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VETERANS HEALTH CARE AUTHORITIES EXTENSION AND IMPROVEMENT ACT OF 2003

NOVEMBER 10, 2003.—Ordered to be printed

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

R E P O R T

[To accompany S. 1156]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (S. 1156), to amend title 38, United States Code, to improve and enhance the provision of long-term health care for veterans by the Department of Veterans Affairs, to enhance and improve authorities relating to the administration of personnel of the Department of Veterans Affairs, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a committee substitute and an amendment to the title, and recommends that the bill, as amended, do pass.

INTRODUCTION

On May 23, 2003, Committee Chairman Arlen Specter introduced S. 1156, the proposed "Department of Veterans Affairs Long-Term Care and Personnel Authorities Enhancement Act of 2003." S. 1156, as introduced, would have extended VA's authority to provide non-institutional long-term care services to all enrolled veterans; modified and extended the requirement that VA provide institutional nursing care to certain disabled veterans; and authorized VA to enter into agreements with appropriate private sector health care institutions for the provision of long-term care services to veterans. In addition, S. 1156 would have authorized major medical facility construction projects; modified VA's authority to appoint certain health care professionals in the VA's Veterans Health Administration (hereinafter, "VHA"); authorized the non-competitive transfer of certain employees of VA's Veterans Canteen Service for

employment within VA; and made permanent VA's authority to enter into contracts with private sector organizations for the provision of disability ratings medical examinations. Finally, the bill would have made retroactive the changes relating to the retirement annuities of certain part-time health-care professionals made in Title 38, United States Code, by section 132 of Public Law 107–135.

On March 6, 2003, Committee Member John D. Rockefeller IV introduced S. 548, a bill to improve mental health programs for veterans, and for other purposes.

On March 13, 2003, Senator Rick Santorum and Chairman Specter introduced S. 615, a bill to name the VA outpatient clinic in Horsham, Pennsylvania, the "Victor J. Saracini Department of Veterans Affairs Outpatient Clinic."

On May 23, 2003, Senator Richard Durbin introduced S. 1144, a bill to name the VA Medical Center at 820 South Damen Avenue, Chicago, Illinois, the "Jesse Brown Department of Veterans Affairs Medical Center." Committee Members Rockefeller, Jim Bunning, and Patty Murray were later added as cosponsors.

On June 9, 2003, Chairman Specter introduced, at the request of the Secretary of Veterans Affairs, S. 1213, a bill to amend Title 38, United States Code, to improve benefits afforded to Filipino veterans of World War II and survivors of such veterans, and for other purposes.

On June 18, 2003, Committee Ranking Member Bob Graham introduced S. 1283, a bill to require advance notification to Congress regarding any action proposed to be taken by VA in connection with the VA Capital Asset Realignment for Enhanced Services (hereinafter, "CARES") initiative. Committee Members Rockefeller and Murray were later added as cosponsors.

On June 19, 2003, Ranking Member Graham introduced S. 1289, a bill to name the VA Medical Center in Minneapolis, Minnesota, the "Paul Wellstone Department of Veterans Affairs Medical Center." Committee Members Rockefeller, Murray, Zell Miller, and Ben Nelson were later added as cosponsors.

On June 26, 2003, Committee Member Kay Bailey Hutchison introduced S. 1341, a bill to name the VA Medical Center in Houston, Texas, the "Michael E. DeBakey Department of Veterans Affairs Medical Center."

On September 2, 2003, Ranking Member Graham introduced S. 1572, a bill to authorize the expansion of VA's pilot program on assisted living for veterans to include an additional health care region.

COMMITTEE HEARINGS

On July 29, 2003, the Committee held a hearing to receive testimony on, among other bills, S. 615, S. 1144, S. 1156, S. 1213, S. 1283, and S. 1289. Testimony was heard from: The Honorable Tim S. McClain, VA's General Counsel; Ms. Cathleen C. Wilembo, Deputy Director for Health Care, Veterans Affairs and Rehabilitation Commission, The American Legion; Mr. Paul A. Hayden, Deputy Director, National Legislative Service, Veterans of Foreign Wars of the United States; Mr. Adrian M. Atizado, Associate National Legislative Director, Disabled American Veterans; Mr. Carl Blake, As-

sociate Legislative Director, Paralyzed Veterans of America; and Mr. Richard Jones, National Legislative Director, AMVETS.

On September 11, 2003, the Committee held a hearing on VA's CARES initiative. The Committee received testimony from the Honorable Anthony J. Principi, Secretary of Veterans Affairs; Robert H. Roswell, MD, VA's Under Secretary for Health; and Mr. Everett Alvarez, Jr., Chairman, Capital Asset Realignment for Enhanced Services Commission, U.S. Department of Veterans Affairs.

COMMITTEE MEETING

After carefully reviewing the testimony from the foregoing hearings, the Committee met in open session on September 30, 2003, and voted by unanimous voice vote to report favorably S. 1156, as amended to include provisions derived from S. 548, S. 615, S. 1144, S. 1156 as introduced, S. 1213, S. 1283, S. 1289, S. 1341, and S. 1572.

SUMMARY OF THE COMMITTEE BILL AS REPORTED

S. 1156, as reported (hereinafter, "Committee bill"), consists of four titles, summarized below.

TITLE I—EXTENSION OF CERTAIN HEALTH CARE AUTHORITIES

Title I contains freestanding provisions and amendments to Title 38, United States Code, that would:

1. Extend for five years VA's authority to provide enrolled veterans with a range of non-institutional extended care services as set forth in Public Law 106–117, the "Veterans Millennium Health Care and Benefits Act," and extend through 2008 the same statute's mandate that VA provide institutional nursing care services, as indicated, to severely service-connected disabled veterans (section 101).

2. Authorize VA to enter into agreements with non-VA providers of institutional nursing care or non-institutional extended care in a manner similar to that which is permitted under the Social Security Act (section 102).

3. Authorize the expansion of a pilot program for the provision of assisted living services to veterans (section 103).

4. Increase from $15 million to $25 million annual funding to be set aside for a program designed to expand and improve services relating to the treatment of post-traumatic stress disorder (hereinafter, "PTSD") and substance use disorders; clarify that these funds are to be provided on an annual basis for a three year period; require that not less than $10 million be allocated by direct grants to programs that are identified by VA's Mental Health Strategic Health Care Group and VA's Committee on Care of Severely Chronically Mentally Ill Veterans; require that not less than $5 million be allocated for PTSD treatment programs; and require that not less than $5 million be allocated for substance use disorder treatment programs (section 104).

TITLE II—CONSTRUCTION AUTHORITIES

Title II contains freestanding provisions and amendments to Title 38, United States Code, that would:

1. Increase from $4,000,000 to $9,000,000 the threshold amount which will result in a medical facility construction project being classified a "major" construction project (section 201).
2. Establish in the Treasury the "Department of Veterans Affairs Facilities Demolition Fund"; authorize that $25 million be appropriated to the fund; and authorize VA to use amounts deposited into the fund for the purpose of demolishing or removing dilapidated or hazardous VA structures (section 202).
3. Authorize VA to carry out major construction projects in Lebanon, Pennsylvania and Beckley, West Virginia (section 211).
4. Authorize VA to enter into major medical facilities leases in Denver, Colorado; Pensacola, Florida; Boston, Massachusetts; and Charlotte, North Carolina (section 212).
5. Authorize $34.5 million in major construction funds and $13.385 million in leasing authority to carry out the projects and leases specified in sections 211 and 212 of the Committee bill (section 213).
6. Name a VA Outpatient Clinic in Horsham, Pennsylvania the "Victor J. Saracini Department of Veterans Affairs Outpatient Clinic" (section 221).
7. Name a VA Medical Center in Chicago, Illinois the "Jesse Brown Department of Veterans Affairs Medical Center" (section 222).
8. Name the VA Medical Center in Houston, Texas the "Michael E. DeBakey Department of Veterans Affairs Medical Center" (section 223).
9. Name the VA Medical Center in Minneapolis, Minnesota the "Paul Wellstone Department of Veterans Affairs Medical Center" (section 224).

TITLE III—PERSONNEL MATTERS

Title IIIuc contains freestanding provisions and amendments to Title 38, United States Code, that would:

1. Modify VA authority to make appointments of certain personnel in VHA (section 301).
2. Provide hourly-rate employees of VA's Veterans Canteen Service with transfer rights to Title 5 positions in VA (section 302).
3. Provide that the effective date of the amendment made by section 132 of Public Law 107–135 shall be January 23, 2002; and require that the Office of Personnel Management (hereinafter, "OPM") recompute the annuities of affected health care professionals who retired between April 7, 1986, and January 23, 2002 (section 303).

TITLE IV—OTHER MATTERS

Title IV contains freestanding provisions and amendments to Title 38, United States Code, that would:

1. Require VA to notify Congress of facility closings proposed under the Capital Asset Realignment for Enhanced Services initiative, and prohibit such closings from occurring until the lapse of 60

days following the notification or 30 days of continuous session of Congress, whichever is longer (section 401).

2. Authorize the Secretary to carry out major construction projects in connection with the CARES initiative no sooner than 60 days following the submission of a report that lists all major construction projects on which VA proposes to expend such funds; require VA, when it develops that list, to develop it in accordance with priorities specified in this section; authorize VA to enter into multi-year contracts for the construction of major medical facilities; and authorize VA to expend funds appropriated for the CARES initiative and for "major construction" to carry out the provisions of this section (section 402).

