agencies covered by this act are: DOD, the Public Health Service, and the Coast Guard.

⁸⁹ Based on experience, about 74% of joint VA/DOD drug purchases are consumed by VA beneficiaries. The VA's FY2003 projections assumed that 74.4% of the total cost avoidance figure would be attributable to VA beneficiaries. Actual data from the first three quarters of FY2003 reflected a 74.3% share.

⁹⁰ The VA does not provide a figure on how much it saves by purchasing pharmaceuticals through negotiations. According to the VA officials, it is difficult to put an exact amount on the amount of money that VA "saves" by its contracting in regard to prescription drugs because although VA knows what the price paid is, it is difficult to develop a baseline comparison.

travel expenses to any veteran traveling to or from a VA facility or other place in connection with vocational rehabilitation counseling or for the purpose of examination, treatment, or care. However, this law changed VA's travel reimbursement into a discretionary authority by stating that VA "may pay" expenses of travel. On April 13, 1987, VA published final regulations that sharply curtailed eligibility for the beneficiary travel program. The Veterans' Benefits and Services Act of 1988, P.L. 100-322, section 108, in large part restored VA travel reimbursement benefits. It required that if VA provides any beneficiary travel reimbursement under section 111 of Title 38 U.S.C. in any given fiscal year, then payments must be provided in that year in the cases of travel for health care services for all the categories of beneficiaries specified in the statute. In order to limit the overall cost of this program, the law imposed a \$3 one-way deductible applicable to all travel, except for veterans otherwise eligible for beneficiary travel reimbursement who are traveling by special modes of transportation such as ambulance, air ambulance, wheelchair van, or to receive a compensation and pension examination. In order to limit the overall impact on veterans whose clinical needs dictate frequent travel for VA medical care, an \$18-per-calendar-month cap on the deductible was imposed for those veterans who are pre-approved as needing to travel on a frequent basis.

Therefore, under current law, veterans are reimbursed at the rate of \$0.11 cents per mile (or at \$0.17 cents a mile if called for a repeat compensation and pension exam) and are subject to a \$3 (one-way) deductible for each visit, not to exceed \$18 per calendar month. A veteran will be fully reimbursed for each visit within the same calendar month once the \$18 deductible is met.⁹¹ It should be emphasized that veterans who are traveling by special modes of transportation such as ambulance, air ambulance, wheelchair van, or to receive a compensation and pension examination are paid full reimbursement and are not subject to this deductible. **Table 4** provides details on veterans who are currently eligible to receive travel benefits.

Table 4. Veterans Eligible for Travel Benefits

- veterans with service-connected conditions of 30% or more;
- veterans with service-connected conditions below 30% traveling for treatment of a service-connected condition;
- veterans in receipt of a VA pension;
- veterans traveling for a compensation or pension (C&P) exam;
- veterans whose income does not exceed the maximum annual VA pension rate with an additional aid and attendance allowance.

With the rise in gasoline prices throughout 2005 and 2006, several measures (H.R. 3147, H.R. 3948, H.R. 4025, S. 996, S. 3276) were introduced to change the method of determining the mileage reimbursement rate and also to eliminate the

⁹¹ 38 U.S.C. 111; 38 C.F.R. §§17.143-17.145.

current deductible amount. However, none of these bills has seen any legislative action. One reason that these bills have not been enacted is because funds for transportation of beneficiaries are used from appropriations for medical services for veterans. There is a strong sense that funds available to provide health care to veterans are more appropriately used for direct patient care programs rather than for transportation costs.

