Congressional Research Service
Informing the legislative debate since 1914

Improving Health Care Access for Veterans: H.R. 3230

Sidath Viranga Panangala
Specialist in Veterans Policy

July 16, 2014

Congressional Research Service
7-5700
www.crs.gov
R43646

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Currently, a House and Senate conference committee is negotiating differences between the House version of H.R. 3230 (Veteran Access to Care Act of 2014) and the Senate-passed version of H.R. 3230 (Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014). In general, among other provisions, the Senate and House versions of H.R. 3230 would authorize the Department of Veterans Affairs (VA) to pay for care provided to eligible veterans in non-VA facilities or by non-VA providers. Although the Department currently has authority to provide care through non-VA facilities or providers, the existing statutory authority does not provide specific criteria as to when VA could authorize non-VA care. Non-VA health care is authorized at the local VA Medical Centers (VAMCs) as a clinical decision, and authorization of patients to non-VA care providers is not uniform or standardized across VAMCs.

The Senate version of H.R. 3230 would require VA to pay for non-VA care for veterans who are enrolled in the VA health care system and exceed the current patient wait-time goals of the Department, or who are enrolled and live more than 40 miles from a VA medical facility. In any case, a veteran would have to be enrolled in the VA health care system for VA to pay for non-VA care. Additionally, the Senate version of H.R. 3230 would authorize VA to contract with Medicare providers; Federally Qualified Health Centers (FQHCs); Department of Defense (DOD) medical facilities; and Indian Health Service (IHS) facilities. The House version of H.R. 3230 would require VA to pay for non-VA care to any enrolled veteran who cannot get an appointment within VA's wait-time goals (as of June 1, 2014), or who lives more than 40 miles from a VA medical facility and chooses to have care in a non-VA facility. The House version of H.R. 3230 would require VA to reimburse non-VA providers (who currently do not have a contract with the VA) at the highest of the Medicare, TRICARE, or VA-established reimbursement rate. In both the House and Senate versions of H.R. 3230, the expanded non-VA care authority would be valid for a period of two years.

This report compares only major provisions contained in Title III of the Senate version and Sections 2 and 3 of the House Version of H.R. 3230. However, though not discussed in this report, the House version of H.R. 3230 would require the VA to conduct an independent assessment of its health care system's performance, and would limit awards or bonuses for VA employees from FY2014-FY2016. Likewise, the Senate version of H.R. 3230 includes several other Titles besides Title III. Title I would require the VA to improve the scheduling, staffing, financial and other processes at each VA medical facility. Title II would allow the VA to utilize direct hire authority to fill health care occupations with the largest staffing shortages. Title IV would establish an independent commission of VA construction projects to review current construction and maintenance projects and facility leasing programs in order to identify any problems they may be experiencing, and also would establish a Commission on Access to Care to examine the access of veterans to health care and to examine how best to organize the VA health care system. Title IV would authorize the VA Secretary to remove or demote any individual from the Senior Executive Service (SES) based on performance. Title V would expand eligibility for care and services for Military Sexual Trauma (MST) at a VA facility to active duty servicemembers. Title VI would authorize the VA to enter into leases to obtain the use of major medical facilities at specified locations. Title VII and VIII address VA benefits and budgetary matters.

Contents

Tables

Contacts

Introduction

Since reports about inappropriate scheduling practices surfaced in mid-April 2014 at the Phoenix Department of Veterans Affairs (VA) Health Care System and at other VA health care facilities, the Department of Veterans Affairs (VA) inspector general (VAOIG),[1] as well as the Veterans Health Administration (VHA), has completed reviews to identify inappropriate scheduling practices used by employees regarding veteran preferences for appointment dates.[2] Both reviews have substantiated significant delays in access to care across VA's health care system. However, it should be the noted that VAOIG reviews are not complete and reviews at other VA medical facilities (VAMCs) are ongoing to determine whether scheduling practices are in compliance with VHA's scheduling policies.[3]

