Order Code RL32961

Veterans' Health Care Issues in the 109th Congress

Updated February 7, 2006

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Summary

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

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

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

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

Several veterans health care-related bills were introduced and passed by either the House or Senate during the first session of this Congress. At present, these bills are pending action in the other chamber. It is likely that some of these measures will be enacted into law during the second session.

This report will be updated as events warrant.

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Background

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

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

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

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

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

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

To provide some context to veterans' health care issues, this report will first provide a brief history of the Veterans Health Administration (VHA).[4] Second, it will provide a brief overview of the evolution of eligibility for VA health care. Third, it will discuss major issues facing veterans' health care programs during the 109th Congress, and fourth, it will provide a summary of major veterans health care-related legislation that has been reported to or passed by either the House or the Senate during the first session.[5]

Veterans Health Administration (VHA)

History. VA's largest and most visible operating unit is the Veterans Health Administration (VHA). Established in 1946 as the Department of Medicine and Surgery, it was succeeded in 1989 by the Veterans Health Services and Research Administration, and renamed the Veterans Health Administration (VHA) in 1991.[6] The veterans' medical system was first developed to provide needed care to veterans injured or sick as a result of service during wartime. When there was excess capacity in VA hospitals, Congress gave wartime veterans without service-connected conditions access to VA hospitals, provided space was available and the veterans signed an oath indicating they were unable to pay for their care.[7] At the end of World War II, the federal government undertook the task of increasing the number of VA medical facilities to meet the expected demand for health care for veterans returning with injuries or illnesses sustained during hostilities. The primary focus of the

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

[4] This report will use VA and VHA interchangeably to describe the Veterans Health Administration.

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

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

[7] World War Veterans Act of 1924 (P.L. 68-242).

expansion was to immediately tend to the medical needs of returning combatants for acute care and then to address the long-term rehabilitation needs of more seriously injured veterans. Within a few years after the cessation of hostilities, the initial demand for acute care services for service-connected conditions diminished and VA initiated what was later to become its specialized services mission, in part because services such as spinal cord injury care, blind rehabilitation, and prosthetics were almost non-existent in the private medical market during the late 1940s.

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

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

Today, VA operates the nation's largest integrated health care system. VHA is divided into 21 Veterans Integrated Service Networks (VISNs, see **Appendix 1** for a map of VISNs). Each network includes a management office responsible for making basic budgetary, planning and operating decisions. Each office oversees between 5 and 11 hospitals as well as community- based outpatient clinics (CBOCs), nursing homes and readjustment counseling centers (Vet Centers) located within each VISN. In FY2005, VA operated 157 hospitals, 750 CBOCs, 134 nursing homes and 42 domiciliary care facilities.[8,9]

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

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

Unlike other federal health programs (such as Medicaid and Medicare), the VA is a direct service provider rather than a health insurer or payer for health care services. VHA offers a standardized medical benefits package that includes a full range of outpatient and inpatient services with an emphasis on preventive and primary care. As defined in regulations, VA medical benefits include among other things, preventive services, including immunizations, screening tests, and health education and training classes, primary health care diagnosis and treatment, prescription drugs, comprehensive rehabilitative services, mental health services including professional counseling, home health care, respite (inpatient), hospice, and palliative care, and emergency care.[10] Some veterans are also eligible to receive long-term care including nursing home care, domiciliary care, adult day care, and limited dental care.

In FY2005, there were 7.7 million enrolled veterans, and 4.8 million unique veteran patients received care from VA.[11] That same fiscal year, VA treated 768,651 inpatients, 89,961 veterans in nursing home care units or in community nursing home facilities, and 30,118 veterans in home and community-based facilities. The VHA's outpatient clinics registered more than 52 million visits by veterans in FY2005.[12]

In addition to providing direct health care to veterans, since 1946 VA has been authorized to enter into agreements with medical schools and their teaching hospitals. Under these agreements, VA hospitals provide training for medical residents and students and appoint medical school faculty as VA staff physicians to supervise resident education and patient care. Across the nation, VA is currently affiliated with 107 medical schools, 54 dental schools, and over 1,000 other schools offering students allied and associated education degrees or certificates in 40 health profession disciplines. More than one-half of all practicing physicians in the U.S. received at least part of their clinical educational experiences in the VA health care system. In FY2005, more than 87,000 health care professionals received training in VA medical centers.[13] VA is also the largest employer of registered nurses in the United States, with 32,582 nurses on its payroll in FY2005.[14]

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[10] 38 C.F.R. § 17.38.

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

[12] VA, *FY2006 Budget Submission*.

[13] Ibid., pp. 8-9.

[14] Ibid., pp. 2-26.

Evolution of Veterans' Eligibility for VA Health Care

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

Eligibility criteria used to determine which veterans must be served by VA and what type of medical care that they can be provided has undergone many changes since the establishment of VA. Congress has made several major changes throughout the years concerning the provision of hospital care, outpatient care and nursing home care. Initially veterans could receive care only for treatment of service-connected conditions that were incurred or aggravated during wartime service. In 1924, Congress gave access to hospital care to World War I veterans with nonservice-connected conditions on a space available basis who signed an oath of poverty. In 1943, hospital care was extended to World War II veterans with nonservice-connected conditions and outpatient care was limited to those with service-connected conditions. However, with the passage of P.L. 86-639 in 1960, Congress authorized VA to provide outpatient treatment for nonservice-connected conditions in preparation for or to complete treatment of hospital care. In 1973, with the passage of the Veterans Health Care Expansion Act (P.L. 93-82), Congress further extended outpatient treatment for nonservice-connected veterans to "obviate the need of hospital admission."[15]

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

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

B on the basis of either income or net worth were placed in Category C.[16] Veterans in Categories B and C were eligible to receive care but were not entitled to care.

It should be noted that the terms eligibility and entitlement had different meanings under the VA health care system than under other public health care programs such as Medicare. For instance, all beneficiaries who meet the basic eligibility requirements for Medicare are entitled to all medically necessary care under the Medicare benefits package. Under the VA health care system, the term "eligible" meant that VA "may" provide care, and the term "entitled" meant that VA was required or "must" provide care.[17] However, neither being eligible for nor being entitled to health care services guaranteed the availability of health services. Since funding for VA health care was, and still is, based on fixed annual appropriations, once the funds were expended VA could no longer provide care, even to veterans who were entitled to care. Being entitled to care essentially gave veterans a higher priority for care than being eligible for VA health care.

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

However, the obviate the need statutory authority was interpreted by VA medical centers in several different ways. Some medical centers interpreted it as care for any medical condition, whereas other medical centers interpreted this statutory authority as care for only certain medical conditions.[18] Similarly, since there was no defined health benefits package prior to eligibility reform, veterans were often uncertain about whether they were entitled to certain services or were merely eligible to receive some services. Likewise, VA health care providers complained that when treating certain veterans, they could only treat the service-connected conditions and not the entire patient, although the nonservice-connected condition could affect the veteran's overall health.

These limitations were addressed by Congress with the passage of the Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262). This act required VA to

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

[17] This is evidenced by the use of words "shall" and "may" throughout 38 U.S.C.§1710.

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

establish priority categories and operate a patient enrollment system to manage access to VA health care if sufficient resources were not available to serve all veterans seeking care. It also substantially revised statutes governing care for veterans, putting inpatient and outpatient care on the same statutory footing so that VA can provide care the patient needs in the most medically appropriate setting.[19] The intent of these changes was to expand the services VHA could provide to veterans while eliminating statutory barriers to providing care in the most economical manner, and to lower the expenses associated with providing care to veterans.[20]

VHA began enrolling veterans beginning October 1, 1998.[21] A detailed list of priority enrollment groups is provided in **Appendix 2**.[22] [23] **Table 1** provides details on eligibility for VA health care prior to the enactment of P.L. 104-262, as it relates to the current priority enrollment groups. For example, as illustrated in **Table 1**, veterans with service-connected conditions rated 50%-100% currently are correlated to Priority Group1 veterans. Veterans with service-connected conditions rated 0%-40% may either be Priority Group 2 or Priority Group 3 depending upon their disability rating. These veterans, along with other veterans discharged for disability, would have had the clearest entitlement to VA services prior to eligibility reform.