Veterans' Health Care Legislation — Enacted into Law

This section provides a brief summary of veterans health care legislation that became public law in either the first or second session of this Congress. This summary does not include appropriation measures for veterans health care programs.⁹²

The Veterans Housing Opportunity and Benefits Improvement Act of 2006 (P.L.109-233, H.Rept. 109-88, H.Rept. 109-263, S.Rept. 109-139)

P.L. 109-233 incorporated provisions from several bills that were introduced in the 109th Congress.⁹³ Among provisions included in this act were the “limitation on premium increases for reinstated health insurance of servicemembers released from active military service” and the “inclusion of additional diseases and conditions in diseases and disabilities presumed to be associated with prisoner of war status” The legislative impact of these provisions is described below.⁹⁴

Limitation on Premium Increases for Reinstated Health Insurance of Servicemembers Released from Active Military Service. Prior to the enactment of P.L.109-233, section 704 of the Servicemembers Civil Relief Act (P.L. 108-189) provided that a servicemember who is ordered to active duty is entitled, upon release from active duty, to reinstatement of any health insurance coverage in effect on the day before such service commenced. However, section 704 of the Servicemembers Civil Relief Act did not address premium increases to protect servicemembers against premium increases when they reinstate their health insurance as civilians. P.L.109-233 would limit health insurance premium increases. The amount charged for the coverage once reinstated would not exceed the amount

⁹² For detailed information on FY2007 appropriations for veterans health care programs, see CRS Report RL33409, *Veterans Medical Care: FY2007 Appropriations*, by Sidath Viranga Panangala.

⁹³ These bills were S. 1235, as amended, H.R. 1220, as amended, H.R. 2046, as amended, and H.R. 3665, as amended. S. 1235, as amended, passed the Senate on September 28, 2005; H.R. 2046, as amended, passed the House on May 23, 2005; H.R. 3665, as amended, passed the House on November 10, 2005.

⁹⁴ For detailed description of other provisions included in the Veterans Housing Opportunity and Benefits Improvement Act of 2006 see CRS Report RL33216, *Veterans' Benefits Issues in the 109th Congress*, by Paul J. Graney.

charged for coverage before the termination, except for any general increase for persons similarly covered by the insurance provider during the period between termination and the reinstatement.

Inclusion of Additional Diseases and Conditions in Diseases and Disabilities Presumed to be Associated with POW Status. Prior to the enactment of this law, section 1112 (b) of Title 38, U.S.C., contained two lists of diseases that were presumed to be related to an individual's experience as a POW. The first presumptive list required no minimum internment period, and included diseases associated with mental trauma or acute physical trauma, which could plausibly be caused by even a single day of captivity. That list included psychosis, any of the anxiety states, dysthymic disorder (or depressive neurosis), organic residuals of frostbite (if the Secretary determines that a veteran was interned in conditions consistent with the occurrence of frostbite), and post-traumatic osteoarthritis. The second list had a 30-day minimum internment requirement. The second list included avitaminosis, beriberi, chronic dysentery, helminthiasis, malnutrition, pellagra, any other nutritional deficiency, cirrhosis of the liver, peripheral neuropathy, irritable bowel syndrome, and peptic ulcer disease. On June 28, 2005, VA issued regulations that added two additional diseases to those presumed related to the POW experience: (1) atherosclerotic heart disease or hypertensive vascular disease (including hypertensive heart disease) and their complications (including myocardial infarction, congestive heart failure, and arrhythmia); (2) stroke and its complications.⁹⁵ P.L. 109-233 codified the two diseases VA established through regulation. These diseases were included under the list requiring a minimum 30-day internment period.

Veterans' Health Care Legislation — Passed by the House

This section provides a brief summary of health care-related legislation passed by the House during the first and second session of the 109th Congress that has not yet received Senate action. This summary does not include appropriations measures for veterans' health care programs.⁹⁶

Veterans' Compensation Cost-of-living Adjustment Act of 2005 (H.R. 1220, H.Rept. 109-162)

There were two provisions affecting veterans' health care that were included in this bill. Although some provisions in this bill were incorporated into S. 1234 and

⁹⁵ U.S. Department of Veterans Affairs, "Presumptions of Service Connection for Diseases Associated With Service Involving Detention or Internment as a Prisoner of War," 70 *Federal Register* 37040, June 28, 2005.