Furthermore, the review conducted by the President's Deputy Chief of Staff, Rob Nabors, found that, among other things, the scheduling standards adopted by the VHA were "arbitrary, ill-defined, and misunderstood" and recommended that the VHA needs to be restructured and reformed. According to his report "[VHA] currently acts with little transparency or accountability with regard to its management of the VA medical structure [health care system]."[4]

To address delays in patient care and to provide veterans with timely access to care, among other things, the Senate and House have introduced and passed several measures. Initially, on June 9, 2014, the Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 (S. 2450) was introduced in the Senate, and the Veteran Access to Care Act of 2014 (H.R. 4810) was introduced in the House. The House passed its measure on June 10, but the Senate chose to act on its proposal by substituting the text of S. 2450 for that of H.R. 3230, a measure previously received from the House.[5] The House then amended the Senate substitute for H.R. 3230 by substituting the text of H.R. 4810 and also that of the Department of Veterans Affairs Management Accountability Act of 2014 (H.R. 4031), a measure it had previously passed on May 21. This action enabled the two chambers to proceed to conference on their respective versions of H.R. 3230.[6] An initial meeting of the conference committee was held on June 24, 2014, and currently the House and Senate conferees are negotiating their differences on H.R. 3230.

---

[1] Department of Veterans Affairs, Office of Inspector General, Veterans Health Administration - Interim Report - Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System, 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf.

[2] Department of Veterans Affairs, *Access Audit System-Wide Review of Access*, Results of Access Audit Conducted May12, 2014, through June 3, 2014, June 9, 2014, http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf.

[3] U.S. Congress, House Committee on Veterans' Affairs, *Oversight Hearing on Data Manipulation and Access to VA Healthcare: Testimony from GAO, IG and VA*, Statement of Richard J. Griffin Acting Inspector General Office of Inspector General Department Of Veterans Affairs, 113th Cong., 2nd sess., June 9, 2014.

[4] Rob Nabors, *Issues Impacting Access to Timely Care at VA Medical Facilities*, June 27, 2014, http://www.whitehouse.gov/sites/default/files/docs/va_review.pdf.

[5] The Senate took this course of action because S. 2450 contained appropriations, which the House traditionally insists must be enacted in a measure it has originated. H.R. 3230 was available for this purpose because Congress had acted in other legislation on issues that H.R. 3230 originally addressed.

[6] The House conferees are Representatives Miller (FL), Lamborn, Roe (TN), Flores, Benishek, Coffman, Wenstrup, Walorski, Michaud, Brown (FL), Takano, Brownley (CA), Kirkpatrick, and Walz. The Senate conferees are: Senators Sanders; Rockefeller; Murray; Brown; Tester; Begich; Blumenthal; Hirono; Burr; Isakson; Johanns; McCain; Coburn; and Rubio.

This report provides a brief comparison of the Senate ("Senate Bill") and House ("House Bill") provisions that would provide expanded authority to the VA to provide care to veterans through non-VA health care providers and facilities.

Section 301 of the "Senate Bill" would make two classes of veterans eligible to receive care in non-VA facilities. The first class of veterans are those who are enrolled in the VA health care system, and the second class of veterans are those who are enrolled but have not received VA hospital care or medical services and have contacted the VA seeking an initial appointment for the receipt of such care or services. These two classes of veterans would qualify to receive care outside the VA health care system if they meet any of the following requirements: (1) attempts, or has attempted to schedule an appointment but is unable to schedule an appointment within the current wait-time goals of the Veterans Health Administration (VHA) for the furnishing of care or services and chooses to receive care in a non-VA facility; or (2) resides more than 40 miles from the nearest VA medical facility including a community-based outpatient clinic (CBOC); or (3) resides in a state without a VA medical facility that provides (I) hospital care; (II) emergency medical services; and (III) surgical care, or more than 20 miles away from such a VA medical facility. Section 2 and 3 of the "House Bill" would authorize the VA to provide non-VA care to any enrolled veteran who cannot get an appointment within VA's wait-time goals (as of June 1, 2014), or who lives more than 40 miles from a VA medical facility and chooses to have care in a non-VA facility.