3. Authorize a three-year extension of a program which assists not-for-profit organizations and State and local government agencies in providing housing assistance for homeless veterans (section 411).

4. Authorize a four-year extension of a program that mandates that VA evaluate the health status of spouses and children of Persian Gulf War veterans (section 412).

5. Authorize VA to provide to U.S.-resident World War II veterans of the Commonwealth Army of the Philippines and so-called "new Philippine Scouts" medical services on the same basis as those services are provided to veterans of the Armed Forces of the United States (section 421).

6. Repeal the requirement that certain officials in VA's Office of the Under Secretary for Health be appointed for terms of four years (section 422).

BACKGROUND AND DISCUSSION

TITLE I—EXTENSION OF CERTAIN HEALTH CARE AUTHORITIES

Section 101. Extension and modification of certain health care authorities

By the enactment of Public Law 106–117, the Veterans Millennium Health Care and Benefits Act" (hereinafter, "Millennium Act") in 1999, the Congress directed that VA establish a comprehensive program to provide non-institutional extended care services for veterans enrolled for VA care. Further, it directed by enactment of the Millennium Act that VA provide institutional nursing care to veterans in need of such care for service-connected disabilities and to veterans who have sustained service-connected disabilities rated at 70 percent or more and who are in need of institutional long-term care to treat any condition. These provisions are scheduled to expire on December 31, 2003.

In January 2003, VA reported to Congress on its experience in providing both non-institutional extended care services and nursing home care as required by the Millennium Act. Some of the information reported by VA is encouraging; some is not. On the positive side, VA reports that over 90 percent of VA medical centers now provide outpatient-based long-term care. VA reported, further, that the proportion of VA long-term care patients treated in an outpatient-based care setting has increased from 57 percent (in 1998) to 64 percent (in 2001). These data suggest that growth in non-in-

stitutional care programs is allowing more veterans to receive necessary extended care services while remaining in a home setting. Additionally, the Committee is encouraged that the number of patients treated in VA long-term care settings grew by 6.7 percent from 1998 thru 2001 and that during the same period geriatric evaluation and management programs grew by over 50 percent.

VA's January 2003 report, however, also sets forth a number of discouraging revelations. VA reports that "only small changes in VA long-term care occur[ed] immediately after enactment of Public Law 106–117" and "overall costs are basically equal to what one would expect in the absence of the Act through fiscal year 2001." In fact, the report notes that, since enactment of the Millennium Act, the percentage of VA's overall health care budget spent on long-term care has declined from just over—to slightly under—7.5 percent. Findings such as these suggest that VA has done too little to provide added extended care services for an aging veterans' population despite Congress' clear direction that it do so.

In response, in part, to the insufficient progress being made to expand VA long-term care services, Chairman Specter introduced legislation, S. 1156, a bill which, as introduced, would have lowered to 50 percent the threshold of service-connected disability that would give rise to qualification for mandatory institutional extended care services. However, testimony rendered by VA General Counsel Tim S. McClain to the Committee on July 29, 2003, raised serious concerns about the costs and consequences of such a change. Mr. McClain stated:

> We estimate that the change from 70 percent to 50 percent would cost $2.5 billion over 5 years * * * [and] the provisions could have serious unintended consequences including slowing the rate of growth of non-institutional long-term care and reducing the availability of services for non-mandatory categories of veterans. * * *

In light of that testimony, and because the current backlog of patients waiting 6 months or more for primary care services still stands at approximately 100,000 veterans, the Committee bill extends the expiration dates of both long-term care authorities for an additional five years, until December 31, 2008, but it does not lower the threshold for eligibility for mandatory institutional care. Even so, the Committee is committed to expanding the range of long-term care services available to veterans. The Committee expects that VA will respond to that commitment despite the Committee's determination to defer for now the issue of modifying the mandatory care threshold.

Sec. 102. Enhanced agreement authority for provision of nursing home care and adult day health care in non-Department of Veterans Affairs facilities

Under current law, VA is authorized to enter into contractual arrangements with private providers of extended care services to serve the needs of veterans. Federal reporting requirements relating to the demographics of contractor employees and applicants are required to be submitted to the Department of Labor under these contractual arrangements. The Committee has learned that, due to these reporting requirements, many small providers of extended

care services are unable, or they are unwilling, to admit VA patients. Many such providers have apparently concluded that reimbursement from VA for caring for one or two veterans is not worth the cost of compiling and reporting the data required by general Federal contract law.

The Social Security Act allows the Centers for Medicare and Medicaid Services (hereinafter, "CMS") to enter into provider agreements for the provision of care to both Medicare and Medicaid beneficiaries. Such agreements require that contractors comply with Federal laws concerning hiring practices. But they do not require that providers prepare reports of such compliance. Nor do they subject providers to annual audits like most Federal contracts do. Not surprisingly, CMS is more successful than VA in inducing smaller providers to provide care to its beneficiaries.

Section 102 of the Committee bill places VA contractors in a similar position as CMS contractors with respect to Federal reporting requirements. By this action, the Committee seeks to encourage VA to bring care closer to veterans' homes and community support structures by contracting with small community-based providers. Even so, however, the Committee fully anticipates and expects that VA will require compliance with all applicable Federal laws concerning employment and hiring practices.

Sec. 103. Expansion of pilot program in the Department of Veterans Affairs to provide assisted living for veterans

Currently, 35 percent of veterans—some 8.75 million veterans—are 65 years of age or older. Of these, approximately 640,000 are over 85 years old. VA estimates that the numbers of this "most-in-need" segment of the veterans' population will more than double, to approximately 1.3 million veterans, by 2012.

These facts lead the Committee to conclude that VA must concentrate on the development of a national policy on the provision of assisted living services for veterans. The assisted living pilot program authorized by section 103(b) of Public Law 106–117 was designed to allow VA to assess veterans' needs for assisted living care, to determine the cost of providing such care, and to explore the best setting in which to provide such care. The success of this initial program—which is still under way in Veterans Integrated Service Network 20—and the strong emphasis the CARES Draft National Plan has placed on assisted-living services, have led the Committee to conclude that another pilot is both warranted, and needed, to allow VA to compile more data and to study this issue further.

By immediately adding an additional site and building on the achievements of the first pilot, VA will be provided with the further information it requires to formulate a national plan. The Committee's expectation is that, eventually, the entire nation will benefit from this important program.

Sec. 104. Improvement of program for provision of specialized mental health services to veterans

VA has a unique responsibility to meet the special requirements of veterans who need spinal cord injury care, prosthetic devices, blind rehabilitation services, and PTSD therapy services. VA's specialized programs to serve these "special need" veterans, however,

have been under budgetary pressure due to VA's shift in health care focus from inpatient-based care to outpatient-based services and the introduction of a new resource allocation system.

In 1996, Congress recognized that specialized services might face such funding pressure, and it took steps to counter the potential erosion of these programs. The Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104–262, mandated that VA maintain its capacity to treat the "special need" disabled veterans at then-current levels, and required VA to report to Congress annually on the maintenance of these specialized services. Further, in December 2001, Congress reinforced its direction that "special need" services be maintained by enacting the Department of Veterans Affairs Health Care Programs Enhancement Act, Public Law 107–135. That statute described the manner in which VA is to maintain such capacity and, in addition, specified that $15 million in VA medical care funding would be set aside solely to assist medical facilities in improving care for veterans with substance use disorders and PTSD. That set-aside provision is scheduled to expire at the end of fiscal year 2003.

The Committee believes that VA has made improvements in substance use disorder treatment and PTSD care—in large part because of this funding set-aside provision. It seeks to sustain that progress. Accordingly, section 104 of the Committee bill would "protect" this set-aside funding for three additional years. Additionally, it would increase the total amount of funding identified specifically for treatment of substance use disorders and PTSD from $15 million to $25 million. The Committee expects that this extension and increase in funding levels will allow VA to continue the trend of improving these vital services for veterans.

TITLE II—CONSTRUCTION AND FACILITIES MATTERS

Subtitle A—Construction Authorities

Sec. 201. Increase in threshold for major medical facility projects

Under current law, VA medical facility construction projects with a projected total cost of less than $4 million are classified as "minor" projects. Those with costs projected to exceed $4 million are "major" construction projects and, as such, they are subject to the statutory requirement that they be individually authorized and funded by Congress. See 38 U.S.C. §8104. While minor projects are not subject to this stricture, all VA construction projects, including "minor" projects, are subjected to internal VA review and are approved and ranked by VHA's Capital Asset Board, VA's Strategic Management Council and VA's Deputy Secretary. Among the factors considered in this approval and ranking process are projected need, projected costs, projected impact on CARES activities, projected impact on medical care quality and access, and projected impact on medical appointment waiting times.

Recent VA requests for the authorization and funding of major medical facility construction projects have shown that major facility projects rarely cost less than $10 million. Indeed, VA's Fiscal Year 2004 budget submission listed 22 "major" projects that are authorized, funded and, in many cases, now under construction. Only two of these 22 projects had projected costs of less than $10 million.

In light of this, the Committee believes that the original intent of the law—that VA not undertake major medical facility construction projects without the approval of Congress—would be advanced by a modification of the major project threshold amount to $9 million. Section 201 of the Committee bill contains language raising the major construction threshold to reflect that view.