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

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

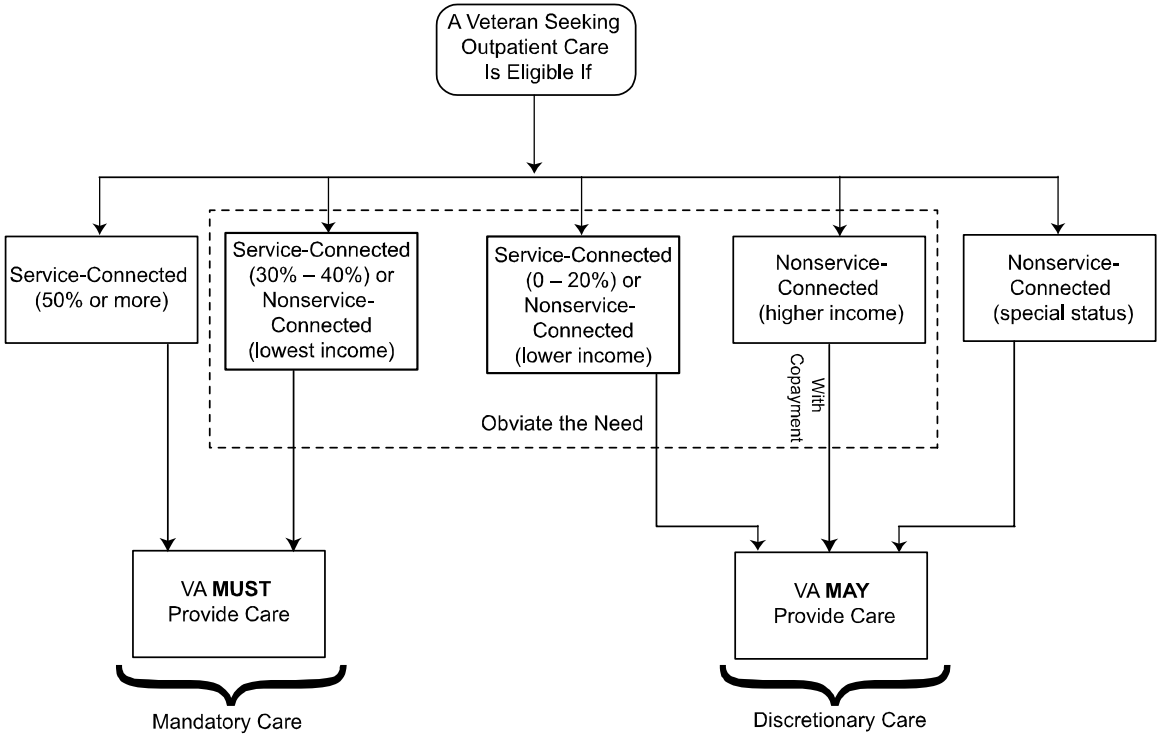
[21] VA has eight priority enrollment groups, with Priority 1 veterans — those with service connected disabilities rated 50% or more — having the highest priority for enrollment. By contrast, Priority 8 veterans are primarily veterans with no service-connected disabilities and higher incomes.

[22] For a detailed description of the current VA enrollment process, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala.

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

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

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



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

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

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

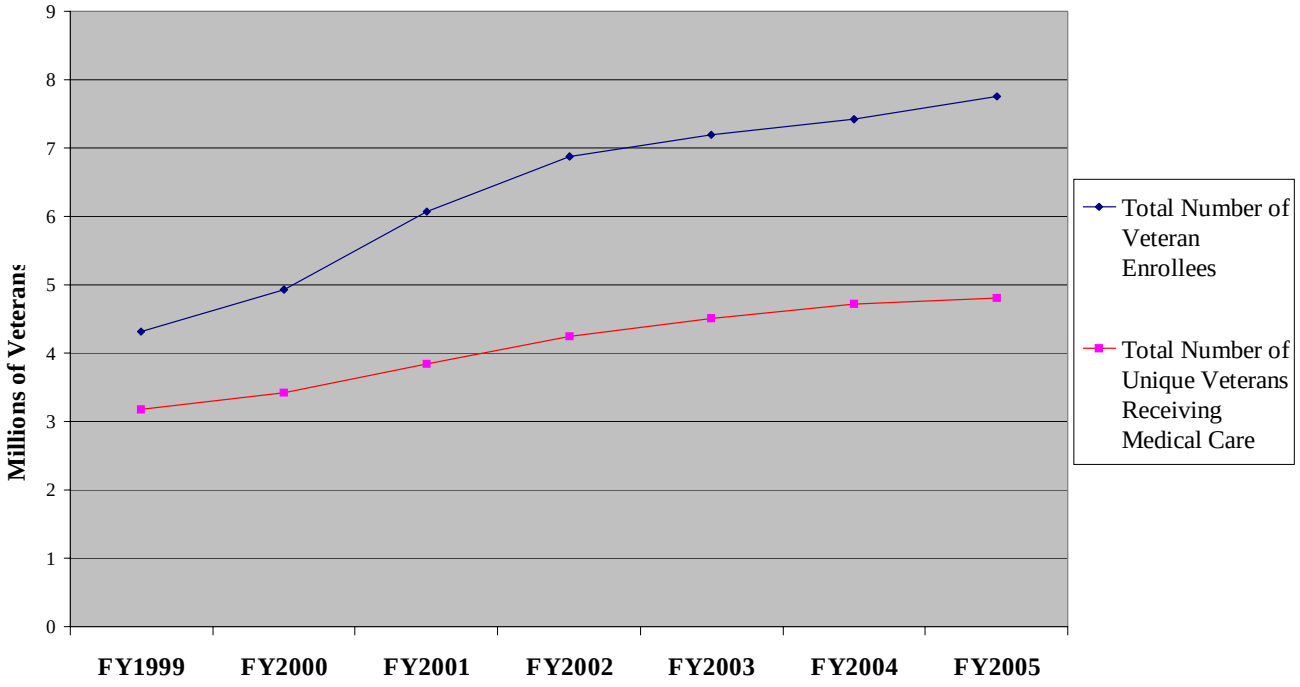
Veteran category prior to eligibility reform	New enrollment priority groups after eligibility reform	Inpatient hospital care	Outpatient care	Nursing home care
Service-connected rated 0-20% obtaining care for a nonservice-connected condition	Priority Group 3	Entitled	Eligible, limited to pre- and post-hospitalization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

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

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

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

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



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

Health Care Issues in the 109th Congress

Introduction. Shortly after the terrorist attacks on the U.S. on September 11, 2001, military personnel began deploying to Afghanistan. Beginning in late 2002 and early 2003, additional military personnel were deployed to Iraq. Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) produced a new generation of war veterans. The return of thousands of these veterans from the Iraq and Afghanistan theaters in need of medical services has put considerable pressure on both VHA personnel and budgets. During the 109th Congress, policymakers will face a number of issues affecting these and other veterans. Among other things, Congress will continue to focus on attempting to ensure a "seamless transition" process for veterans moving from active duty into the VA health care system, improving mental health care services for veterans, funding the growing demand for veterans' health care services, and overseeing improvements to the effectiveness and efficiency of VA's provision of health care services. Moreover, in recent years, some in Congress have shown a keen interest in using VA as a model to inform changes in certain aspects of private and public health care delivery systems; that intent is likely to continue in this Congress as well. The discussion below focuses on these major issues facing VA's health care programs.

Seamless Transition of Returning Servicemembers. As of October 21, 2005, 433,398 OEF and OIF veterans had separated from active duty. Of this amount, 185,230 veterans, or 42.7%, were separated Active Duty troops, while 248,168 were separated Reservists or National Guard members. Approximately 28%, or 119,247, of these separated veterans have sought health care from VA. Most of these veterans have received outpatient care, while approximately 3% of 119,247 enrolled veterans have been hospitalized at least once in a VA health care facility. Reservists and National Guard members make up the majority of those who have sought VA health care, accounting for approximately 61,759, or 51.7%, of those who received care. Those who separated from regular active duty have accounted for 48.2%, or 57,488 veterans.