Furthermore, the Congressional Budget Office (CBO) has provided a final cost estimate of implementing provisions of Title III of the "Senate Bill." According to CBO, enacting Title III would cost approximately $33 billion (excluding revenues) for the period of two years.[7] Additionally, CBO has released a preliminary cost estimate of enacting Sections 2 and 3 of the "House Bill."[8]

Table 1 below provides a side-by-side comparison of major provisions contained in Title III of H.R. 3230 as passed by the Senate on June 11 and Sections 2 and 3 of H.R. 3230 as agreed to in the House on June 18. Where appropriate, notes are provided in the notes column to provide context to the proposed provisions in the House- and Senate-passed measures.

[7] Congressional Budget Office, Cost Estimate, *H.R. 3230, Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014*, as passed by the Senate on June 11, 2014, July 10, 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr3230_1.pdf.

[8] Congressional Budget Office, Letter to Rep. Jeff Miller, Chairman, Committee on Veterans'Affairs, June 17, 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr3230_0.pdf.

Table 1. Side-by-Side Comparison of Major Provisions in Title III of the Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] and Sections 2 and 3 of the Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230]

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
Hospital and Medical Services in Non-Department of Veterans Affairs (VA) facilities and by non-VA providers	In general, Section 301 of the bill would authorize the VA to pay for care provided to eligible veterans in non-VA facilities or by non-VA providers and would define when VA should authorize non-VA care.	In general, Sections 2 and 3 of the bill are similar to Section 301 of the Senate bill in that the House bill would provide VA with authority to provide health services to eligible veterans through contracts with non-VA health care providers.	Currently, the VA is authorized to pay for care provided by non-VA providers or facilities (1) when a clinical service cannot feasibly be provided at a VA medical center (VAMC); (2) when a veteran is unable to access VA health care facilities due to geographic inaccessibility; or (3) in emergencies when delays could lead to life-threatening situations. Non-VA health care is authorized at the local VAMCs as a clinical decision, and authorization of patients to non-VA care providers is not uniform or standardized across VAMCs. Recently, VA has begun implementing two new initiatives, the Patient Centered Community Care (PC3) program and the Non-VA Care Coordination (NVCC) program. In September 2013, the VA awarded contracts to two private companies (Health Net Federal Services and TriWest) to implement the PC3 program. These two companies are responsible for developing provider networks in six geographic regions covering the whole country. Under the PC3 contracts, covered care includes

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
			specialty care, mental health care, limited emergency care and limited newborn care. NVCC is an internal program to improve referral management practices. It was formerly known as 'Fee Basis', 'Purchased Care', or 'Non-VA Care.'
Non-VA Providers	Section 301 of the bill would authorize VA to contract with Medicare providers; Federally Qualified Health Centers (FQHCs);[b] Department of Defense (DOD) medical facilities; and Indian Health Service (IHS) facilities.	Section 2 of the bill would authorize the VA to enter into contracts or utilize existing contracts to provide care to eligible veterans in "non-Department facilities" as defined in 38 U.S.C § 1701."	Medicare providers include for example, physicians, and psychologists, as well as patient care institutions such as hospitals, critical access hospitals, hospices, nursing homes, and home health agencies. See, http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/index.html.
Choice of Non-VA Providers	Section 301 of the bill would allow eligible veterans to select among any of the following providers: Medicare providers; Federally Qualified Health Centers (FQHCs); Department of Defense (DOD) medical facilities; and Indian Health Service (IHS) facilities.	No comparable provision.	
Care Coordination	Section 301 of the bill would require the VA to coordinate non-VA care through the Non-VA Care Coordination (NVCC) program.	No comparable provision.	As previously noted, NVCC is an internal program to improve referral management practices. It was formerly known as "Fee Basis," "Purchased Care," or "Non-VA Care."
Eligible Veterans	Section 301 of the bill defines an eligible veteran as : • (A) a veteran enrolled in the VA health care system;	Sections 2 and 3 of the bill define an eligible veteran as a veteran who is enrolled in the VA health care system and who:	As stated previously non-VA health care is authorized for an enrolled veteran at a local VAMC as a clinical decision. For instance, a VA health care provider (generally a clinician) requests a specific