Sec. 202. Demolition of obsolete, dilapidated and hazardous structures on Department of Veterans Affairs property

There are many buildings on VA property, e.g., former staff living quarters and even farming structures, that lie vacant and, in many cases, are semi-derelict. In August 1999, the U.S. General Accounting Office (hereinafter, "GAO") reported that VA lacks an incentive to dispose of such structures because VA construction funds may, by law, only be spent to build, alter or acquire facilities, not to tear down unneeded and unused ones.

Section 202 of the Committee bill authorizes the appropriation of $25 million for a VA Facilities Demolition Fund. It further authorizes VA to use amounts deposited into the fund for the purpose of demolishing or removing dilapidated or hazardous structures from VA property. Such properties are, at best, eyesores. Worse, they are potential hazards.

Subtitle B—Construction Authorizations

Sec 211. Authorization of major medical facility projects

As noted above, VA may not obligate or expend funds on any "major medical facility project" unless that project has been specifically authorized by law.

Section 211 of the Committee bill authorizes two projects that Congress had previously approved, but which have not yet been funded. First, the Committee bill authorizes $20 million to construct a nursing care facility at the Beckley, West Virginia VA Medical Center. Second, the Committee bill extends the $14.5 million authorization now in place for the construction of a nursing home project at the Lebanon, Pennsylvania VA Medical Center. These projects continue to have merit for the reasons cited in previous legislative reports.

Sec. 212. Authorization of major medical facility leases

VA may not obligate or expend funds on any major medical facility lease unless that lease has been specifically authorized by law. Id. A "major medical facility lease" is one that involves the annual expenditure of $600,000 or more in rent.

In its Fiscal Year 2004 budget request, VA requested authority to enter into the following leases: (1) The relocation and expansion of a health administration center in Denver, Colorado ($4.08 million); (2) an outpatient clinic extension in Pensacola, Florida ($3.8 million); (3) an outpatient clinic extension in Boston, Massachusetts ($2.879 million); and (4) a Satellite Outpatient Clinic in Charlotte, North Carolina ($2.626 million). Each of these proposed leases is, in the judgment of the Committee, necessary to improve health care for all veterans. Accordingly, section 212 of the Committee bill would authorize each of them.

The Committee is aware that many communities and organizations have made efforts to provide VA with space to lease for the provision of health care services to veterans. Many of these proposals—such as one offered for services in Elko, Nevada—are potentially of great importance to the local health care and veterans' communities. The Committee urges VA to work with such organizations where possible to bring care closer to veterans.

Sec. 213. Authorization of appropriations

Section 8104(a)(2) of title 38, U.S. Code, requires statutory authorization of all major medical facility projects and major medical facility leases prior to appropriation of funds. In its Fiscal Year 2004 budget request, VA requested the authorization of $98.5 million for major medical facility projects and $10.759 million for major medical facility leases in 2004.

Section 213 of the Committee bill authorizes appropriations for major VA medical facility projects and major VA medical facility leases for fiscal year 2004. Specifically, section 213 authorizes a total of $34.5 million for the major medical facility projects specified in section 211 of the Committee bill, and $13.385 million for leases specified in section 212 of the Committee bill. The Committee believes these major medical facility projects and leases are in the interest of improving health care for all veterans.

Subtitle C—Designation of Facilities

Sec. 221. Designation of Department of Veterans Affairs Outpatient Clinic, Horsham, Pennsylvania

Victor J. Saracini was a decorated United States Navy officer. He ended his naval career in the Naval Reserve at Naval Air Station Willow Grove, Pennsylvania. During his civilian career as a United Airlines pilot, Mr. Saracini was captain of United Airlines Flight 175, one of the four commercial jets hijacked by terrorists on September 11, 2001. Flight 175 was flown into the South Tower of the World Trade Center in New York City, killing all people onboard including Captain Saracini.

The Committee believes that naming the VA outpatient clinic in Horsham, Pennsylvania would be an appropriate tribute to a devoted aviator and veteran. Section 221 of the Committee bill would so name the VA Outpatient Clinic in Horsham, Pennsylvania the "Victor J. Saracini Department of Veterans Affairs Outpatient Clinic."

Sec. 222. Designation of Department of Veterans Affairs Health Care Facility, Chicago, Illinois

The Honorable Jesse Brown was disabled by enemy fire in 1965 while serving as a United States Marine in Vietnam. He later served in the Disabled American Veterans, rising to the office of Executive Director. Subsequently, he was appointed Secretary of Veterans Affairs by President Bill Clinton in January 1993. He served with distinction in that position until July 1997. Secretary Brown died on August 15, 2002.

The Committee believes that naming a VA Medical Center in Chicago, Illinois—Secretary Brown's home town—would be an appropriate tribute to the Secretary's service. Section 222 of the Com-

mittee bill would so name the VA Medical Center at 820 South Damen Avenue, Chicago, Illinois, the "Jesse Brown Department of Veterans Affairs Medical Center."

Sec. 223. Designation of Department of Veterans Affairs Medical Center, Houston, Texas

Dr. Michael E. DeBakey is one of the world's foremost heart surgeons. During World War II, he served as a Colonel on the staff of the U.S. Army Surgeon General and conducted studies that led to the development of mobile army surgical hospital ("MASH") units. He is a recipient of the U.S. Army Legion of Merit Award, and he is credited with assisting in the establishment of the system of treating military personnel returning from war which eventually evolved into VA's modern Veterans Health Administration.

The Committee believes that naming the VA Medical Center in Houston, Texas would be an appropriate tribute to Dr. DeBakey's longstanding commitment to the health care of veterans. Section 223 of the Committee bill would so name the VA Medical Center in Houston, Texas the "Michael E. DeBakey Department of Veterans Affairs Medical Center."

Sec. 224. Designation of Department of Veterans Affairs Medical Center, Minneapolis, Minnesota

The late Paul Wellstone of Minnesota served as a distinguished member of the Senate Committee on Veterans' Affairs, and was the principal author of the Hmong Veterans' Naturalization Act and the Heather French Homeless Veterans Assistance Act. During his life, Senator Wellstone was honored by the Military Order of the Purple Heart, the Disabled American Veterans, the Minnesota chapter of the Paralyzed Veterans of America, the Minnesota Department of the Veterans of Foreign Wars, and the Vietnam Veterans of America for his commitment to veterans' issues. On October 25, 2002, Senator Paul Wellstone died in a tragic plane crash.

The Committee believes that naming the VA Medical Center in Minneapolis, Minnesota would be an appropriate tribute to Senator Wellstone. Section 224 of the Committee bill would so name the VA Medical Center in Minneapolis, Minnesota as the "Paul Wellstone Department of Veterans Affairs Medical Center."

TITLE III—PERSONNEL MATTERS

Sec. 301. Modification of authority on appointment of personnel in the Veterans Health Administration

Under current law, VHA employs its hospital and clinical staff under three separate legal authorities; the authority under which a particular staff member is employed is a function of the duties the employee in question performs. Critical "hands-on" clinical staff—physicians, dentists, and registered nurses—are employed under legal authorities unique to VHA contained in chapter 74 of title 38, U.S. Code. As distinguished from these "Title 38" employees, other VA staff—so-called "Title 5" employees—are employed under traditional civil service legal authorities specified in Title 5 of United States Code. A third group of VA staff, discussed below, is employed under a system known as "hybrid Title 38" status.

VHA's Title 38 employees work within a "rank-in-person" system; each clinician's pay grade, and his or her pay scale within each grade, are determined by comparing the individual's professional qualifications against published VA standards. Under the Title 38 employment system, VA has considerable hiring flexibility—it can hire professional employees directly—to assure that necessary health care staffing levels are always maintained. Further, VHA has flexibility to remunerate Title 38 employees at levels that are consistent with such staff's professional qualifications, thereby enhancing VA's ability to retain highly-trained staff. Promotions under the Title 38 system are awarded by review panels comprised principally of clinical peers having similar credentials and experience.

Title 5, or traditional civil service employment is, by contrast, a "rank-in-position" system that is administered according to standards specified by the Office of Personnel Management. Positions within the Title 5 employment system are graded according to classification standards, and employee pay is determined based on the position classification, not on the individual qualifications of the person occupying the position. As distinguished from Title 38 hiring, VHA management cannot fill Title 5 positions by direct hiring. Rather, management is provided a "certificate" of eligible candidates by OPM (or by a VA Delegated Examining Unit) which administers competitive examinations to candidates seeking employment. VHA managers may choose from among the top three candidates on the certificate.

The Title 5 hiring process is time-consuming; it typically takes a minimum of several weeks, and often as long as several months, to fill a position. Title 5 employees are afforded many protections and benefits not extended to Title 38 employees, including grievance procedures, Reduction-in-Force protections, annual pay increases based on increases in the consumer price index, and leave time accrued according to length of service.

Finally, VA employs limited clinical staff—e.g., clinical and counseling psychologists, respiratory and physical therapists, etc.—under so-called "hybrid Title 38" status. VA's "hybrid" system was developed to merge the best characteristics of the Title 38 and Title 5 hiring and compensation schemes. Candidates for employment under hybrid Title 38 status can be hired quickly, and they may receive special pay rates and promotions based on individual qualifications and peer review. However, hybrid Title 38 employees also enjoy grievance protections and annual leave accrual rights, and other benefits and protections, afforded to "conventional" Title 5 employees.