⁹⁶ For detailed information on FY2006 appropriations for veterans health care programs, see CRS Report RL32975, *Veterans Medical Care: FY2006 Appropriations*, by Sidath Viranga Panangala.

passed into law (Veterans' Compensation Cost-of-Living Adjustment Act of 2005, P.L.109-111), the two provisions described below were excluded from P.L.109-111⁹⁷.

Demonstration Project to Improve Business Practices of Veterans Health Administration. Under certain circumstances, VA is authorized to collect reasonable charges from a veteran's health insurance company to offset the cost of medical care and medications for treatment of nonservice-connected conditions. Specifically, VA may bill insurance companies for treatment of conditions that are not a result of injuries or illnesses incurred or aggravated during military service. VA is not authorized to bill for health care conditions that result from military service; nor is it generally authorized to collect from Medicare and Medicaid. According to the House Veterans' Affairs Committee (HAVC), there are weaknesses in the billings and collections processes that impair VA's ability to maximize the amount of dollars paid by third-party insurance companies. Under H.R. 1220, VA would have been required to hire a contractor to evaluate the current business practices at two VHA facilities, to recommend and implement improvements to those practices aimed at increasing payments from third-party payers, and to establish a database of third-party payer information for veterans receiving health care and services at these two facilities.

Parkinson's Disease Research, Education, and Clinical Centers. In 2001, VA established six Parkinson's Disease Research Education and Clinical Centers (PADRECCs) located at VA medical centers in Houston, Texas; West Los Angeles, California; Philadelphia, Pennsylvania; Portland, Oregon-Seattle, Washington; Richmond, Virginia; and San Francisco, California. These centers conduct clinical and basic science research, administer national outreach and education programs, and provide state-of-the-art clinical care. Currently, VA treats about 42,000 veterans with Parkinson's disease. H.R. 1220 would have permanently authorized six PADRECCs, subject to appropriations, and given priority to the existing PADRECCs for medical care and research dollars.

Department of Veterans Affairs Medical Facility Authorization Act of 2006 (H.R. 5815, H.Rept. 109-643)

This bill was introduced on July 17, 2006, and was ordered reported by the House Veterans' Affairs Committee by unanimous voice vote on July 20. The bill was passed by the House on September 13, 2006. H.R. 5815 would, among other things, authorize the construction of 17 major facility projects authorized in the first session of Congress, and would authorize a total of about \$2.4 billion for VA medical facility construction projects and leases. However, the House-passed measure did not include bill language providing authority to extend the blanket authority granted under the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (P.L.108-170) to implement CARES projects. According to the committee report to accompany H.R. 5815, the committee believes that any authority granted to the department to undertake major medical facility projects must be granted explicitly

⁹⁷ For detailed description of other provisions included in the Veterans' Compensation Cost-of-Living Adjustment Act of 2005, see CRS Report RL33216, *Veterans' Benefits Issues in the 109th Congress*, by Paul J. Graney.

by the committee, and be consistent with the committee's oversight and authorization authority.⁹⁸

Veterans Health Care Legislation — Passed by the Senate

This section provides a brief summary of health care related legislation passed by the Senate during the first and second session of this Congress but were not enacted into law. This summary does not include appropriation measures for veterans health care programs.⁹⁹

Vet Center Enhancement Act of 2005 (S. 716)

This bill was introduced on April 6, 2005, and was reported by the Senate Veterans Affairs Committee without an amendment on September 15, 2005 (S.Rept. 109-180). The Senate passed the measure on December 22 (legislative day of December 21), 2005. S. 716 is awaiting House action. The legislative impact of these provisions is described below.

Expansion of Outreach Activities of Vet Centers. This provision would authorize 50 additional veterans of OIF and OEF to perform outreach efforts for Vet Centers. Under the Senate-passed bill, these veteran-employees may be assigned to any Vet Center deemed appropriate by the Secretary of Veterans Affairs. Furthermore, under this provision outreach coordinators would not be subject to VA's stipulation that these positions be limited to only three years of hiring authority. It should be noted here that shortly after the introduction of S. 716, VA announced that it has hired 50 additional outreach workers for Vet Centers. However, the Senate Veterans Affairs Committee believed that as the number of returning OIF and OEF veterans continues to grow, the number of outreach workers needed must be increased to provide services to veterans.