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
	or • (B) a veteran enrolled in the VA health care system and has not received hospital care or medical services from the VA and has contacted the VA seeking an initial appointment for the receipt of such care or services; **and** • (I) attempts, or has attempted to schedule an appointment for the receipt of hospital care or medical services but is unable to schedule an appointment within the current wait-time goals of the Veterans Health Administration (VHA) for the furnishing of care or services and elects to receive care in a non-VA facility; **or** (2) resides more than 40 miles from the nearest VA medical facility including a community-based outpatient clinic (CBOC), that is closest to the residence of the veteran; **or** (3) resides in a State without a VA medical facility that provides (I) hospital care; (II) emergency	• has waited longer than the wait-time goals of the Veterans Health Administration (as of June 1, 2014) for an appointment for hospital care or medical services in a VA facility; and has been notified by the VA facility that an appointment for hospital care or medical services is not available within such wait-time goals; **or** • resides more than 40 miles from a VA medical facility, including a community-based outpatient clinic (CBOCs), that is closest to the residence of the veteran; **and** • who makes an election to receive such care or services in a non-VA facility.	health care service or procedure for the veteran and justifies use of non-VA care because of the lack of clinical capacity or capability to provide the service to the veteran. After the initial consult is received by the fee basis care program office at the local VA medical center (VAMC), the Chief Medical Officer (CMO) at the program office, or a designated official, reviews the request and authorizes the care if it is determined to be appropriate. Following this first stage of review, fee basis care program office staff reviews the authorization to see if the veteran is eligible for the program and whether an appropriate justification has been provided. The referral of authorized cases to non-VA care providers is not uniform or standardized across VAMCs.

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
	medical services; and (III) surgical care rated by the Secretary as having a surgical complexity standard; **and** more than 20 miles from a VA medical facility that does not provide hospital care; (II) emergency medical services; and (III) surgical care rated by the Secretary as having a surgical complexity standard.[c]		
Follow-up Care	No comparable provision.	Section 2 of the bill would require non-VA care authorizations to include a complete episode of care (but for a period not to exceed 60 days), including all specialty and ancillary services deemed necessary as part of an episode of recommended treatment (see notes column).	Currently, VHA authorizes non-VA care on a service or procedure basis, or for limited number of visits per episode of care. For example, a veteran is referred to a non-VA specialist by the VA to examine the case of his recurring ankle pain. During the visit the non-VA provider recognizes the need for additional imaging tests including a MRI (magnetic resonance imaging) which was not authorized in the original authorization for care. Because the imaging tests were not covered in the original authorization the doctor's office must call the referring VAMC to get a second authorization for the imaging tests. In another example, a veteran is receiving authorized non-VA physical therapy for a shoulder injury. The physical therapist would like to conduct additional physical therapy sessions to address the pain. Although the additional

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
			therapy sessions are related to the same episode of care, the physical therapist must call the referring VAMC and request an extension of the current authorization. For more information see, http://www.nonvacare.va.gov/docs/provider-resources/ISMP_Authorizations.pdf
Authorization of Non-VA Care	Section 301 of the bill would require the VA • to place an eligible veteran who does not elect to receive non-VA care on an electronic waiting list if the veteran so chooses to be on such a list **or** • to authorize non-VA care for a specific period if the VA confirms that an appointment for the receipt of hospital care or medical services is unavailable within the current wait-time goals of the VA for furnishing of such care or services. • The VA would be required to send a letter to the eligible veteran describing the care and	No comparable provision.	Currently, all NVCC consults MUST be authorized by the VA; except in certain emergency situations.