Veterans' advocates are concerned that returning servicemembers from OIF and OEF do not have a smooth transition from DOD health care to VA health care; the shift from active duty to private citizen can be particularly frustrating and confusing for those who need health care services. At a congressional hearing held in October 2003, some witnesses testified about a lack of an integrated medical information system between DOD hospitals and the VA. The then VA Undersecretary for Health testified that "too often Reservists and National Guard personnel have not received timely information about the benefits and access to health care they have earned."[24] The President's Taskforce to Improve Health Care Delivery for Our Nation's Veterans had also discussed the importance of providing a seamless transition from military to veteran status, including the coordination and sharing of electronic health information between VA and DOD. In March 2005, the Government Accountability Office (GAO) testified that VA still does not have systematic access to DOD data about returning servicemembers who may need its services.[25]

In response to these criticisms, VA has stationed its employees at major DOD Military Treatment Facilities (MTFs) to act as VHA/DOD liaisons.[26] VA has also identified staff members at every Veterans Administration Medical Center (VAMC) to serve as Points of Contacts (POCs). VHA/DOD liaisons help the MTF treatment team with a veteran's discharge from the MTF and informs the POC that the veteran is being transferred to the VA medical facility.[27] VA has provided a vocational rehabilitation counselor to work with hospitalized patients at Walter Reed Army

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[24] Statement of Robert H. Roswell, M.D., Undersecretary for Health, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, Subcommittee on Health on "*Handoffs or Fumbles?*" *Are DOD and VA Providing Seamless Health Care Coverage to Transitioning Veterans?*, Oct. 16, 2003.

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

[26] There are nine VA/DOD Liaisons located at Walter Reed Army Medical Center (two VA/DOD liaisons); National Naval Medical Center; Brooke Army Medical Center; Eisenhower Army Medical Center; Fort Hood Army Medical Center; Madigan Army Medical Center (two VA/DOD liaisons); and Evans Army Medical Center.

[27] Statement of Harold Kudler, M.D., Co-Chair, Undersecretary for Health's Special Committee on PTSD, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, Subcommittee on Health, Oct. 16, 2003.

Medical Center (WRAMC), where the largest number of seriously injured service-members has been treated.

In August 2003 VA created a Seamless Transition Task Force to coordinate and streamline VBA and VHA activities and work with DOD on long-range activities. According to this task force, VA has been increasing its presence in MTFs and has educated servicemembers still receiving care about VA benefits including health care. Its annual report states that VA staff have coordinated more than 1,400 transfers of veterans from MTFs to VHA medical facilities in FY2004.[28]

VA has also stated that it has enhanced its outreach efforts through the Vet Center program. This is a special VHA program designed to provide readjustment counseling to veterans returning from military service. VA's Vet Center program consists of 206 community-based Vet Centers located across the country. VA has emphasized that it has augmented the Vet Center program's capacity to provide outreach to veterans returning from combat operations in Afghanistan and Iraq. Specifically, the Vet Centers have hired and trained up to 50 new outreach workers from among the ranks of recently separated OIF and OEF veterans at targeted Vet Centers. The Vet Center outreach is primarily for the purpose of providing information that will facilitate a seamless transition and the early provision of VA services to new returning veterans and their family members upon their separation from the military. These positions are being located on or near active military out-processing stations, as well as National Guard and Reserve facilities. New veteran hires are providing briefing services to transitioning servicemen and women regarding military-related readjustment needs, as well as the complete spectrum of VA services and benefits available to them and their family members.

On April 30, 2004, the Army, at the direction of the Acting Secretary of the Army, introduced the Disabled Soldier Support System (DS3), and later renamed it the U.S. Army Wounded Warrior (AW2), to serve as a program advocate for severely disabled soldiers and their families. AW2 is available to all active and reserve component soldiers who have been classified as a Special Category as a result of war-related injuries or illness incurred after September 10, 2001, and who have been awarded an Army disability rating of 30% or greater.[29]

In November 2004, DOD and VA signed an agreement to implement cooperative separation processes and physical examinations for the service- members

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[28] Department of Veterans Affairs, *Seamless Transition Task Force Year End Report*, Dec. 2004. This number represents the transfer of medical records from DOD to VA, and the number may be different from those who received treatment at a VA facility.

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

at discharge sites. Servicemembers who file for VA disability compensation must have two physical examinations, one provided by VA and the other by DOD, within months of each other; neither exam fully satisfies the needs of both VA and DOD. These redundant examinations are said to inconvenience servicemembers, delay claims processing and access to VA healthcare, and create added costs. VA and DOD agreed to begin exploring the technical feasibility, scheduling, and cost requirements for the implementation of an electronic physical exam, through a single, consistent electronic physical examination record, which will meet military service and VA requirements.

To identify and monitor those whose injuries may result in a need for VA disability and health services, VA has been working with DOD to develop a formal agreement on what specific information to share. VA has requested personal identifying information, medical information, and DOD's injury classification for each listed servicemember. VA has also requested monthly lists of servicemembers being evaluated for medical separation from military service. Since late 2003, DOD has provided updated rosters on a recurring basis to the VA of those servicemembers who served in OIF and OEF and then separated from active duty. VA has used these lists to determine the rates of VA health care utilization.

On January 3, 2005, VA established the National Veterans Affairs Office of Seamless Transition to ensure that there is no interruption of care as a person moves from being a DOD patient to a VA patient, that whatever kinds of treatment are being delivered in the MTF are continued, and that treatment plans are shared. The office also facilitates priority access to care by enrolling patients in the VA system before they leave an MTF.

In June 2005, VA and DOD signed a Memorandum of Understanding (MOU) to share appropriate protected health information. The issues that hinder a formal agreement between DOD and VA include their differing understanding of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), particularly the HIPAA privacy provisions that govern the sharing of individually identifiable health data.[30] According to GAO, VA believes that HIPAA allows DOD to share servicemembers' health data with VA because the departments serve the same or similar populations — active duty servicemembers who transition to veteran status. In contrast, DOD believes that serving the same or similar populations would mean that servicemembers have a dual eligibility for both DOD and VA services. Although DOD acknowledges that some former servicemembers are dually eligible for DOD and VA services, not all qualify for both services simultaneously. Furthermore, according to VA, HIPAA allows DOD to share data sooner than the decision by DOD that the servicemember will separate from active duty. However, DOD is reluctant to provide individually identifiable health data to VA until DOD is certain that a service member will separate from the military. Furthermore, DOD is concerned that VA's outreach to servicemembers who are still on active duty could work at cross-purposes to the military's retention goals.[31]

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[30] P.L. 104-191, § 264, 110 Stat. 1936, 2033-34; 45 C.F.R. §164.500.

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

The Veterans Health Care Act of 2005 (S. 1182) as passed by the Senate on December 21, 2005, included a provision that would provide VA with access to certain medical records of servicemembers while they are still on active duty. This provision would ensure that DOD would not violate HIPAA by providing VA with access to certain medical records. This bill is pending House approval.

Two-Year Eligibility for Veterans Returning from Iraq and Afghanistan. Veterans who have served or are now serving in Iraq and Afghanistan may, following separation from active duty, enroll in the VA health care system and, for a two-year period following the date of their separation, receive VA health care without copayment requirements for conditions that are or may be related to their combat service. Following this initial two-year period, they may continue their enrollment in the VA health care system but may become subject to any applicable copayment requirements.[32] There were several legislative proposals (H.R. 1588, S. 481) in the first session of this Congress to extend the period of eligibility for health care for combat service in the Persian Gulf War or future hostilities from two years to five years after discharge or release. During a hearing in June 2005, the Administration voiced opposition to this proposal. According to VA, the current two-year post-combat eligibility period provides ample opportunity for a veteran to apply for enrollment in the VA system.[33] However, some proponents of this proposal are concerned that restricting enrollment eligibility for only a two-year period may prevent veterans from enrolling in VHA when health conditions manifest, especially for conditions such as PTSD that may not manifest until years after veterans return from combat. The Administration's response to this concern has been that "if PTSD appears in a non-enrolled combat veteran following the end of his or her two-year period of eligibility, and is subsequently determined to be service-connected, that veteran would then become eligible for enrollment in Priority Group 1, 2, or 3, and thus they would be able to receive needed care."[34]

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[31] (...continued)
Help Expedite Servicemember's Transition to VA Services, GAO-05-722T, p. 7.

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

[33] U.S. Congress, Senate Committee on Veterans Affairs, hearing on legislation related to veterans' health care, 109th Cong., 1st sess., June 9, 2005.

[34] U.S. Congress, Senate Committee on Veterans Affairs, hearing on the *Proposed FY2006 Budget for the Department of Veterans Affairs Programs*, 109th Cong., 1st sess., Feb. 15, (continued...)

Mental Health and Post-Traumatic Stress Disorder (PTSD). With the ongoing conflicts in Iraq and Afghanistan, Congress is greatly concerned about VA's current and future capacity to treat mental health issues of these new veterans. Among the mental health issues that could affect veterans, Post-Traumatic Stress Disorder (PTSD) has attracted the most attention. This a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged; these symptoms can be severe enough and last long enough to significantly impair the person's daily life.[35] While there is no cure for PTSD, mental health experts believe that early identification and treatment of PTSD symptoms may lessen the their severity and improve the overall quality of life for individuals with PTSD.