Clarification and Enhancement of Bereavement Counseling. This provision would provide express authority to Vet Centers to provide bereavement counseling to all immediate family members. The provision would also ensure the furnishing of bereavement counseling services to parents by defining them as members of the immediate family when a servicemember dies in active duty. In August of 2003, the Secretary of Veterans Affairs enabled Vet Centers to provide bereavement counseling services to immediate family members of servicemembers who died while on active duty, as well as federally activated Reserve and National Guard personnel on active duty. However, the Committee believed that the current

⁹⁸ U.S. Congress, House Committee on Veterans' Affairs, *Department of Veterans Affairs Medical Facility Authorization Act of 2006*, Report to accompany H.R. 5815, 109th Cong., 2nd sess., H.Rept. 109-643, p.5.

⁹⁹ For detailed information on FY2006 appropriations for veterans health care programs, see CRS Report RL33409, *Veterans Medical Care: FY2007 Appropriations*, by Sidath Viranga Panangala.

law is unclear on whether or not a bereaved parent can receive such services. Therefore, this provision would give VA the authority to provide bereavement counseling to all immediate family members, including parents.

Funding for the Vet Center Program. This provision would authorize \$180 million for VA in FY2006 for the purpose of increased funding for Vet Centers.

Veterans' Health Care Act of 2005 (S. 1182)

This bill was introduced on June 9, 2005. On September 15, 2005, the Senate Veterans Affairs Committee reported the measure, as amended, to incorporate provisions derived from the Veterans Mental Health Care Capacity Enhancement Act of 2005 (S. 1177); Sheltering All Veterans Everywhere Act of 2005 (S. 1180); an act to require the Secretary of Veterans Affairs to publish a strategic plan for long-term care (S. 1189); Blinded Veterans Continuum of Care Act of 2005 (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 (S. Rept.109-139). The Senate passed the measure on December 22 (legislative day of December 21), 2005. S. 1182 is awaiting House action. Given below is a brief summary of major provisions of this bill.

Care for Newborn Children of Women Receiving Maternity Care.

Under current law, VA is only authorized to provide medical care and treatment to veterans. Therefore, VA provides maternity, prenatal, and postnatal care for female veterans. However, VA is not authorized to provide, or pay for, any care for the newborn child of a female veteran. This provision would authorize VA to provide up to 14 days of care for newborn children of female veterans who are receiving maternity care furnished by VA.

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. In general, the payment provided by VA is considered payment in full for all services provided to the patient. However, in some circumstances a care provider may seek reimbursement for certain services not otherwise covered by VA. S. 1182 would designate VA as the primary payer for care or services furnished to certain children of Vietnam veterans, and permit a provider who furnishes care to children to seek payment for the difference between the amount billed and the amount paid by the VA from a third-party payer if the beneficiary has health insurance that would otherwise be responsible for the payment. Furthermore, this bill would prohibit the health care provider from imposing any additional charges on the beneficiary who received the care, or on the beneficiary's family, for any service that VA has paid for.

Additional Mental Health Providers. This 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. Under current law, VA is not permitted to employ any professional not mentioned in statute.

Repeal of Cost Comparison Studies Prohibition. This provision would allow VA to compare its performance with the experience of those conducting a similar business in the private sector. Under current law, VA is prohibited from using any appropriated funds to carry out studies comparing the costs of services provided by VHA with the same services provided under contract through a private-sector company.