Section 301 of the Committee bill would place three clinical professions—certain psychologists not already within the "hybrid" system, social workers, and kinesiologists—who are now hired under Title 5 authority into hybrid Title 38 status. As discussed above, these professionals would then be subject to hybrid rules concerning hiring authority and peer review-based promotion. But they would also retain many of the protections enjoyed by staff employed under Title 5, United States Code. The Committee believes that it is in the interest of veterans and the VA health care system to hire and promote clinicians in these professions on the basis of individual qualifications and performance. However, the Committee

also recognizes that many clinicians in these professions have worked for, and enjoy, the greater protections and employment security afforded under their current Title 5 status, and they ought to retain the bulk of such benefits.

Sec. 302. Coverage of employees of Veterans' Canteen Service under additional employment laws

Hourly-rate employees of VA's Veterans Canteen Service (hereinafter, "VCS") are Federal employees under authority of 38 U.S.C. §7802. However, while they are hired through a merit system and they are provided many of the same benefits as other Federal employees—e.g., workers compensation, health, and retirement benefits, and veterans' preference rights—there are benefits to which they are not entitled. For example, VCS hourly-rate employees do not have the same rights to transfer to positions within VA that VCS managers have. As a consequence, when an hourly food service employee in a VCS canteen applies for a similar position in VA food service operations, he or she is not treated as a transferring VA employee (or, in technical terms, as an "internal competitive service candidate"). His or her years of service and experience in a VCS position are irrelevant to VA hiring; in practical terms, the VCS employee cannot transfer to a job within VA without first going through civil service competition despite a history of service within a VA health care facility.

In 1979, OPM approved an interchange agreement that permits eased movement between VA and VCS—but only for management-level employees. VA has repeatedly sought (in 1984, 1987 and in 1998) to establish a similar interchange agreement for VCS hourly employees, but OPM has declined to approve these VA proposals. The Committee disagrees with OPM's judgment on this issue. It believes that principles of equity dictate that VCS hourly-rate employees be afforded the same transfer rights as their managerial counterparts. Section 302 of the Committee bill so specifies.

Sec. 303. Effective date of modification of treatment for retirement annuity purposes of part-time service of certain Department of Veterans Affairs health-care professionals

In 1985, Congress enacted Public Law 99–272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (hereinafter, "COBRA"). That law granted to all part-time Federal employees full-time annuity credits for part-time work. Previously, the government had prorated part-time work for Title 38 employees.

The following year, VA requested legislation to exclude all part-time Title 38 employees from the 1985 COBRA retirement change. VA's request was based on the premise that part-time VA physicians earn significant outside salaries, and that the granting to them of full-time annuity credit for part-time work would have disproportionately enriched them. Congress granted VA's request and incorporated the requested change into Public Law 99–509, the 1986 Omnibus Budget Reconciliation Act.

In 2001, it was recognized that the 1986 legislation affected all part-time Title 38 employees—including VA nurses. VA nurses, unlike VA physicians, do not engage in lucrative outside practices. In recognition of that fact, Congress enacted section 132 of Public Law 107–135, "The Department of Veterans Affairs Health Care Pro-

grams Enhancement Act of 2001" in an attempt to "undo" the 1986 exclusion of nurses from the COBRA liberalization of retirement benefits so that, once again, VA nurses would get full-time credit for part-time work for purposes of computing retirement annuities. OPM, however, interpreted the changes contained in Public Law 107–135 as applying only to nurses who retired after the enactment date. As a consequence, similarly situated VA nurses receive different retirement annuities based not on their terms of service, but based purely on the date on which they retired.

Section 303 of the Committee bill would rectify this unintended situation by requiring OPM to recalculate the annuities for these retired health care professionals using a system that awards full-time credit for part-time service.

TITLE IV—OTHER MATTERS

Subtitle A—Capital Asset Realignment for Enhanced Services Initiative

Sec. 401. Advance notification of capital asset realignment initiatives

VA's Capital Assets Realignment for Enhanced Services initiative is a nine-step process that was initiated in late 2000. The purpose of CARES is to evaluate the projected health care needs of veterans over the next twenty years and to realign VA's infrastructure to better meet those needs. To simplify the procedures which have taken place to date—and which the Committee anticipates will give rise to CARES recommendations in late 2003—VA's Under Secretary for Health has issued a preliminary CARES report (hereinafter, the "Draft National Plan"), see 68 Fed. Reg. 50224 et seq. (August 20, 2003). That plan relies heavily—but not exclusively—on recommendations which the Directors of 20 of VA's veterans integrated service networks had submitted to the Under Secretary earlier in the year. The Draft National Plan, the contents of which are discussed below, is now being reviewed by a Commission appointed by the Secretary of Veterans Affairs (hereinafter, "CARES Commission") which, as of the date of this report, is in the midst of conducting a series of public hearings throughout the Nation in advance of its issuance of recommendations to the Secretary. The preliminary stages of the CARES process—preliminary in the sense that VA will only have identified actions it proposes to take—will culminate with the issuance of a Final CARES Report by the Secretary in, if he is able to adhere to a time line that he has set, December 2003.

The Draft National Plan, among other things, recommends the closing of seven VA health care facilities, and recommends major mission changes at over 30 other VA facilities. The sites slated to be closed are 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 VA sites will still be provided care, but at other nearby sites. In many cases, e.g., in Pittsburgh, new capacity at alternative nearby sites will have to be built before those sites may be closed.

VA proposals to close sites now providing services to veterans will, if they are adopted, affect hundreds of thousands of veterans. Accordingly, section 401 of the Committee bill provides for a 60-day notice and wait period before the VA would be authorized to take such actions. The Committee intends to continue vigorous oversight of the identification of sites where VA proposes to close VA medical facilities under CARES, and the implementation of such proposals.

Sec. 402. Authorization of major construction projects in connection with capital asset realignment initiative

The Draft National Plan proposes to do more than close VA facilities. It also recommends that new major medical facilities be built in Las Vegas, Nevada and East Central Florida. In addition, the CARES Commission has held hearings on proposals to build a replacement hospital in Denver, Colorado. Further, the Draft National Plan anticipates significant infrastructure upgrades at numerous sites including, as noted above, at or near locations where VA proposes to close facilities. Finally, the Draft National Plan suggests that VA open new Community Based Outpatient Clinics (hereinafter, "CBOCs") in over 100 communities not currently served by a VA-operated health care facility.

The Committee supports VA efforts to modernize existing VA facilities, to place major medical facilities in locales where they are needed, and to expand veterans' access to CBOCs so that they might receive care close to their homes and families. And it supports VA's movement toward these objectives with all deliberate speed. At this point, however, the Committee does not authorize specific major construction projects, except those specified in subtitle B of title II of the Committee bill, since VA has not yet finalized its CARES proposals. Yet the Committee does want VA to be able to proceed without inordinate delay once the Secretary issues the Final CARES Report. Accordingly, section 402 of the Committee bill authorizes major construction projects as may be contained in the Secretary's Final CARES Report. That authority, however, would be contingent upon the Secretary submitting to the Congress a report that lists the projects on which VA proposes to expend construction funds under authority of this section. And it would be contingent, further, upon the Secretary specifying projects that conform to the priorities specified in section 402 and described below.

It is likely that the Final CARES Report will identify far more needed construction projects than can be started simultaneously. Thus, once the Final CARES Report is issued, it will still be necessary to prioritize projects. The non-specific authorization specified in section 402—qualified as it is to require VA reporting and VA ranking of projects in accordance with Congressionally-mandated priorities—is intended to assure that VA priorities conform to the Committee's judgment on such matters. The Committee believes VA must proceed first on projects involving the construction or renovation of facilities that the Final CARES Report states are necessary in order to facilitate the closure of existing healthcare sites. For example, VA's Draft National Plan proposes to close the Highland Drive VA Medical Center in Pittsburgh, Pennsylvania. But that facility is currently in use; its closure would require significant construction at two other VA sites in Pittsburgh—at Uni-

versity Drive and in Aspinwall—so that patients served, and care modalities provided, at Highland Drive may be provided at those sites. Similar considerations apply to Draft National Plan proposals at Montrose and Canandaigua, New York; at Leestown, Kentucky; at Livermore, California; and at Waco, Texas. If these Draft recommendations ripen to proposed actions under the Final CARES Report, it would be the Committee's expectation that such projects have first priority to construction funds. Further, if other projects of this nature not included in the Draft National Plan—e.g., a proposed replacement hospital in Denver, Colorado—are specified in the Final CARES Report, the Committee would also expect that those projects have first priority. For it is abundantly clear that many veterans do not believe that CARES will result in the building of new and modern facilities; they believe CARES is only about closing "surplus" hospitals. By listing the completion of replacement or enhancement projects in places in which a major facility is slated for closure as the highest construction priority, the Committee intends to convey the following message to both VA and America's veterans: CARES will modernize and enhance care; it will not cut care.

Second, the Committee is aware that the Draft National Plan recommends that two new tertiary care hospitals (in East Central Florida and in Las Vegas, Nevada) be built. The Committee believes that the construction of such facilities will advance the CARES objective of providing modern medical care in modern 21st Century facilities, close to where the veterans reside. These two sites are among the fastest growing areas of the country. Accordingly, construction at these locations would be accorded a high priority under the standards specified in the Committee bill if, indeed, these sites are identified in the Final CARES Report.

Additionally, the Committee lists the construction of new CBOCs, and projects necessary to make facilities attractive for "enhanced-use leases," as important priorities to which VA should devote post-CARES construction funding.