According to DOD, only 3% of soldiers report serious mental health issues in post-deployment assessments given as they prepare to return home.[36] Early in the Iraq War, the Army surveyed 3,671 returning veterans and found that up to 17% of the soldiers were already suffering from depression, anxiety and symptoms of PTSD.[37] Other studies have indicated that protracted warfare in Iraq — with its intense urban street fighting, civilian combatants and terrorism — could drive PTSD rates even higher.[38] According to the VA, of the 119,247 OEF and OIF veterans who have sought care from VA, 37,618 have been diagnosed with a psychiatric disorder. As of October 21, 2005, 3.7% of those veterans who have been diagnosed with a psychiatric disorder have been classified as having symptoms of PTSD.[39]

Among the challenges faced by DOD and VA in treating returning servicemembers with mental health issues is the apparent stigma associated with disclosing PTSD symptoms to DOD clinicians. Reportedly, there is less stigma associated with disclosing PTSD symptoms in VA settings, but there are perceived

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[34] (...continued)
2005, p. 36.

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

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

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

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

[39] B. Christopher Frueh, *Improving PTSD Treatment for Veterans*, presentation given at the American Enterprise Institute for Public Policy Research, Nov. 7, 2005.

risks associated with disclosure within military settings.[40] Nondisclosure could result in servicemembers not receiving early intervention and an underestimation of the future demand for VA mental health services.

For more than two decades, Congress has highlighted the importance of PTSD services for veterans. In 1984 Congress established the Special Committee on Post-Traumatic Stress Disorder (Special Committee) to determine VA's capacity to provide assessment and treatment for Post-Traumatic Stress Disorder and to guide VA's educational, research and benefits activities with regard to PTSD.[41] The Special Committee is composed of PTSD experts from across a broad spectrum of VA's Mental Health and Readjustment Counseling Services (RCS). The Special Committee issued its first report on ways to improve VA's PTSD services in 1985 and its latest report, which includes 37 recommendations for VA, in 2004.[42]

The Special Committee's 2004 report indicates that combat veterans of OEF and OIF are at high risk for PTSD and related problems. According to the Special Committee, the suicide rate for soldiers in Iraq is higher than the Army's base rate and higher than suicide rates during the first Gulf War or the Vietnam War. It estimates that an estimated 40% of OEF and OIF casualties returning by the way of Walter Reed Army Medical Center report symptoms consistent with PTSD.[43] Moreover, the Special Committee in its 2004 report concluded that "VA must meet the needs of new combat veterans while still providing for veterans of past wars. Unfortunately, VA does not have sufficient capacity to do this."[44]

GAO reported in September 2004 that VA does not have a reliable estimate of the total number of veterans it currently treats for PTSD and lacks the information it needs to determine whether it can meet an increased demand for PTSD services.[45] In February 2005, GAO reviewed 24 of the Special Committee's 37 recommendations and reported that VA has not fully met any of the 24

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

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

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

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

[44] Ibid., p. 5.

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

recommendations.[46] Specifically, GAO determined that VA has not met 10 recommendations and has partially met 14 of these 24 recommendations.[47]

Furthermore, as stated in the House report (H.Rept. 109-95) accompanying the Military Quality of Life and Veterans Affairs, and Related Agencies appropriations bill, 2006 (H.R. 2528), VA has not been able to meet the Special Committee's recommendation to set up a PTSD Clinical Team (PCT) in every VA medical center. The House Appropriations Committee expressed its concerns about the lack of PCTs in every VA medical center in its committee report language:

> VA's primary care program is a de facto mental health system for the majority of those seeking VA care. But the VA must ensure that PTSD services are provided in primary care settings by design, not by default. To provide the true continuum of care necessary to treat PTSD effectively, the primary care services need to be fully integrated with general mental health and specialty PTSD services. The VA has a long road to travel before this becomes the actual practice, but effective PCTs at the VA Medical Centers will provide the basis to travel down that road. The Committee is very concerned about this lack of responsiveness to the Special Committee recommendation in this regard and directs the VA to develop a plan for implementation of effective PCTs at each VA Medical Center and identify any resource shortfalls which would impede implementation. [48]

The Senate report (S.Rept. 109-105) accompanying the Military Construction and Veterans Affairs and Related Agencies appropriations bill, 2006 (H.R. 2528), also express concern about returning veterans who are experiencing PTSD. The Senate Appropriations Committee requested VA to establish three PTSD "Centers of Excellence." These centers will be established at the Waco Veterans Affairs Medical Center (VAMC), in Texas; the San Diego VAMC, in California; and the Canandaigua VAMC, in New York. Furthermore, the Committee encouraged VA to establish a PTSD clinical team at each VA Medical Center; provide a certified family therapist within each Vet Center; and appoint a regional PTSD coordinator within each VISN and Readjustment Counseling Service region to evaluate programs, promote best practices, and make resource recommendations.[49]

According to VA it has undertaken many efforts to improve PTSD care delivered to veterans. VA points out that it has developed an Iraqi War guide for

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

[47] Ibid., p. 3.

[48] U.S. Congress, House Committee on Appropriations, *Military Quality of Life and Veterans Affairs and Related Agencies appropriations bill ,2006*, report to accompany H.R. 2528, 109th Cong., 1st sess., H.Rept. 109-95, p. 16.

[49] U.S. Congress, Senate Committee on Appropriations, *Military Construction and Veterans Affairs and Related Agencies appropriations bill, 2006*, report to accompany H.R. 2528, 109th Cong., 1st sess., S.Rept. 109-105, p. 53.

clinicians; implemented a national clinical reminder to prompt clinicians to assess OEF and OIF veterans for PTSD, depression, and substance abuse; implemented a national system of 144 specialized PTSD programs in all states;[50] required all VA outpatient clinics to either have a psychiatrist or psychologist on staff full-time or ensure that veterans can consult a mental health provider in their community; elevated the VHA's chief psychiatrist to the agency's National Leadership Board (a key policymaking group that includes VHA's other top executives and medical personnel); and established uniform budgets for mental health care at VA's 21 VISNs.[51] In 2004, a new Mental Illness Research, Education and Clinical Center (MIRECC) was established at the VAMC in Durham, North Carolina, to focus on issues of post-deployment health for returning OIF and OEF veterans. This center will collaborate with the National Center for Post-Traumatic Stress Disorder (NCPTSD) and nine other MIRECCs spread throughout the country.[52] VHA also established a new MIRECC in Denver, Colorado, to focus on suicide and its prevention, which is a growing concern in the OIF and OEF veteran population. Furthermore, in October 2004, in response to GAO's report that stated that VA lacked the information it needs to determine whether it can meet an increased demand for VA PTSD services, VA consolidated the necessary data into a national report and distributed the report to all VISNs, medical centers, and Vet Centers to assist them in estimating potential PTSD workload expansion. VA has pointed out that it updates and distributes this report on a quarterly basis.

PTSD Claims Review Controversy. On May 19, 2005, VA's Inspector General (IG) reported on an examination of files from a sample of 2,100 randomly selected veterans with disability ratings for PTSD.[53] The IG cited insufficient documentation in the files and a dramatic increase in veterans filing for disability compensation for PTSD since 1999. The IG reported that about 25% of the 2,100 PTSD awards it reviewed were based on inadequate evidence of the occurrence of a traumatic event (stressor). VA conducted its own review of the 2,100 cases reviewed by the IG. VA's preliminary findings showed that some of the decisions on PTSD claims were premature. According to VA, it found that a large percentage of cases judged to have insufficient evidence were older cases in which VA statutes prohibit a change in the rating decision. According to statute, if a condition has been determined to be service-connected for a period of 10 years or more, service connection is protected and may not be severed except for a finding of fraud on the

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[50] Statement of Jonathan B. Perlin, Mar. 17, 2005.

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

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

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

part of the veteran.[54] Following the IG's finding, VA proposed to review 72,000 individual cases of veterans who were rated at 100% disabled and unemployable within the last five years due to PTSD. After intense criticism by both Congress and veterans advocacy groups, on November 10, 2005, VA announced that it will not initiate a review of the 72,000 claims.

On November 16, 2005, VA announced that it has requested the Institutes of Medicine (IOM) to conduct a review of PTSD. Under the agreement, one IOM committee will be established to review the current scientific and medical literature related to the assessment of PTSD, and assess how accurate the current screening instruments are. Another IOM committee will provide technical assistance on issues related to treatment, prognosis, and compensation of PTSD. The first committee's report is expected to be completed within six months, and IOM expects that the second committee will complete its task in 12 months.