Improvement and Expansion of Mental Health Services. This provision would require VA to enhance and improve mental health services for veterans. Specifically, it would require VA to 1) expand the number of clinical treatment teams dedicated to the treatment of PTSD; 2) expand treatment and diagnosis services for substance abuse; 3) expand telehealth initiatives dedicated to mental health care in communities located great distances from current VA facilities; 4) improve programs that provide education in mental health treatment to primary care clinicians; and 5) expand the number of community based outpatient clinics (CBOC) capable of providing treatment for mental illness. Furthermore, this provision would authorize \$95 million in FY2006 and FY2007 to carry out these activities. It establishes a joint VA — DOD workgroup that will consist of seven experts in the fields of mental health and readjustment counseling from VA and DOD. The workgroup is tasked with looking at ways to combat stigmas associated with mental health, to better educate families of servicemembers on how to deal with such issues, and is required to report its findings to Congress.

Data Sharing Improvements. This provision would permit DOD to share certain medical records of servicemembers with VA, and ensure that DOD would not violate the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) by providing such information. As stated in S.Rept. 109-177, due to requirements under 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 delay hinders the seamless transition from active duty to veterans status.

Expansion of National Guard Outreach Program. This provision would require VA to expand the total number of personnel employed by the Department as part of the Readjustment Counseling Service's Global War on Terrorism (GWOT) Outreach Program. It also requires VA to ensure that all appropriate health, education, and benefits information is available to returning members of the National Guard.

Expansion of Telehealth Services. This provision would require VA to expand the number of Vet Centers capable of providing health services and counseling through telehealth linkages. According to S.Rept. 109-177, the Committee believes that it will allow VA to reach more veterans in rural areas and provide more services in a setting closer to veterans' homes.

Mental Health Data Sources Report. This provision would require VA to submit a report to the Senate and House Committees on Veterans' Affairs describing the mental health data maintained by VA. The report must include a comprehensive list of the sources of all such data, including the geographic locations of VA facilities maintaining such data; an assessment of the limitations or advantages

of maintaining the current data configurations and locations; and any recommendations for improving the collection, use, and location of mental health data maintained by VA.

Strategic Plan for Long-term Care. This provision would require VA to publish a strategic plan for long-term care. The plan must include policies and strategies for the delivery of care in many different settings such as domiciliaries, residential treatment facilities, and nursing homes. It must also include policies to maximize the use of state veterans nursing homes, locate domiciliary units as close to patient populations as feasible, and identify freestanding nursing homes as an acceptable model for care. The plan must also include data on the care of catastrophically disabled veterans, and the geographic distribution of catastrophically disabled veterans. Furthermore, the plan must address the full spectrum of noninstitutional long-term care options, including respite care, home-based primary care, geriatric evaluation, adult day health care, skilled home health care, and community residential care. The strategic plan must provide an analysis on cost and quality among all the different levels of care, detailed information about geographic distribution of services and gaps in care, and specific plans for working with Medicare, Medicaid, and private insurance companies to expand care.

Blind Rehabilitation Outpatient Specialists. This provision directs VA to employ 35 new Blind Rehabilitation Outpatient Specialists at VA facilities over the next three years.

Health Care and Services for Veterans Affected by Hurricane Katrina. This provision would authorize VA to treat any veteran from one of the affected states in the Gulf Coast in any VA facility, regardless of whether the veteran is enrolled in the VA health care system or eligible to enroll. This authority also waives any applicable copayments or fees. This authority would expire on January 31, 2006.

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 health care provider in the past two years. However, a veteran who obtains emergency care in a non-VA facility 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. This provision would amend the current law and 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.

Veterans Choice of Representation and Benefits Enhancement Act of 2006 (S. 2694, S.Rept. 109-297)

This bill was introduced on May 2, 2006. On June 22, the Senate Veterans' Affairs Committee voted to report S. 2694, as amended, and included provisions derived from several original measures introduced in the Senate.¹⁰⁰ The bill was passed by the Senate on August 3, 2006. The bill is awaiting House action. This section provides a brief summary of provisions that have a legislative impact on veterans' health care.¹⁰¹

Parkinson's Disease Research, Education, Clinical Centers, and Multiple Sclerosis Centers of Excellence. As stated previously, VA has established six PADRECCs. Similarly, in 2003, VA established two Multiple Sclerosis Centers of Excellence (MSCoE) in three locations to serve the health care needs of approximately 28,000 veterans with multiple sclerosis. These centers are located in Seattle, Washington, and Portland, Oregon (collectively known as MSCoE, West), and in Baltimore, Maryland (known as MSCoE, East). S. 2694 would permanently authorize the six PADRECCs and the two MSCoEs, subject to appropriations. In providing a statutory basis for these centers, the committee's intent is to ensure their continued existence.