The non-specific construction authorization contained in section 402—and the Committee's willingness to grant to this Secretary project authority not heretofore delegated—do not signal complete approval by the Committee, or the Congress, of all VA proposals that are identified in the Draft National Plan. Indeed, the Committee anticipates changes in that plan; were that not the case, the Committee would now proceed to authorize the projects recommended by the Draft National Plan that, in the Committee's judgment, have merit. For this year, however, the Committee is willing to afford this Secretary considerable authority subject, as noted, to his adherence to Committee priorities and reporting requirements. The Committee anticipates hearings and informal interactions between VA and Congress to assure full oversight—and opportunity to object—prior to the obligation of funds.

Subtitle B—Extension of Other Authorities

Sec. 411. Three-year extension of housing assistance for homeless veterans

VA currently furnishes assistance to homeless veterans through two major mechanisms: by providing services directly and by as-

sisting community-based not-for-profit entities, and State or local governmental agencies, that furnish services to homeless veterans. One of the legal authorities under which VA provides assistance to community-based and governmental service-providers is scheduled to expire on December 31, 2003. See 38 U.S.C. § 2041(c). Specifically, this expiring provision authorizes VA to enter into agreements with the above-mentioned providers for the sale, lease, or donation of real property acquired by VA as a result of a default of a loan made, insured, or guaranteed by VA. The Committee believes such providers are invaluable in addressing the needs of homeless veterans.

Section 411 of the Committee bill would extend VA authority to enter into such agreements for three additional years to December 31, 2006.

Sec. 412. Four-year extension evaluation of health status of spouses and children of Persian Gulf war veterans

Section 107(b) of the Persian Gulf War Veterans' Benefits Act, title I of Public Law 103–446, directs that VA monitor and study the health status of the spouses and children of Persian Gulf War veterans. It also specifies that VA develop standard protocols and guidelines for providing diagnostic testing of these spouses and children to ensure the uniform development of medical data. Finally, the statute requires that VA enter its study results into a Persian Gulf War Veterans Health Registry. These mandates are scheduled to expire on December 31, 2003.

Section 412 of the Committee bill would extend these mandates for an additional four years, to December 31, 2007.

Subtitle C—Other Matters

Sec. 421. Modification of eligibility of Filipino veterans for health care in the United States

Section 107 of title 38, U.S. Code, specifies that World War II service by Filipinos in the organized military forces of the Commonwealth of the Philippines (the so-called Philippine Commonwealth Army) shall be considered to be active service in U.S. forces for purposes of eligibility for veterans benefits, but only as provided by law. Similarly, that statute specifies that service as a so-called new Philippine Scout will be considered to be active service in U.S. forces for purposes of veterans benefits, but only as specified by law.

Under section 1734 of title 38, U.S. Code, Commonwealth Army veterans who are citizens or lawful residents of the United States are eligible to receive VA medical care benefits, but only if the Commonwealth Army veteran in question is disabled and receiving compensation benefits under chapter 11 of title 38, U.S. Code (as limited by section 107). Similarly, New Philippine Scouts who are disabled and receiving compensation benefits under chapter 11 (as limited by section 107) and who are citizens or lawful residents of the United States are eligible to receive VA medical care benefits, but they may only be provided treatment for their service-connected disabilities.

By letter dated May 12, 2003, VA Secretary Anthony J. Principi proposed legislation (S. 1213) on behalf of the Administration to modify the above-summarized limitations, stating as follows:

> The proposal would extend to new Philippine Scouts who reside legally in the United States the same eligibility for medical care * * * that currently exists for Commonwealth Army veterans, while eliminating the receipt-of-compensation requirement for these veterans and scouts.

Section 421 of the Committee bill would extend to new Philippine Scouts who reside legally in the United States the same eligibility for medical care services, including care for non-service-connected disabilities, that are currently afforded to Commonwealth Army veterans. And it would eliminate for both groups of Filipino veterans the requirement that they be receiving compensation in order to be eligible for VA-provided medical care services.

Sec. 422. Repeal of limits on terms of certain officials in the Office of the Under Secretary for Health

Under current law, the Office of the VA Under Secretary for Health shall include a number of positions subordinate to the Under Secretary including a Deputy Under Secretary, an Associate Deputy Under Secretary, several Assistant Deputy Under Secretaries and Directors of various enumerated clinical services, e.g., Dental Services, Nursing Services, Podiatric Services, etc. By statute, the appointees to these subordinate positions are appointed for four year terms, and they may be removed from such positions only for cause. See 38 U.S.C. § 7306(d). This is true whether the incumbent Under Secretary who appointed them "turns over" or not.

The clinicians appointed to these key positions are directly responsible to the Under Secretary. In the view of the Committee, the Under Secretary must have a positive working relationship with these professionals, and the Under Secretary must personally value their respective judgments. A statutory mandate that, in effect, requires the Under Secretary to retain his or her predecessor's staff is, in the judgment of the Committee, contrary to these purposes. Further, it interferes more than the Committee deems necessary or advisable with the prerogative of a very senior VA official to assemble the team of advisors that he or she believes will best assist in the execution of his or her responsibilities. Accordingly, section 422 of the Committee bill eliminates the terms for appointments to positions in the Office of the Under Secretary for Health. The Committee stresses that it is not of the view that a newly-appointed Under Secretary must—or should—replace all incumbents of such positions. To the contrary, the interests of the Under Secretary, and veterans, are generally served by maintaining continuity at senior management levels.

COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (hereinafter, "CBO"), estimates that enactment of the Committee bill would increase direct spending for veterans programs by $4 million in 2004, $28 million over the 2004–2008 period, and $62 million over the 2004–2013 period.

In addition, CBO estimates that enactment of the Committee bill would increase direct spending outlays by $71 million in 2004, and $51 million over the 2004–2008 period, assuming appropriation of the estimated amounts. Enactment of the Committee bill would not affect the budgets of state, local, or tribal governments.

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

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 27, 2003.

Hon. ARLEN SPECTER,
Chairman, Committee on Veterans' Affairs
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) has prepared the enclosed cost estimate for S. 1156, the Veterans' Health Care Authorities Extension and Improvement Act of 2003.

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

Sincerely,

DOUGLAS HOLTZ-EAKIN,
Director.

Enclosure.

Veterans Health Care Authorities Extension and Improvement Act of 2003

Summary: S. 1156 would extend an authorization that the Department of Veterans Affairs (VA) provide nursing home care to certain veterans. In addition, the bill would:

- Affect annuities for certain part-time employees of VA,
- Provide new health care benefits to some Filipino veterans,
- Require that VA provide more mental health care to veterans than it currently does,
- Establish a pilot program to provide assisted living services to veterans,
- Authorize appropriations for major construction,
- Create and authorize appropriations for a new fund to pay for the demolition and removal of obsolete, dilapidated and hazardous structures on VA property,
- Change the names of four health care facilities operated by VA, and
- Authorize VA to lease three medical facilities.

CBO estimates that enacting this bill would increase direct spending by $4 million in 2004, $28 million over the 2004–2008 period, and $62 million over the 2004–2013 period. Additionally, S. 1156 would modify provisions governing discretionary spending for veterans' health care and construction programs, which CBO estimates would result in outlays of $71 million in 2004 and $451 million over the 2004–2008 period, assuming appropriation of the estimated amounts.

S. 1156 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 1156 is shown in Table 1. The costs of this legislation fall within budget functions 600 (income security) and 700 (veterans benefits and services).

TABLE 1.—ESTIMATED BUDGETARY IMPACT OF S. 1156

[By fiscal year, in millions of dollars]

	2004	2005	2006	2007	2008
CHANGES IN DIRECT SPENDING					
Estimated Budget Authority	4	6	6	6	6
Estimated Outlays	4	6	6	6	6
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Estimated Authorization Level	135	100	101	64	61
Estimated Outlays	71	114	120	80	66

Basis of estimate: This estimate assumes that S. 1156 will be enacted by the end of calendar year 2003 and that the necessary amounts for implementing the bill will be appropriated for each year.

Direct spending

The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (Public Law 107–135), enacted on January 23, 2002, made changes to the way retirement benefits are determined for federal retirees who performed part-time service as registered nurses, physician's assistants, and certain dental technicians at VA prior to April 7, 1986, and retired on or after the enactment date of that legislation. That legislation treated pre-April 7, 1986, part-time service as full-time service for the purposes of calculating retirement annuities.

S. 1156 would extend these changes to the types of workers covered by Public Law 107–135, but who retired between April 6, 1986, and January 23, 2002, by treating their pre-April 7, 1986, part-time service as full-time service for the purpose of calculating retirement annuities. Retirement benefits for these workers currently are set according to a formula that prorates all part-time service performed in these positions. For most other federal workers, including those covered by Public Law 107–135, part-time service performed prior to April 7, 1986, is treated as full-time service when calculating retirement annuities. In most cases, the changes result in higher retirement benefits.

Information about retirees who would be covered by S. 1156 is limited, but based on data provided by the Office of Personnel Management, CBO estimates that about 1,500 current retirees would have their benefits increased by the bill. CBO estimates that the new formula would increase benefits for affected retirees by 13 percent to 22 percent, depending on how much part-time service was performed prior to April 7, 1986. As a result, CBO estimates that enacting S. 1156 would increase direct spending by $4 million in 2004, $28 million over the 2004–2008 period, and $62 million over the 2004–2013 period (see Table 2).