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

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

The remaining programs, primarily VA health care programs, medical facility construction, medical research, and VA administration, are funded through annual discretionary appropriations. Congress must act each year to provide budget authority for discretionary programs. As a discretionary program, the amount of

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[54] 38 U.S.C. 1159; 38 C.F.R. 3.957; 38 U.S.C. 110; 38 C.F.R. 3.951(b).

funds VHA can spend on health care programs for veterans is limited by the amount of its appropriation.

Generally the mandatory funding proposals that have been suggested by veterans' advocates are based on a formula that takes into account the number of enrolled and nonenrolled veterans eligible for VA medical care, and the rate of medical care inflation. Proponents believe that mandatory funding will eliminate the year-to-year uncertainty about funding levels and close the gap between funding and demand for veterans' health care. Opponents believe that with these proposals spending for VHA will increase significantly as enrollment in the VA health care system soars; in most of the proposed funding formulas, automatic funding increases are primarily based on enrollment figures. Furthermore, critics believe that a static funding formula cannot adequately take into consideration the changing needs of veterans, which could affect the funding level necessary to provide a different mix of services, and that Congress is better able to evaluate the funding needs through the current appropriation process.

As highlighted by some budget analysts, changing veterans' medical care into a mandatory budget authority will not solve the issue of closing the gap between funding and demand for veterans' health care, since Congress could place caps on spending for mandatory programs through budget reconciliation language which could limit spending on veterans' health programs. [55] Since Congress can act to change the formula or cap the spending amounts, the issue of uncertainty in funding amounts may not be resolved either.

Assured Funding for Veterans Health Care Act, 2005 (H.R. 515) was introduced during the first session. This proposal would require the Secretary of the Treasury to make mandatory appropriations for VA health care based on the following formula: the amount of funds available for VA medical care in FY2007 would equal 130% of the total obligations made by VA for medical care programs in FY2005. The amounts in succeeding years would be adjusted for medical inflation and growth in the number of veterans enrolled in VA's health care system and other non-veterans eligible for care from VA. A companion measure, S. 331, was introduced in the Senate. Another measure introduced in the Senate, S. 13, uses a similar formula for determining funding available for VA health care and adjusts spending for changes in the veteran population and inflation. Neither measure has yet seen any legislative action.

Continued Suspension of Priority Group 8 Veterans. Veterans' advocates want the suspension of Priority Group 8 veterans from enrolling in VA's health care system lifted, since they believe that all veterans must be able to receive care from VA. It should be noted that some of these veterans may have other types of health care coverage. The Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262) included language that stipulated that medical care to veterans will be furnished to the extent appropriations were made available by Congress on an

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

annual basis. Based on this statutory authority, the Secretary of Veterans Affairs announced on January 17, 2003 that VA would temporarily suspend enrolling Priority Group 8 veterans. Those who enrolled prior to January 17, 2003 in VA's health care system were not to be affected by this suspension. VA claims that, despite its funding increases, it cannot provide all enrolled veterans with timely access to medical services because of the tremendous increase in the number of veterans seeking care from VA. In July 2002, VA estimated that there were more than 310,000 enrolled veterans who had been unable to schedule an appointment or have an appointment scheduled by VA more than six months from the veteran's desired date of appointment for a non-emergency clinic visit. As of September 15, 2005, VA is reporting that there are 56,257 veterans waiting for six months or more for a non-emergency clinic visit (**Table 2**).

Table 2. Total Number of New and Established Patients Who Will Have to Wait Six Months or More

VISN	Number of new enrollees[a]	Number of established patients[b]	Total number of Veterans
1	1,510	3,002	4,512
2	26	199	225
3	0	18	18
4	227	532	759
5	3	81	84
6	920	1,294	2,214
7	4,055	4,416	8,471
8	2,062	3,944	6,006
9	1,929	3,126	5,055
10	299	1,604	1,903
11	1,041	1,025	2,066
12	1,508	2,335	3,843
15	698	1,067	1,765
16	2,686	4,075	6,761
17	52	497	549
18	251	900	1,151
19	299	409	708
20	3,945	3,061	7,006
21	241	884	1,125
22	363	602	965
23	223	848	1,071
Totals	**22,338**	**33,919**	**56,257**

Source: Table prepared by CRS based on data provided by the Department of veterans Affairs (VA). Data current as of September 15, 2005.

a. Represents a manual count of veterans who have enrolled and requested an appointment, but the veteran's preferred site of care cannot schedule the appointment within six months, and the veteran is placed on a wait list.

b. Represents a manual count of established patients (patients have been seen at least once) who are on a wait list (cannot be scheduled within six months) for follow-up care for a Primary Care Clinic or Specialty Care Clinic visit. (Examples would include veterans waiting for reassignment to a new Primary Care Provider, or patients waiting for consults in Specialty Care clinics). It is also a count of veterans scheduled electronically for appointments; however, the wait time meets or exceeds six months.

Effect of the Enrollment Freeze. According to VA data, in FY2003 approximately 164,000 Priority Group 8 veterans could not enroll in VA health care because of the suspension. In FY2004 an estimated 360,000 Priority Group 8 veterans were similarly effected; this number is expected to grow to 522,000 veterans by the end of FY2005.[56] Moreover, the number of Priority Group 8 veterans already enrolled in VA's health care system is expected to decline from 1.27 million in FY2005 to 1.22 million in FY2006; this will be mostly due to projected death rates for these veterans as well as the continued suspension of new enrollments.[57] In 2004, VA estimated that resumption of enrollment for Priority Group 8 veterans would require an additional $519 million over the FY2005 requested VHA budget and an estimated $2.3 billion in FY2012.[58]

Congress has shown a keen interest in access to care for Priority Group 8 veterans, and it is likely that legislative proposals will be introduced in this Congress directly related to lifting the freeze on enrollment. However, since enrollment of lower priority veterans is tied to available resources, there are doubts that such measures will be enacted into law.

VA's Cost Recoveries from Medicare. In general, VA is statutorily prohibited from receiving Medicare payments for services provided to Medicare-covered veterans.[59] Many veterans' advocates have suggested that VA should receive Medicare payments for nonservice-connected disability care that VA provides for veterans who are also covered by Medicare. However, there has been opposition to these proposals because authorizing VA recoveries from Medicare could further jeopardize the solvency of the Medicare trust fund and increase overall federal health care costs, since Medicare is an entitlement program without a cap on its total spending. GAO suggested that allowing VA to bill and retain recoveries from Medicare would create strong incentives for VA facilities to shift their priorities towards providing care to veterans with Medicare coverage.[60]

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

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[56] Department of Veterans Affairs, "Enrollment — Provision of Hospital and Outpatient Care to Veterans Subpriorities of priority Categories Seven and Eight and Annual Enrollment Level Decision; Final Rule," 68 *Federal Register*, Jan. 17, 2003.

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

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

[59] 42 U.S.C § 1395f(c).

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

The Balanced Budget Act of 1997 (P.L. 105-33) authorized the DOD to implement a Medicare subvention pilot program in their MTFs. The Medicare subvention demonstration permitted DOD to create managed care organizations that participated in the Medicare+Choice program (now Medicare Advantage) and enroll Medicare-eligible retirees. In this demonstration, Medicare payments were structured on a capitation basis, with DOD receiving monies after meeting its level of effort to ensure that it sustained its prior level of spending on its Medicare beneficiaries. Under the demonstration, enrolled retirees received their Medicare-covered benefits and additional TRICARE benefits (notably prescription drugs) through TRICARE Senior Prime, the DOD-run managed care organizations set up by the demonstration. To be eligible for Senior Prime, retirees had to reside in one of the six geographic areas covered by the demonstration, be enrolled in both Medicare Part A and Part B, and had to be eligible for military health care benefits. They also had to have either (1) used an MTF before July 1, 1997, or (2) turned age 65 on or after July 1, 1997. While the demonstration had positive results for enrollees, the three-year pilot program was judged not to be cost-effective for DOD and it expired at the end of 2001.[61]

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

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

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

Filling of Privately Written Prescriptions at VA. As part of VA's comprehensive medical care benefits package, VA provides all veterans who are enrolled for VA care appropriate prescription medications, at the nominal charge of $7 for a 30-day supply. In general, the copayments are waived if the prescription is for a service-connected condition or if the veteran is severely disabled or indigent. VA dispenses medications, however, only to those veterans who are enrolled for, and who actually receive VA-provided care. Generally, VA does not provide medications to veterans unless those medications are prescribed by a physician who is employed by or under contract with VA.