State Veterans' Home Per Diem Program. The state veterans' nursing home program is a federal-state partnership to construct or acquire nursing home, domiciliary, and adult day health care facilities. VA provides up to 65% of the cost to states to construct, acquire, remodel, or modify state homes. In addition to providing grants to states for construction, VA also provides a fixed per diem to the state for each veteran provided care in a state veterans' home. In 2006, that rate is \$63.40 per veteran per day. Each state has different methods of funding the balance of the cost of care. Some states bill the balance amount in full to the veteran, and others bill Medicare or Medicaid for those veterans who qualify for those programs.

S. 2694 would require VA to pay state nursing homes the full cost of care for veterans who have a service-connected disability rating of 70% or more. The committee believes that the current reimbursement methodology is "unfair and irrational."¹⁰² Under current law, if a veteran who is service-connected and rated 70% or more receives long-term care at a VHA facility or at a VHA-contracted facility, the care is provided at no cost to the veteran. However, if the same veteran

¹⁰⁰ S. 2694, as amended, included provisions derived from S. 909, S. 1252, S. 1537, S. 1759, S. 2121, S. 2416, S. 2433, S. 2634, S. 2659, S. 2694, S. 2753, S. 2762, S. 3069, S. 3363, and S. 3545.

¹⁰¹ For a detailed description of other provisions included in the Veterans Choice of Representation and Benefits Enhancement Act of 2006, see CRS Report RL33216, *Veterans' Benefits Issues in the 109th Congress*, by Paul J. Graney.

¹⁰² U.S. Congress, Senate Committee on Veterans' Affairs, *Veterans' Choice of Representation and Benefits Act*, report to accompany S. 2694, 109th Cong., 2nd sess., S.Rept. 109-297, p. 30.

receives long-term care at a state veterans' nursing home, the veteran may likely be charged out-of-pocket expenses.

Prescription Medications for Veterans in State Veterans Homes.

VHA dispenses medications only to those veterans who are enrolled for, and who actually receive, VA-provided care. Generally, VHA does not provide medications to veterans unless those medications are prescribed by a physician employed by or under contract with VHA.

However, there are two exceptions to this general requirement: VHA is required to provide medications, upon the order of **any licensed physician**, to 1) veterans receiving additional disability compensation under Chapter 11 of Title 38 of the United States Code (U.S.C.), as a result of being permanently housebound or in need of regular aid and attendance due to a service-connected condition, or veterans who were previous recipients of such compensation and in need of regular aid and attendance; and 2) veterans who are receiving nonservice-connected pensions under Chapter 15 of Title 38 U.S.C. as a result of being permanently and totally disabled from a nonservice-connected disability, and who are permanently housebound or in need of regular aid and attendance.¹⁰³

This creates a condition whereby VHA is required to provide medications to service-connected veterans residing in state veterans nursing homes who are receiving an additional aid and attendance allowance, and to veterans who are receiving a VA pension for a nonservice-connected condition and an additional aid and attendance allowance.

However, VHA cannot provide medications to veterans with service-connected conditions residing in state veterans homes who do not receive an additional aid and attendance allowance — although by definition, veterans residing in state veterans homes are receiving regular aid and attendance. The committee believes that this situation is “simply irrational.”¹⁰⁴ S. 2694 would require VHA to provide medications for the treatment of service-connected conditions to veterans residing in state veterans homes, regardless of whether they receive an aid and attendance allowance, and to provide medication for any condition — service-connected or nonservice-connected — to all veterans with a 50% or more service-connected disability rating who reside in state veterans homes.