TABLE 2.—ESTIMATED CHANGES IN DIRECT SPENDING UNDER S. 1156

[By fiscal year, in millions of dollars]

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
CHANGES IN DIRECT SPENDING										
Estimated Budget Authority	4	6	6	6	6	6	7	7	7	7
Estimated Outlays	4	6	6	6	6	6	7	7	7	7

Spending Subject to Appropriation

As shown in Table 3, CBO estimates that implementing S. 1156 would increase discretionary spending for veterans' health care programs and major construction by $71 million in 2004 and $451 million over the 2004–2008 period, assuming that appropriations are provided in the authorized and estimated amounts. Individual provisions that would affect discretionary spending are described below.

Veterans Medical Care. Federal spending for all veterans medical care totals more than $25 billion a year. Several sections of the bill would affect medical care for veterans. In total, CBO estimates that implementing these provisions would cost $64 million in 2004 and $370 million over the 2004–2008 period.

TABLE 3.—ESTIMATED SPENDING SUBJECT TO APPROPRIATION FOR S. 1156

[By fiscal year, in millions of dollars]

	2003	2004	2005	2006	2007	2008
VETERANS MEDICAL CARE						
Baseline Spending Under Current Law:						
Estimated Authorization Level [1]	25,279	26,153	26,987	27,890	28,824	29,452
Estimated Outlays	25,677	26,179	26,783	27,655	28,583	29,271
Proposed Changes:						
Estimated Authorization Level	0	71	95	96	59	56
Estimated Outlays	0	64	93	96	61	56
Spending Under S. 1156:						
Estimated Authorization Level	25,279	26,224	27,082	27,986	28,883	29,508
Estimated Outlays	25,677	26,243	26,876	27,751	28,644	29,327
CONSTRUCTION AND LEASING						
Spending Under Current Law:						
Estimated Authorization Level [1]	99	101	103	105	107	110
Estimated Outlays	174	155	130	112	106	105
Proposed Changes:						
Estimated Authorization Level	0	64	5	5	5	5
Estimated Outlays	0	7	21	24	19	10
Spending Under S. 1156:						
Estimated Authorization Level	99	165	108	110	112	115
Estimated Outlays	174	162	151	136	125	115
SUMMARY OF CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	0	135	100	101	64	61
Estimated Outlays	0	71	114	120	80	66

[1] The 2003 level is the estimated net amount appropriated for that year. No full-year appropriation has yet been provided for fiscal year 2004. The current-law amounts for the 2004–2008 period assume that appropriations remain at the 2003 level with adjustments for anticipated inflation.

Long-Term Care. Section 101 would extend a requirement in current law that VA provide nursing home care to veterans that have a disability rating of 70 percent or greater. Under current law, this requirement expires on December 31, 2003. This provision would extend the requirement through December 31, 2008. According to VA, the department currently spends more than $2 billion for nurs-

ing home care. VA provided nursing home care to veterans with disability ratings of 70 percent or greater before the requirement in current law was enacted. According to VA, since enactment of this requirement in 1999, the number of veterans with disability ratings of 70 percent or greater receiving nursing home care from VA increased from about 1,800 to 2,300 at a cost of about $56 million in 2002. CBO assumes that 75 percent of that increase resulted from the current requirement to provide such care. Adjusting for inflation, CBO estimates that extending this requirement would cost $34 million in 2004, and $254 million over the 2004–2008 period, assuming appropriation of the estimated amounts. Costs are slightly lower in 2004 because the extension would only affect the last nine months of fiscal year 2004.

Mental Health Programs. Section 104 would require VA to spend an additional $25 million a year on mental health care over the 2004–2006 period, above the level spent in 2003 ($583 million). Under current law, VA is required to spend $15 million more each year than what they otherwise would have spent on post-traumatic stress disorder and substance use disorders; there is no expiration date associated with this requirement. Under section 104, VA would be required to spend $25 million more than specified under current law over the 2004–2006 period, but would then not be required to spend any additional amounts after 2006. Thus, CBO estimates that implementing this section would cost $23 million in 2004, cost $73 million over the 2004–2006 period, and save $27 million over the 2007–2008 period, assuming appropriation of the required amounts.

Health Care for Filipino Veterans. Under current law, only certain Filipino veterans who served during World War II are eligible for health care benefits from VA. Under section 421 of the bill, any individual who is a veteran of the Philippine Commonwealth Army or a former New Philippine Scout living legally in the United States would be eligible for health care benefits provided by VA. Using information from VA, CBO estimates that in 2004 about 9,500 Filipino veterans would qualify for this new benefit and that they would be classified as Category 5 veterans, based on income and other factors. Based on average enrollment and use rates for Category 5 veterans, CBO estimates that about 35 percent of these veterans would use VA health care benefits in 2004 at an estimated cost of $5,100 per person. After adjusting for mortality, CBO expects that the number of eligible Filipino veterans using VA health care benefits would grow to 2,900 in 2005 as more of these veterans become aware of the benefit, and then gradually decline to about 1,900 by 2008. Accordingly, CBO estimates that implementing this section would cost $7 million in 2004 and $61 million over the 2004–2008 period, assuming appropriation of the estimated amounts.

Assisted Living Pilot Program. Section 103 would allow VA to establish another pilot program to help veterans obtain assisted living services for a period of three years. VA currently administers one pilot program to provide these services and, according to VA, expects to spend a total of about $9 million for this program. Assuming that costs for the new program are similar, CBO estimates that implementing this section would cost less than $500,000 in 2004 and $9 million over the 2004–2008 period.

Construction and Leasing. S. 1156 contains several sections that would authorize appropriations for major construction projects, the leasing of facilities in three cities, and establish a new fund that would pay for the demolition and removal of obsolete, dilapidated and hazardous structures on VA property. CBO estimates that implementing these sections would cost $7 million in 2004 and $81 million over the 2004–2008 period, assuming appropriation of the authorized amounts.

Section 213 would authorize the appropriation of $34.5 million for the construction of two long-term care facilities. The long-term care facilities would be located in Lebanon, Pennsylvania, and Beckley, West Virginia. Section 201 would create the Department of Veterans Affairs Facilities Demolition Fund for the purpose of removing obsolete, dilapidated, and hazardous buildings and structures on VA property and would authorize the appropriation of $25 million in 2004 to be deposited into that fund. CBO estimates that implementing these two sections would cost $3 million in 2004 and $57 million over the 2004–2008 period, assuming appropriation of the authorized amounts.

Section 213 also would authorize VA to lease three medical facilities for lease payments that together could not exceed $5 million a year. The three medical facilities would be located in Denver, Colorado; Pensacola, Florida; and Boston, Massachusetts. While the bill does not specify the length of the leases, according to VA, it expects to lease these facilities for up to 20 years. The actual length of each lease will depend on the results of an ongoing process that VA is using to determine its future construction and leasing needs. Based on information from VA, CBO believes these leases would meet the criteria for an operating lease. CBO estimates that implementing these leases would cost $4 million in 2004 and $24 million over the 2004–2008 period, assuming appropriation of the authorized amounts.

S. 1156 also would raise the threshold for projects to be financed out of the appropriation for construction of major medical facilities from $4 million to $9 million. (Thus, under the bill, projects costing up to $9 million would be considered minor construction.)

Naming Provisions. S. 1156 also contains four provisions that would change the names of health care facilities operated by VA. Section 221 would name the VA outpatient clinic in Horsham, Pennsylvania, as the "Victor J. Saracini Department of Veterans Affairs Outpatient Clinic." Section 222 would name the VA health care facility located at 820 South Damen Avenue in Chicago, Illinois, as the "Jesse Brown Department of Veterans Affairs Medical Center." Section 223 would name the VA Medical Center in Houston, Texas, as the "Michael E. DeBakey Department of Veterans Affairs Medical Center." Finally, section 224 would name the VA medical center in Minneapolis, Minnesota, as the "Paul Wellstone Department of Veterans Affairs Medical Center." All four sections would require that any reference to such medical center or outpatient clinic in any law, regulation, map, document, record, or other paper of the United States be considered to be a reference to the medical center or clinic by the new name. CBO estimates that implementing those provisions would have a negligible cost, subject to the availability of appropriated funds.

Intergovernmental and private-sector impact: S. 1156 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Previous CBO estimates: On June 30, 2003, CBO transmitted a cost estimate of H.R. 2357, the Veterans Health Care Improvement Act of 2003, as ordered reported by the House Committee on Veterans' Affairs on June 26, 2003. Section 2 of H.R. 2357, which would authorize the provision of health care to certain Filipino veterans, is similar to section 421 of S. 1156 and CBO's estimated cost is the same for both provisions.

On May 13, 2003, CBO transmitted a cost estimate of H.R. 1908, a bill to name the health care facility of the Department of Veterans Affairs located at 820 South Damen Avenue in Chicago, Illinois, as the "Jesse Brown Department of Veterans Affairs Medical Center," as introduced on May 1, 2003. On May 19, 2003, CBO also transmitted an estimate of H.R. 1562, the Veterans Health Care Cost Recovery Act of 2003, as ordered reported by the House Committee on Veterans' Affairs on May 15, 2003. H.R. 1908 and section 4 in H.R. 1562 are both the same as section 222 in S. 1156.

Estimate prepared by: Federal Costs: Sam Papenfuss and Geoffrey Gerhardt. Impact on State, Local, and Tribal Governments: Melissa Merrell. Impact on the Private Sector: Daniel G. Frisk.