However, to address the growing wait lists for primary care and specialty care appointments and to reduce the waiting times for a first appointment, VA implemented a program in September 2003 to provide access to VA prescription drugs for veterans experiencing long waits for their initial primary care appointment. This temporary program was known as the Transitional Pharmacy Benefit (TPB). Under this program, VA pharmacies and VA's Consolidated Mail Outpatient Pharmacies (CMOPs) were authorized to fill prescriptions written by non-VA (private) physicians until a VA physician could examine the veteran and determine an appropriate course of treatment. The TPB included most, but not all, of the drugs listed on the VA National Formulary (VANF). To be eligible for the program, veterans had to be enrolled in the VA health care system prior to July 25, 2003, and had to have requested their initial primary care appointment prior to July 25, 2003. To qualify for this program, veterans also must have been waiting more than 30 days for the initial primary care appointment as of September 22, 2003.

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

There was considerable interest in the 108th Congress to provide a prescription-only health care benefit for veterans. While several bills were introduced none of them were enacted into law. Furthermore, in FY2004 and FY2005 the House and Senate Committees on Appropriations, and the conference committee, included bill language authorizing the dispensing of prescription drugs from VHA pharmacies to enrolled veterans with privately written prescriptions based on requirements established by VHA.[62] [63] The following bills were introduced during the first session

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

[63] U.S. Congress, Conference Committees, *Making Appropriations for Foreign Operations,* (continued...)

of the 109th Congress: H.R. 693, H.R. 1585, H.R. 2379, S. 13, and S. 614. These measures would, among other things, require VA pharmacies to dispense medications on prescriptions written by private medical practitioners. Of these measures, a hearing was held on S. 614 by the Senate Veterans Affairs Committee on June 9, 2005. At this hearing, both the Administration and several Veterans Service Organizations (VSO's) expressed concerns about the legislation. Many believed that opening up the VA pharmacy system, as proposed in S. 614, would ultimately change the basic, primary mission of the entire VA. The Administration testified that "enactment of this measure could encourage situations where a veteran is receiving care and prescriptions from VA, and from outside sources, yielding increased costs, increased confusion, and decreased patient safety."[64]

Capital Asset Realignment for Enhanced Services (CARES). VA holds a substantial inventory of real property and facilities throughout the country. A majority of these buildings and property support VHA's mission. Much of VA's medical infrastructure was built decades ago when its focus was inpatient care. In the past several years VA has been shifting from a hospital-based system and, today, more than 80% of the treatment VA provides is on an outpatient basis through Community Based Outpatient Clinics (CBOCs). GAO projected that one in four medical care dollars is spent on maintaining and operating VA's buildings and land, and estimated that VA has over 5 million square feet of vacant space which can cost as much as $35 million a year to maintain.[65]

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

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[63] (...continued)
Export Financing, and Related Programs for the Fiscal Year Ending September 30, 2005, Conference Report to accompany H.R. 4818, 108th Cong., 2nd sess., H.Rept. 108-792, p. 483.

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

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

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

The final plan includes consolidating the following facilities: (1) Highland Drive campus in Pennsylvania with University Drive and Heinz campuses in Pennsylvania; (2) Brecksville campus in Ohio with Wade Park campus in Cleveland, Ohio; and (3) Gulfport campus with Biloxi campus in Mississippi. The following facilities will be partially realigned: (1) Knoxville campus in Iowa; (2) Canandaigua campus in New York; (3) Dublin campus in Georgia; (4) Livermore campus in California; (5) Montrose campus in New York; (6) Butler campus in Pennsylvania; (7) Saginaw campus in Michigan; (8) Ft. Wayne campus in Indiana, and (9) Kerrville campus in Texas.[66]

The final plan also calls for building new hospitals in Orlando and Las Vegas; adding 156 new CBOCs, four new spinal cord injury centers, and two blind rehabilitation centers; and expanding mental health outpatient services nationwide. By opening health care access to more veterans, VA expects to increase the percentage of enrolled veterans from 28% of the veterans' population today, to 30% in 2012 and 33% in 2022. This percentage increase can be attributed in part to a projected decline in the veteran population. Nationally, the number of veteran enrollees is projected to increase 6% by 2012 and decrease 5% by 2022 from the number of veteran enrollees reported in 2001. VA asserts that the CARES plan will reduce the cost of maintaining vacant space over the period 2006 to 2022 from an estimated $3.4 billion to $750 million and allow VA to redirect those funds to patient care.[67]

Critics of the CARES plan contend that closures are being considered without assessing what kind of facilities will be needed for long-term care and mental health care in the future. For instance, at the time of the release of the DNCP, projections for outpatient and acute psychiatric inpatient care contained data inconsistencies on future needs. VA asserted that it would improve its forecasting models to ensure that projections adequately reflect future need. Also, some believe that the CARES plan does not focus enough on future nursing home needs, would leave VA short of beds in a few decades, and thus VA would not have any choice but to privatize some parts

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

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

of the health care system. Moreover, some veterans' groups believe that CARES is only about closing "surplus" hospitals and do not believe that CARES will result in the building of new and modern facilities. Finally, the closure of some VA medical facilities raised serious concern among some Members of Congress who felt that they had little control over the CARES process.[68]

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

The Secretary's CARES Decision identified implementation issues that required further study, including additional stakeholder input at selected sites. On September 29, 2004, the Secretary of VA established an Advisory Committee for CARES Business Plan Studies. The committee and its subcommittees generally consists of representatives from veterans' service organizations, governmental agencies, health care providers, planning agencies, and community organizations with a direct interest in the CARES process. This committee will consult with stakeholders during implementation of the Secretary's CARES Decision. The committee will ensure that the full range of stakeholder interests and concerns are assembled, publicly articulated, accurately documented, and considered in the development of site-level business plans. In January 2005, VA awarded a contract to PriceWaterhouseCoopers to complete studies at 18 sites throughout the country during a 13-month period as required by the Secretary's CARES Decision. According to VA, the studies will be completed no later than February 2006.[69]

Furthermore, the Senate Appropriations Committee expressed concern about the ongoing CARES implementation process. As stated in S.Rept. 109-105 to accompany the Military Construction and Veterans Affairs and Related Agencies appropriations bill, 2006:

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

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

> The Committee understands that the VA is now seeing large concentrations of veterans in areas that were not originally anticipated to receive the increased workload. The Committee is concerned that the original 2004 snapshot of the Department's infrastructure and mission requirements for each facility has changed due to the large number of veterans returning from Operations Enduring Freedom and Iraqi Freedom [OEF/OIF], as a result of these issues, it would be prudent to carefully and systematically reevaluate the 18 facilities on the Secretary's list requiring additional study based on a more global situation now facing our Nation's veterans and the impact of the returning OEF/OIF veterans.[70]

The Senate Appropriations Committee included bill language prohibiting VA from using any funds appropriated to VA to change the current infrastructure, service, or mission of the 18 facilities that are been studied. The Committee encouraged the VA to continue studying these locations and submit its recommendations to Congress as part of the CARES recommendation in the VA's FY2007 capital plan.

VA as a Model for Other Health Care Systems. For decades the VA health care system had a reputation for providing suboptimal care to veterans, at least in certain circumstances.[71] These quality problems were highlighted in the popular press at that time.[72] As described earlier, however, VA initiated a systemwide reengineering, among other things, to improve the quality of care.[73] VA is seen by many as a leader in improving quality of care. One of the most highly regarded VA initiatives is the National Surgical Quality Improvement program (NSQIP). The initiatives key components are: periodic performance measurement and feed back, along with self-assessment tools, site visits, and best practices to improve the outcome of major surgeries performed by VA surgeons.

Recent studies have shown that VA's quality of care has improved dramatically when compared to the quality of care in the VA health care system before its reengineering.[74] Moreover, studies done following VA's transformation have shown that some aspects of VA's quality of care are better than what is offered in the general health care system. For instance, researchers (affiliated with VA, the RAND Corporation, and several universities) found that patients in the VA health care

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[70] U.S. Congress, Senate Committee on Appropriations, Military Construction and Veterans Affairs and Related Agencies Appropriations Bill, 2006, report to accompany H.R. 2528, 109th Cong., 1st sess., S.Rept. 109-105, p. 64.