Treatment of Certain Health Facilities as State Homes. S. 2694 would authorize a three-year pilot program that would require a VA to deem 100 beds in non-VA nursing facilities as eligible to receive state veterans' nursing home per-diem payments.

Office of Rural Health. S. 2694 would create a new office in the department to develop strategies and solutions to help reduce disparities in access to care between rural and non-rural veterans.

¹⁰³ 38 U.S.C. § 1712(d); 38 C.F.R. §17.96.

¹⁰⁴ Ibid., p.31.

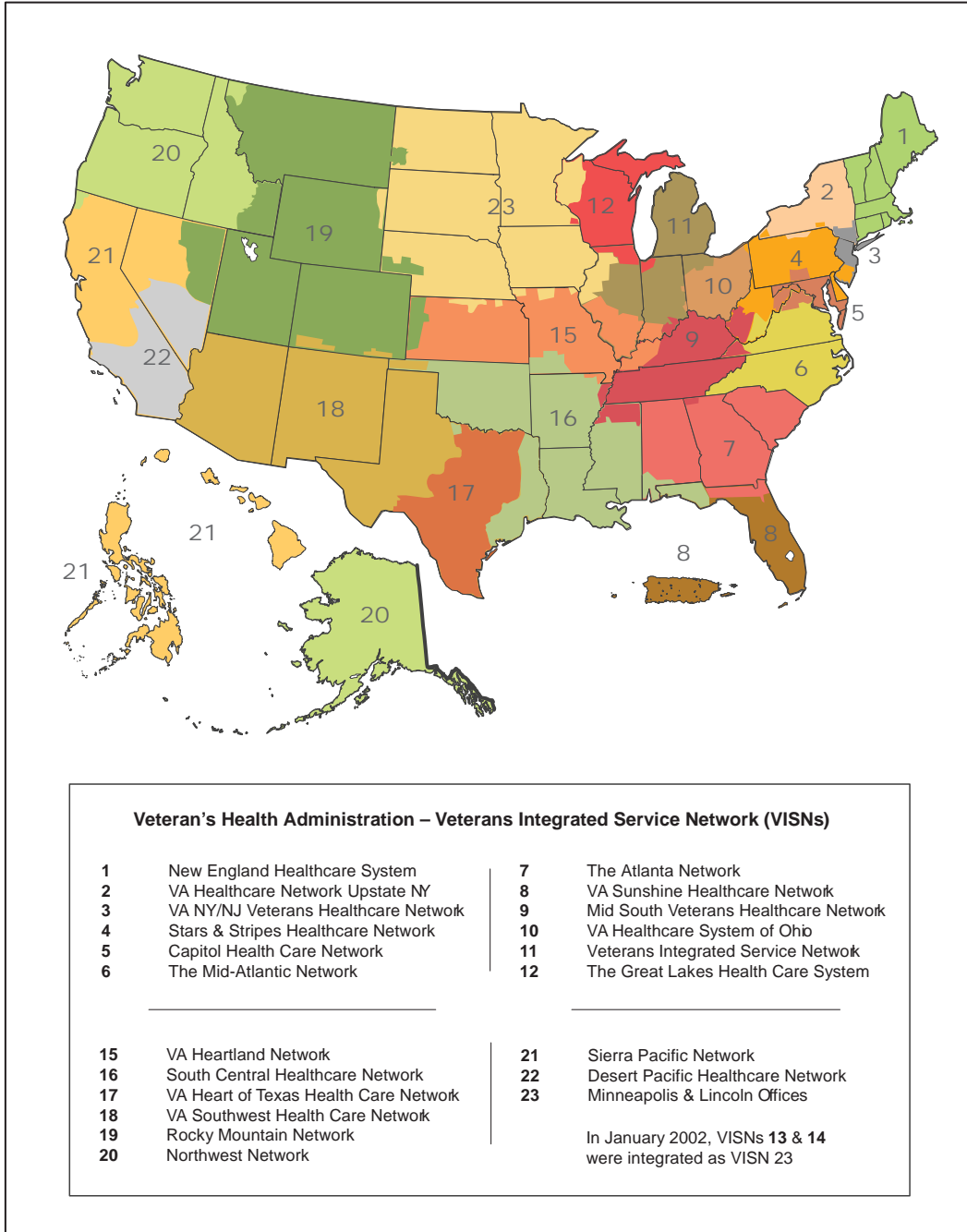
Pilot Program on Caregiver Assistance Services. VA currently provides a variety of support services to aging veterans and their families. Among these services are adult day care, respite care, case management and coordination, transportation services, home care services, hospice, and general caregiver support such as education and training of family members. S. 2694 would require the department to conduct a two-year pilot program to improve assistance provided to caregivers, particularly in home-based settings. Under this provision, \$5 million would be authorized for the purpose of carrying out the pilot program. This amount of funding would be in addition to whatever other funds VA is already spending on caregiver assistance services.