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

REGULATORY IMPACT STATEMENT

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

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at its September 30, 2003, meeting. On that date, the Committee, by unanimous voice vote, ordered H.R. 1156, a bill to amend title 38, United States Code, to improve and enhance the provision of long-term health care to veterans by the Department of Veterans Affairs, to enhance and improve authorities relating to the Administration of personnel of the Department of Veterans Affairs, and for other purposes, as amended, reported favorably to the Senate.

AGENCY REPORT

On July 29, 2003, VA General Counsel, the Honorable Tim S. McClain, appeared before the Committee on Veterans' Affairs and submitted testimony on, among other things, S. 615, S. 1144, S. 1156, S. 1213, S. 1283, and S. 1289. Excerpts from this statement are reprinted below:

STATEMENT OF TIM S. MCCLAIN, GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS

Good afternoon Mr. Chairman and Members of the Committee. I am pleased to be here to present the Administration's views on six bills that pertain primarily to the veterans health-care system.

S. 1156

Mr. Chairman, I will begin by addressing S. 1156, your omnibus health-care bill. It includes provisions pertaining to long-term health care in VA, personnel matters, authorization for construction of two major medical facilities, and permanent authorization of the Veterans Benefits Administration to obtain disability examinations on a contract basis.

Long-term care provisions

In 1999, the Congress made significant changes in our long-term-care programs through enactment of what we commonly refer to as "The Millennium Act." Among other things, that law directed that VA "shall" furnish nursing home care to any veteran needing such care for a service-connected disability and to any veteran with a service-connected disability rated at least 70 percent. It also directed that VA include various non-institutional extended care services in the medical benefits package. At the time of enactment, the impact both provisions would have on VA was uncertain, and Congress chose to limit their applicability to the four-year period ending December 31st of this year. Section 101 of your bill would extend the provisions for an additional five years through December 31, 2008. That section would also extend the requirement that we furnish needed nursing home care to all veterans with service-connected disabilities rated 50 or 60 percent.

The Department's view is that it would be premature at this time to extend the two Millennium Act provisions for five years. As you know, we provided the Congress with a report on implementation of the Millennium Act in March. We are continuing to gather information and will provide the Congress with an additional report later this year. That report, and other actuarial analyses, will provide data that will aid VHA leaders and Congressional policymakers in determining appropriate longer-term directions for development of VA long-term care services. Accordingly, we recommend only a one-year extension at this time.

We are also concerned about extending so-called "mandatory" nursing home eligibility to all veterans with service-connected disabilities rated at least 50 percent. We estimate that the change from 70 percent to 50 percent would cost $2.5 billion over 5 years and has not been planned for in the budget process. As a result, the provision could have serious unintended consequences including slowing the rate of growth of non-institutional long-term

care services and reducing the availability of services for non-mandatory categories of veterans because of competing priorities for limited resources. We recommend that the Committee defer any such change in law until further data about VA's experience under the Millennium Act are available to better inform its decision. We also believe State homes should be included in the options available to these severely disabled service-connected veterans. State-home care should be made available to these veterans without out-of-pocket cost. We would like to work with the Committee to develop the necessary legislation.

Section 102 of your bill would amend existing law to clarify that we have authority to provide veterans with nursing home care and adult day health care in private community nursing homes and other facilities using agreements for reimbursement similar to those used under the Medicare Program. That approach would differ from our current practice of providing such care only through actual contracts with the nursing homes or providers of adult day health care. To implement the authority, the Department would have to promulgate regulations to establish a program to directly reimburse the community facilities on behalf of veterans for the care furnished. The regulations would include all of the parameters for the program, including amounts VA would pay for various types of care, and the standards that facilities would have to meet to receive VA reimbursement. In many respects, the parameters for the program could mirror those now used in the Medicare Program. We do not object to section 102 as an alternative approach to assist us in meeting the needs of veterans for nursing home care and adult day health care in non-Department facilities.

Construction authorization

Section 201 of the bill would authorize construction of a long-term care facility in Lebanon, Pennsylvania, in an amount not exceeding $14,500,000 and a long-term care facility in Beckley, West Virginia, in an amount not to exceed $20,000,000. We would point out that the cost for the project in Beckley is now estimated to be $20,800,000. We generally support these projects in concept and we will be considering them in the context of future budget preparations.

Mr. Chairman, the President's fiscal year 2004 budget included a request for authorization for a major construction project at Chicago (West Side), Illinois for a new inpatient tower; outpatient clinic leases in Boston, Massachusetts and Pensacola, Florida; and a lease for the Health Administration Center in Denver, Colorado. In addition we requested an authorization for an outpatient lease in Charlotte, North Carolina that received an appropriation in FY 2002. We ask that you act favorably on those requests, as well as those seismic projects that were listed in the President's FY 2003 budget. The facilities at Palo Alto, San Francisco, and West Los Angeles remain as a

critical risk to the safety of patients and staff in the case of seismic events and those projects remain a high priority for the Department. We are confident that the CARES studies will validate the continued need for these major facilities. In addition, we request authorization for a health care facility in Las Vegas to replace the existing clinic that we were required to vacate on July 1st because of structural inadequacies in the building. It is important that the Department be provided this authorization so we will be able to move forward next year.

Personnel provisions

S. 1156 also contains four separate sections that address personnel matters. The first provision, section 301, would amend existing law to add a significant number of mission-critical, scarce, skilled health care positions, such as dietitians, medical technologists, and medical records administrators/specialists to the current list of title-38 hybrid positions. We support the goals of increased flexibility in staffing these positions because of today's fierce competition for qualified candidates (particularly those who possess skills acquired in primary care settings), market-wide shortages in these health care occupations, and VA's aging health care work force. We are currently considering a similar proposal to increase flexibility in staffing these positions, and the Office of Personnel Management recently issued interim final regulations greatly expanding availability of direct hire authority for critical need or shortage situations. We are examining whether or not we need legislation given these brand new regulations, and will work with Congress to reconcile if we do.

In the past, we have not been able to quickly and efficiently recruit candidates. Our inability to consistently make timely job offers is a chief reason why the Department is experiencing hiring difficulties. These difficulties can adversely affect access to care for many of our veterans. Second, the delays cause many qualified candidates to forego consideration of VA employment. With multiple job opportunities in hand, they turn to the private sector where the hiring process is more responsive.

Section 302 of the bill would amend the law establishing the Veterans Canteen Service (VCS) to permit persons employed by VCS to be considered for competitive service appointments in the Department in the same manner that Department employees in the competitive service are considered for transfers to competitive service positions. Currently, VCS Management Program employees may be appointed to positions in the competitive service under an interchange agreement between the Department and the Office of Personnel Management (OPM). Section 302 would authorize a similar interchange agreement for non-managerial VCS employees. It would authorize all VCS employees to transfer into a competitive service position. Time served in the Canteen Service would count toward the 3-year service requirement for career civil service status.

The Administration does not support section 302 because it believes that establishing eligibility for the non-competitive conversions of VCS hourly employees into competitive service positions would provide an unfair advantage over excepted service employees from other Departments and agencies seeking appointment to competitive service positions at VA.

Section 303 of the bill would retroactively apply recently legislated changes to the method of computing retirement annuities for certain VA health-care personnel who are already retired. The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 prospectively changed the way part-time service performed before April 7, 1986, by certain VA health-care personnel is credited for annuity purposes. Section 303 would extend this change to individuals who retired before the effective date of enactment. Traditionally, retirement benefit changes have been applicable only to individuals retiring after enactment of the change. This change would recreate a very expensive precedent for government-wide application of the principle of retroactivity in retirement cases involving part-time service. Consequently, the Administration strongly opposes this provision, as it would impact retirement fund outlays and have a PAYGO cost not contemplated in the President's Budget

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S. 1213

S. 1213, a bill entitled the "Filipino Veterans" Benefits Act of 2003," is the Administration's bill that you introduced on our behalf. I want to express my sincere appreciation to you for introducing the measure. As you know, section 2 of the bill would extend health care benefits to Filipino veterans residing legally in the United States who served in the Commonwealth Army and new Philippine Scouts. I urge that you act on the bill as expeditiously as possible so we can meet the needs of these very deserving Filipino veterans.

S. 615, S. 1289 AND S. 1144

S. 615 would designate the outpatient clinic located in Horsham, Pennsylvania, as the "Victor J. Saracini Department of Veterans Affairs Outpatient Clinic". S. 1289 would designate the Minneapolis VA Medical Center as the Paul Wellstone Department of Veterans Affairs Medical Center. S. 1144 would designate the facility in Chicago now known as the West Side VA Medical Center as the "Jesse Brown Department of Veterans Affairs Medical Center". While we ordinarily defer to the views of Congress on the naming of Federal properties, in the case of former Senator Wellstone and former Secretary Jesse Brown we make an exception. Enactment of S. 1144 and S. 1289 would be an altogether fitting tribute to these two truly courageous and steadfast advocates for America's veterans.

S. 1283

S. 1283 would impose new Congressional notice-and-wait requirements on VA before we could take any action to implement our Capital Asset Realignment for Enhances Services (CARES) decisions. The bill would prohibit VA from taking a proposed action for 60 days following submission of advance written notice of the action to Congress, or before 30 days during a continuous session of Congress.

Mr. Chairman, we must object to enactment of this bill. As drafted, the bill is overly broad, unnecessary, and would significantly impede our completion of the CARES process. By stating that VA must provide prior notice of "any action," apparently including even minor actions, the measure would effectively prevent completing the CARES process in anything like a timely manner. I can assure you we will provide Congress and this Committee with our CARES plan well in advance of undertaking significant actions to implement it. Congress will have considerable lead-time to consider our proposed actions before they are undertaken.