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

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

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

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

system are more likely to receive better chronic and preventive care than the general population. This study also found that VA performed better across the entire spectrum of care: screening, diagnosis, treatment, and follow-up.[75]

Moreover, certain attributes of VA's health care system may have relevance to improving the quality of care provided in the broader health care system. For instance, VHA's Barcode Medication Administration System for dispensing pharmaceuticals has been in place since 2000, before the Food and Drug Administration's (FDA) attempt to put a similar system in place in the broader health care system.[76] The Barcode Medication Administration System, which is in all VA hospitals now, lets doctors and nurses verify the time, dose and name of a patient receiving a medication. VA hospitals give patients a bar-coded wristband inscribed with patient information, and attaches a bar code to every medication. A nurse scans the patient's wristband for identity verification, and the system retrieves the medication record from VA's Electronic Healthcare Record System and displays it on the PC or handheld screen.

VA is also leading an effort to reduce medication errors with a wireless application designed to ensure that patients receive the correct medications. Industry press indicates that VA not only has outpaced private hospitals in implementing health care IT systems, but the department is leapfrogging its private-sector counterparts in using mobile and wireless devices and applications directly in patient care.[77]

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

Since the late 1990s, VA has been generally recognized as a leader in patient safety. In 1999, the VA established a National Center for Patient Safety (NCPS) to lead the agency's patient safety efforts and develop a culture of safety throughout the VA health care system. The NCPS developed an internal, confidential, non-punitive reporting and analysis system, the Patient Safety Information System (PSIS), which permits VA employees to report both adverse events and close calls without fear of

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

[76] FDA issued its final bar coding rule in Feb. 2004. It applies to medications used in hospitals, as well as blood and blood products used in transfusions. New medications covered by the rule will have to include bar codes within 60 days of their approval; most previously approved medicines and all blood and blood products will have to comply with the new requirements within two years.

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

punishment. Other countries such as Australia, Japan, Denmark, the United Kingdom have adopted strategies from portions of VA's patient safety program. Furthermore, the Joint Commission for the Accreditation of Health Care Organization's (JCAHO) patient safety goals have been influenced by VA's advances in this area. In May 2000, the VA signed an agreement with the National Aeronautics and Space Administration (NASA) to develop the Patient Safety Reporting System (PSRS), an independent, external reporting system. The PSRS, which was inaugurated in 2002 at VA hospitals nationwide, is operated by NASA. It is intended to provide VA employees with a "safety valve" that allows them confidentially to report close calls or adverse events that, for whatever reason, would otherwise go unreported.

In the area of pharmaceutical purchasing VA has been able to obtain prescription drugs at competitive prices. VA has been successful in using a number of purchasing arrangements to obtain substantial discounts on prescription drugs. For the bulk of its pharmaceutical purchases, VA obtains favorable prices through the Federal Supply Schedule (FSS).[78] By statute, in order to be able to obtain reimbursement for drugs for Medicaid beneficiaries, manufacturers must offer their drugs on the FSS.[79] FSS prices are intended to be no more than the prices manufacturers charge their most-favored non-federal customers under comparable terms and conditions. VA also buys some brand-name drugs for prices less than-those listed under the FSS. For example, by statute VA can buy brand-name drugs-at a price at least 24% lower than the non-federal average manufacturer price (NFAMP), which may be lower than the FSS price for many drugs.[80] In addition, VA has obtained some drugs at lower than FSS prices through national contracts with a single manufacturer based on a competitive-bid process. VA may solicit competitive bids for therapeutically equivalent drugs and may select one winner based on price alone for exclusive or preferred use on their formularies. Often VA and DOD consolidate their buying power and negotiate contracts together. In FY2003, the total cost avoidance was estimated to be $376 million for VA and DOD contacts.[81] [82]

Several measures (H.R. 376, H.R. 563, H.R. 1626, H.R. 4610, H.R. 4652, S. 123, S. 563) were introduced in the first session of this Congress to allow the

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

[79] 38 U.S.C. § 8126(a)(4).

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

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

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

Department of Health and Human Services (DHHS) to negotiate contracts with manufacturers of covered Medicare Part D pharmaceuticals similar to VA. However, many veterans' advocates have voiced concerns that if prices offered to VA were extended to Medicare recipients or other entities, it would result in increased prices for VA, since pharmaceutical companies will not give the same price discounts that it presently offers VA.

Beneficiary Travel Program. In general, the beneficiary travel program reimburses certain veterans for the cost of travel to VA medical facilities when seeking health care. P.L. 76-432, passed by Congress on March 14, 1940, authorized VA to pay the actual travel expenses, or instead an allowance based upon the mileage traveled by any veteran traveling to or from a VA facility or other place for the purpose of examination, treatment, or care. P.L. 85-857, signed into law on September 2, 1958, authorized VA to pay necessary travel expenses to any veteran traveling to or from a VA facility or other place in connection with vocational rehabilitation counseling or for the purpose of examination, treatment, or care. However, this law changed VA's travel reimbursement into a discretionary authority by stating that VA "may pay" expenses of travel. On April 13, 1987, VA published final regulations that sharply curtailed eligibility for the beneficiary travel program. The Veterans' Benefits and Services Act of 1988, P.L. 100-322, section 108, in large part restored VA travel reimbursement benefits. It required that if VA provides any beneficiary travel reimbursement under section 111 in any given fiscal year, then payments must be provided in that year in the cases of travel for health care services for all the categories of beneficiaries specified in the statute. In order to limit the overall cost of this program, the law imposed a $3 one-way deductible applicable to all travel, except for veterans otherwise eligible for beneficiary travel reimbursement who are traveling by special modes of transportation such as ambulance, air ambulance, wheelchair van, or to receive a compensation and pension examination. In order to limit the overall impact on veterans whose clinical needs dictate frequent travel for VA medical care, an $18-per-calendar-month cap on the deductible was imposed for those veterans who are pre-approved as needing to travel on a frequent basis.

With the rise in gasoline prices throughout 2005, several measures (H.R. 3147, H.R. 3948, H.R. 4025 and S. 996) were introduced to change the method of determining the milage reimbursement rate and also to eliminate the current deductible amount. However, none of these bills has seen legislative action. One reason that these bills did not get enacted is because funds for transportation of beneficiaries are used from appropriations for medical services for veterans. There is a strong sense that funds available to provide health care to veterans are more appropriately used for direct patient care programs rather than for transportation costs.

Veterans Health Care Legislation

This section provides a brief summary of veterans health care legislation reported by the House or Senate Veterans Affairs Committees or passed by either the

House or Senate during the first session of the 109th Congress. This summary does not include appropriation measures for veterans health care programs.[83]

House-Passed Legislation

Servicemembers Health Insurance Protection Act of 2005 (H.R. 2046). This bill was introduced on May 3, 3005, and on May 11, 2005, the House Committee on Veterans Affairs reported the measure as amended by unanimous vote (H.Rept. 109-88). The House passed H.R. 2046 as amended on May 23, 2005. This bill is awaiting Senate action. Given below is a brief summary of major provisions of this bill.

- *Limitation on Premium Increases for Reinstated Health Insurance of Servicemembers Released from Active Military Service*. This provision would require health insurance companies to allow servicemembers leaving the armed forces to rejoin their previous civilian health plans at the same rate they were previously paying. The Servicemembers Civil Relief Act (PL 108-189) ensures that returning reserve members can reinstate their old policies, but does not address premium increases to protect servicemembers against premium increases when they reinstate their health insurance as civilians. However, H.R. 2046 would permit health insurance companies to increase a servicemember's premium if such a general premium increase was implemented for persons similarly covered during the period between the termination and the reinstatement.

Department of Veterans Affairs Information Technology Management Improvement Act of 2005 (H.R. 4061). This bill was introduced on October 17, 2005, and was reported out of the House Veterans Affairs Committee on October 27, 2005 (H.Rept. 109-256). The bill was passed by the House on November 2, 2005. This bill awaiting Senate action. Given below is a brief summary of major provisions of this bill.

- *Management of Information Technology in Department of Veterans Affairs.* This provision would improve the management of information technology (IT) within VA by giving the Chief Information Officer (CIO) authority over resources, budget, and personnel related to the support function of information technology for the Department. At present, VA IT resources are operated and managed within a decentralized management structure. While the CIO is charged with overall responsibility for the successful management of all VA IT resources, the CIO has no direct management control or organizational authority over any of these resources. As stated in H.Rept. 109-256, the Committee believes

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

that the failure of several major IT projects at VA are related to this decentralized management structure.