Authorizing Major Medical Facility Projects and Leases (S. 3421, S.Rept. 109-328)

This bill was introduced on June 6, 2006. On June 22, the Senate Veterans Affairs Committee voted by voice vote to report favorably S. 3421, as amended by Chairman Craig. The bill was passed by the Senate on September 26, 2006. S. 3421, among other things, would authorize major medical facility projects in New Orleans, Louisiana; Biloxi, Mississippi; and Denver, Colorado; extend the period during which VA is authorized to enter into contracts for major medical facility construction projects originally authorized as CARES projects by the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (P.L.108-170); and authorize FY2006 and FY2007 major medical facility leases.

S. 3421 would also authorize \$15 million for improvements to the VA hospital in San Juan, Puerto Rico. The House bill (H.R. 5815) did not include such a provision. The House bill did authorize \$70 million for the reconstruction of a co-located, joint-use major medical facility project in Charleston, South Carolina, with the Medical University of South Carolina. However, S. 3421 did not include a provision authorizing this project. H.R. 5815 and S. 3421 are awaiting conference.

Appendix 1. Map of All 21 Veterans' Integrated Services Networks



Source: Information provided by the Department of Veteran Affairs. Map Resources.
Adapted by CRS. (K.Yancey 1/31/06).

Appendix 2. Priority Groups and Their Eligibility Criteria

<p>Priority Group 1 Veterans with service-connected disabilities rated 50% or more disabling</p>
<p>Priority Group 2 Veterans with service-connected disabilities rated 30% or 40% disabling</p>
<p>Priority Group 3 Veterans who are former POWs Veterans awarded the Purple Heart Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty Veterans with service-connected disabilities rated 10% or 20% disabling Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, “benefits for individuals disabled by treatment or vocational rehabilitation”</p>
<p>Priority Group 4 Veterans who are receiving aid and attendance or housebound benefits Veterans who have been determined by VA to be catastrophically disabled</p>
<p>Priority Group 5 Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA means test thresholds Veterans receiving VA pension benefits Veterans eligible for Medicaid benefits</p>
<p>Priority Group 6 Compensable 0% service-connected veterans World War I veterans Mexican Border War veterans Veterans solely seeking care for disorders associated with — exposure to herbicides while serving in Vietnam; or — ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or — for disorders associated with service in the Gulf War; or — for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.</p>
<p>Priority Group 7 Veterans who agree to pay specified copayments with income and/or net worth <i>above</i> the VA means test threshold and income <i>below</i> the HUD geographic index Subpriority a: Noncompensable 0% service-connected veterans who were enrolled in the VA Health Care system on a specified date and who have remained enrolled since that date Subpriority c: Nonservice-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date. Subpriority e: Noncompensable 0% service-connected veterans not included in Subpriority a above Subpriority g: Nonservice-connected veterans not included in Subpriority c above</p>
<p>Priority Group 8 Veterans who agree to pay specified copayments with income and/or net worth <i>above</i> the VA means test threshold and the HUD geographic index Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date Subpriority e: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003</p>

Source: Department of Veterans Affairs.

Note: Service-connected disability means with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval or air service.