I would also point out that we are already subject to various existing notice-and-wait requirements that serve the same purpose as that intended by this legislation. We currently provide such advance notice under section 510 of title 38 whenever we undertake a significant reorganization of any office or facility. Congress must also approve in advance any significant construction project, and we provide Congress with advance notice of any proposed enhanced-use leases. The additional requirements this bill would impose are therefore unnecessary.

* * * * *

That concludes my prepared statement. I would be pleased to answer any questions you may have.

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

In compliance with paragraph 12 of Rule XXVI of the Standing Rules of the Senate, changes in existing law made by the Committee bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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§ 1701. Definitions

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(1) * * *

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(10) (A) During the period beginning on November 30, 1999, and ending on [December 31, 2003] *December 31, 2008*, the term "medical services" includes noninstitutional extended care services.

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§ 1710A. Required nursing home care

(a) * * *

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

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§ 1720. Transfers for nursing home care; adult day health care

(a) * * *

* * * * * * *

(c) *(1) In furnishing nursing home care, adult day health care, or other extended care services under this section, the Secretary may enter into agreements for furnishing such care or services utilizing such authorities relating to agreements for the provision of services under section 1866 of the Social Security Act (42 U.S.C. 1395cc) as the Secretary considers appropriate.*

(2) In applying the provisions of section 2(b)(1) of the Service Contract Act of 1965 (41 U.S.C. 351(b)(1)) with respect to any contract entered into under this section to provide nursing home care of veterans, the payment of wages not less than those specified in section 6(b) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(b)) shall be deemed to constitute compliance with such provisions.

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(f)(1) * * *

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(B) The Secretary may provide in-kind assistance (through the services of Department employees and the sharing of other Department resources) to a facility furnishing care to veterans under subparagraph (A) of this paragraph. Any such in-kind assistance shall be provided under a contract *or agreement* between the Secretary and the facility concerned. The Secretary may provide such assistance only for use solely in the furnishing of adult day health care and only if, under such contract *or agreement*, the Department receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds allotted to the Department facility that provided the assistance.

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§ 1734. Hospital and nursing home care and medical services in the United States

(a) The Secretary *shall*, within the limits of Department facilities, **[**may**]** furnish hospital and nursing home care and medical services to **[**Commonwealth Army veterans and new Philippine Scouts for the treatment of the service-connected disabilities of such veterans and scouts.**]** *an individual described in subsection (b) in the same manner as provided for under section 1710 of this title*.

(b) An individual **[**who is in receipt of benefits under subchapter II or IV of chapter 11 of this title [38 USCS §§ 1110 et seq. or 1131 et seq.] paid by reason of service**]** described in **[**section 107(a) of this title**]** *this subsection is any individual* who is residing in the United States and **[**who**]** is a citizen of, or an alien lawfully admitted for permanent residence in, the United States **[**shall be eligible for hospital and nursing home care and medical services in the same manner as a veteran, and the disease or disability for which such benefits are paid shall be considered to be a service-connected disability for purposes of this chapter [38 USCS §§ 1701 et seq.].**]** *as follows:*

(1) A Commonwealth Army veteran

(2) A new Philippine Scout.

* * * * * * *

§ 2041. Housing assistance for homeless veterans

(a) * * *

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(c) The Secretary may not enter into agreements under subsection (a) after **[**December 31, 2003**]** *December 31, 2006*.

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§ 7306. Office of the Under Secretary for Health

(a) * * *

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[(d)—Except as provided in subsection (e)—

[(1) any appointment under this section shall be for a period of four years, with reappointment permissible for successive like periods,

[(2) any such appointment or reappointment may be extended by the Secretary for a period not in excess of three years, and

[(3) any person so appointed or reappointed or whose appointment or reappointment is extended shall be subject to removal by the Secretary for cause.**]**

[(e)**]**(*d*)(1) The Secretary may designate a member of the Chaplain Service of the Department as Director, Chaplain Service, for a period of two years, subject to removal by the Secretary for cause. Redesignation under this subsection may be made for successive like periods or for any period not exceeding two years.

(2) A person designated as Director, Chaplain Service, shall at the end of such person's period of service as Director revert to the position, grade, and status which such person held immediately be-

fore being designated Director, Chaplain Service, and all service as Director, Chaplain Service, shall be creditable as service in the former position.

[(f)](*e*) In organizing the Office and appointing persons to positions in the Office, the Under Secretary shall ensure that—

(1) the Office is staffed so as to provide the Under Secretary, through a designated clinician in the appropriate discipline in each instance, with expertise and direct policy guidance on—

(A) unique programs operated by the Administration to provide for the specialized treatment and rehabilitation of disabled veterans (including blind rehabilitation, care of spinal cord dysfunction, mental illness, and long-term care); and

(B) the programs established under section 1712A of this title; and

(2) with respect to the programs established under section 1712A of this title, a clinician with appropriate expertise in those programs is responsible to the Under Secretary for the management of those programs.

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§ 7401. Appointments in Veterans Health Administration

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(1) * * *

(2) [Psychologists (other than those described in paragraph (3)), dietitians,] *Dietitians,* and other scientific and professional personnel, such as microbiologists, chemists, biostatisticians, and medical and dental technologists.

(3) Clinical or counseling psychologists who hold diplomas as diplomates in psychology from an accrediting authority approved by the Secretary, *other psychologists,* certified or registered respiratory therapists, licensed physical therapists, licensed practical or vocational nurses, pharmacists, [and] occupational therapists, *kinesiologists, and social workers.*

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§ 7802. Duties of Secretary with respect to Service

The Secretary shall—

(1) * * *

* * * * * * *

(5) employ such persons as are necessary for the establishment, maintenance, and operation of the Service, and pay the salaries, wages, and expenses of all such employees from the funds of the Service. Personnel necessary for the transaction of the business of the Service at canteens, warehouses, and storage depots shall be appointed, compensated from funds of the Service, and removed by the Secretary without regard to the provisions of title 5 governing appointments in the competitive service and chapter 51, and subchapter III of chapter 53 of title 5 [5 USCS §§ 5101 et seq., 5331 et seq.]. Those employees are subject to the provisions of title 5 relating to a preference eligible described in section 2108(3) of title 5, subchapter I of chapter 81 of title 5 [5 USCS §§ 8101 et seq.], and subchapter III

of chapter 83 of title 5 [5 USCS §§ 8331 et seq.]. *Employees and personnel under this clause may be considered for appointment in Department positions in the competitive service in the same manner that Department employees in the competitive service are considered for transfer to such positions. An employee or individual appointed as personnel under this clause who is appointed to a Department position under the authority of the preceding sentence shall be treated as having a career appointment in such position once such employee or individual meets the three-year requirement for career tenure (with any previous period of employment or appointment in the Service being counted toward satisfaction of such requirement);*

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§ 8104. Congressional approval of certain medical facility acquisitions

(a)(1) * * *

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(3) For the purpose of this subsection:

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

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VETERANS MILLENNIUM HEALTH CARE AND BENEFITS ACT

SEC. 103. PILOT PROGRAM RELATING TO ASSISTED LIVING

(a) * * *

(b) **[**LOCATION**]** *LOCATIONS* OF PILOT PROGRAM.—

(1) The pilot program shall be carried out in a designated health care region of the Department selected by the Secretary for purposes of this section.

(2)(A) In the addition to the health care region of the Department selected for the pilot program under paragraph (1), the Secretary may also carry out the pilot program in not more than one additional designated health care region of the Department selected by the Secretary for purposes of this section.

(B) Notwithstanding subsection (f), the authority of the Secretary to provide services under the pilot program in a health care region of the Department selected under subparagraph (A) shall cease on the date that is three years after the commencement of the provision of services under the pilot program in the health care region.

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SEC. 116. SPECIALIZED MENTAL HEALTH SERVICES

(a) * * *

* * * * * * *

(c) FUNDING.—

(1) In carrying out the program described in subsection (a), the Secretary shall identify, from funds available to the Department for medical care, an amount of not less than [$15,000,000] *$25,000,000 in each of fiscal years 2004, 2005, and 2006* to be available to carry out the program and to be allocated to facilities of the Department pursuant to subsection (d).

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

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

(B) For purposes of this paragraph, in fiscal years 2004, 2005, and 2006, the fiscal year utilized to determine the baseline amount shall be fiscal year 2003.

(d) Allocation of funds to Department facilities. [The Secretary] *(1) In each of fiscal years 2004, 2005, and 2006, the Secretary* shall allocate funds identified pursuant to subsection (c)(1) to individual medical facilities of the Department as the Secretary determines appropriate based upon proposals submitted by those facilities for the use of those funds for improvements to specialized mental health services.

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

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

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

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

(3) The Secretary shall provide that the funds to be allocated under this section during each of fiscal years 2004, 2005, and 2006 are funds for a special purpose program for which funds are not allocated through the Veterans Equitable Resource Allocation system.

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PERSIAN GULF WAR VETERANS' BENEFIT ACT

TITLE I—PERSIAN GULF WAR VETERANS

SEC. 107. EVALUATION OF HEALTH STATUS OF SPOUSES AND CHILDREN OF PERSIAN GULF WAR VETERANS.

(a) * * *

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(b) DURATION OF PROGRAM. The program shall be carried out during the period beginning on November 1, 1994, and ending on [December 31, 2003] *December 31, 2007*.

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