Senate-Passed Legislation

Vet Center Enhancement Act of 2005 (S. 716). This bill was introduced on April 6, 2005, and was reported by the Senate Veterans Affairs Committee without an amendment on September 15, 2005 (S.Rept. 109-180). The Senate passed the measure on December 22 (legislative day of December 21), 2005. S. 716 is awaiting House action. Given below is a brief summary of major provisions of this bill.

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

- *Clarification and Enhancement of Bereavement Counseling*. This provision would provide express authority to Vet Centers to provide bereavement counseling to all immediate family members. The provision would also ensure the furnishing of bereavement counseling services to parents by defining them as members of the immediate family when a servicemember dies in active duty. In August of 2003, the Secretary of Veterans Affairs enabled Vet Centers to provide bereavement counseling services to immediate family members of servicemembers who died while on active duty, as well as federally activated Reserve and National Guard personnel on active duty. However, the Committee believed that the current law is unclear on whether or not a bereaved parent can receive such services. Therefore, this provision would give VA the authority to to provide bereavement counseling to all immediate family members, including parents.

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

Veterans' Health Care Act of 2005 (S. 1182). This bill was introduced on June 9, 2005. On September 15, 2005, the Senate Veterans Affairs Committee reported the measure, as amended, to incorporate provisions derived from the Veterans Mental Health Care Capacity Enhancement Act of 2005 (S. 1177);

Sheltering All Veterans Everywhere Act of 2005 (S. 1180); an act to require the Secretary of Veterans Affairs to publish a strategic plan for long-term care (S. 1189); Blinded Veterans Continuum of Care Act of 2005 (S. 1190); as well as an amendment offered by Committee Ranking Member Daniel K. Akaka and an amendment from Committee Ranking Member Daniel K. Akaka, as amended by Committee Chairman Larry E. Craig (S. Rept.109-139). The Senate passed the measure on December 22 (legislative day of December 21), 2005. S. 1182 is awaiting House action. Given below is a brief summary of major provisions of this bill.

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

- *Enhancement of Payer Provisions for Health Care Furnished to Certain Children of Vietnam Veterans.* This would permit private-sector providers of care to certain disabled children of Vietnam veterans to bill private insurers for costs of care not paid by VA. Under current law, VA provides, or pays for, care for certain children of Vietnam veterans. In general, the payment provided by VA is considered payment in full for all services provided to the patient. However, in some circumstances a care provider may seek reimbursement for certain services not otherwise covered by VA. S. 1182 would designate VA as the primary payer for care or services furnished to certain children of Vietnam veterans, and permit a provider who furnishes care to children to seek payment for the difference between the amount billed and the amount paid by the VA from a third-party payer if the beneficiary has health insurance that would otherwise be responsible for the payment. Furthermore, this bill would prohibit the health care provider from imposing any additional charges on the beneficiary who received the care, or on the beneficiary's family, for any service that VA has paid for.

- *Improvements to Homeless Veterans Service Providers Programs.* This provision would permanently authorize the Homeless Grant and Per Diem Program and would increase the amount of money authorized for these efforts to $130 million in FY2006 and each fiscal year thereafter. The grantee assistance program would be authorized through 2011 with an authorized funding level of $1 million for FY2006 and each fiscal year thereafter.

- *Additional Mental Health Providers.* This would add the professions of "Marriage and Family Therapist" and "Licensed Mental Health Counselor" to the list of clinical care providers VA

is authorized to hire. Under current law, VA is not permitted to employ any professional not mentioned in statute.

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

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

- *Data Sharing Improvements.* This provision would permit DOD to share certain medical records of servicemembers with VA, and ensure that DOD would not violate the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) by providing such information. As stated in S.Rept. 109-177, due to requirements under HIPAA, VA must wait until the veteran actually enrolls for care at a VA facility before requesting that DOD send the veteran's medical records from active duty service. This delay hinders the seamless transition from active duty to veterans status.

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

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

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

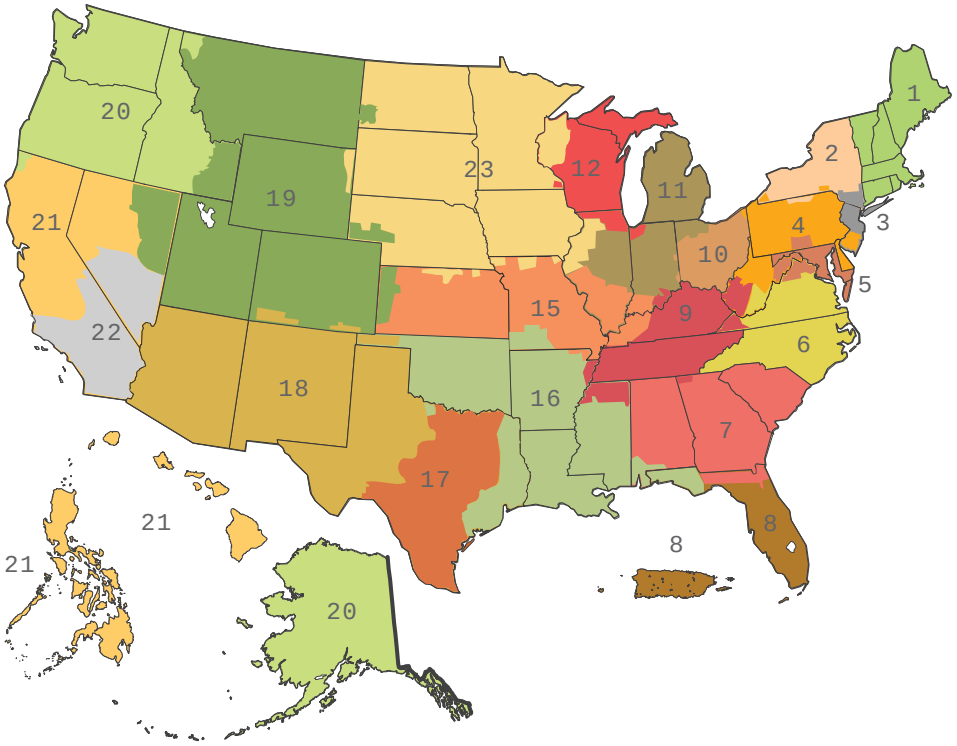
- *Strategic Plan for Long-term Care.* This provision would require VA to publish a strategic plan for long-term care. The plan must include policies and strategies for the delivery of care in many different settings such as domiciliaries, residential treatment facilities, and nursing homes. It must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

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

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

- *Reimbursement for Certain Veterans' Outstanding Emergency Treatment Expenses*. This provision would reimburse certain veterans for expenses resulting from emergency treatment furnished to the veteran in a non-VA facility for which the veteran remains personally liable. Under current law, VA is authorized to pay for emergency care services provided to veterans in non-VA facilities if the veteran seeking the services is an enrolled patient and has seen a VA health care provider in the past two years. However, a veteran who obtains emergency care in a non-VA facility for a nonservice-connected condition is not eligible for VA reimbursement for the related expenses if the veteran has any insurance or other coverage for the cost of the care, in whole or in part. This provision would amend the current law and authorize VA to reimburse veterans who receive emergency treatment from a non-VA medical facility for costs that the veteran remains personally liable for if the veteran is enrolled in VA's health care system, received medical care from VA during the 24-month period preceding emergency treatment, has health insurance that partially reimburses the cost of emergency treatment, is financially liable for the cost of treatment that is not reimbursed by his or her health insurance, and is not eligible for reimbursement under current law.

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



Veteran's Health Administration – Veterans Integrated Service Network (VISNs)

1	New England Healthcare System
2	VA Healthcare Network Upstate NY
3	VA NY/NJ Veterans Healthcare Network
4	Stars & Stripes Healthcare Network
5	Capitol Health Care Network
6	The Mid-Atlantic Network
7	The Atlanta Network
8	VA Sunshine Healthcare Network
9	Mid South Veterans Healthcare Network
10	VA Healthcare System of Ohio
11	Veterans Integrated Service Network
12	The Great Lakes Health Care System
15	VA Heartland Network
16	South Central Healthcare Network
17	VA Heart of Texas Health Care Network
18	VA Southwest Health Care Network
19	Rocky Mountain Network
20	Northwest Network
21	Sierra Pacific Network
22	Desert Pacific Healthcare Network
23	Minneapolis & Lincoln Offices

In January 2002, VISNs **13** & **14** were integrated as VISN 23

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

Appendix 2. Priority Groups and Their Eligibility Criteria

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

Source: Department of Veterans Affairs.

crsphpgw

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