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
	services that the veteran is eligible to receive under this authorization.		
Non-VA Care through Contracts	Section 301 of the bill would require the VA to enter into contracts with Medicare providers.	No comparable provision.	
Rates and Reimbursement of Contracted Care	Section 301 of the bill would require the VA to negotiate reimbursement rates with non-VA Medicare providers for the furnishing of care and services.	Section 3 of the bill would require the VA to reimburse any non-VA facility with which the VA has not entered into a contract to furnish hospital care or medical services (at the time of enactment) to an eligible veteran at the **greatest** of the following rates: (1) VA PAYMENT RATE- The rate of reimbursement established by the VA; or (2) MEDICARE PAYMENT RATE- The payment rate under the Medicare program under title XVIII of the Social Security Act; or (3) TRICARE PAYMENT RATE- The reimbursement established under chapter 55 of title 10, United States Code (U.S.C).	
Limitation on Rates for Contracted Care and Exceptions	Section 301 of the bill stipulates that negotiated rates with non-VA Medicare providers can be no more than the payment rate under the Medicare program under Title XVIII of the Social Security Act, set by the Centers for Medicare & Medicaid Services. However, the VA may negotiate a higher rate than	No comparable provision.	Currently, VA uses applicable Medicare rates as its basis for reimbursing non-VA providers for all inpatient and outpatient services. If the VA has a sharing or negotiated agreement with a non-VA provider to reimburse at a non-Medicare rate, VA will pay that amount instead of the Medicare rate. The rates are specific

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
	the Medicare reimbursement rate if the VA determines that there is no other health care provider that would provide services to an eligible veteran at the Medicare reimbursement rate.		to each individual agreement. In some instances it could be higher or lower than the Medicare rate.
Choice Card	Section 301 of the bill would require the VA to issue to each eligible veteran a card that the eligible veteran would be required to present to a health care provider that is eligible to furnish care before the veteran could receive care. Among other things, the following statement will be printed on the card: "This card is for qualifying medical care outside the Department of Veterans Affairs. Please call the Department of Veterans Affairs phone number specified on this card to ensure that treatment has been authorized."	No comparable provision.	
Information on Care Availability	Section 301 of the bill would require the VA to provide information on non-VA care to veterans when they enroll in the VA health care system **or** when the veteran attempts to schedule an appointment for the receipt of hospital care or medical services from the VA but is unable to schedule an appointment within the current wait-time goals of the VHA for the delivery of such care or services.	No comparable provision.	
Participating Providers	Section 301 of the bill would require participating providers to maintain the same or similar credentials and licenses	No comparable provision.	The VA requires its physicians to undergo credentialing and privileging. The credentialing process is used to

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
	as required of VA health care providers, and to submit verification at least annually.		determine whether a physician's professional credentials, such as licensure, education, and training, are valid. VA's privileging process is used to determine which health care services or clinical privileges, such as surgical procedures a VA physician is qualified to provide without supervision. VA physicians must be credentialed and privileged when they initially apply to work and at least once every 2 years thereafter.
Copayments	Section 301 of the bill would require the VA to charge veterans who are authorized non-VA care applicable copayment just as they would be assessed a copayment if treatment was provided in a VA facility.	No comparable provision.	VA provides treatment for service-connected conditions free of charge to all enrolled veterans. Some veterans are required to pay copayments for nonservice-connected care.
Health Care Claims Processing	Section 301 of the bill would require the VA to establish an efficient nationwide system for processing and paying Non-VA care bills or claims, and the Chief Business Office (CBO) of the VHA will oversee the implementation and maintenance of the claims processing system.	No comparable provision.	
Medical Records	Section 301 of the bill would require the VA to ensure that non-VA providers submit to the VA any medical record information related to the care and services provided to an eligible veteran for inclusion in the veteran's Computerized Patient Record System	No comparable provision.	

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
	(CPRS) maintained by the VA.		
Implementation Regulations	Section 301 of the bill would require the VA to prescribe and publish interim final regulations on the implementation of Section 301 no later than 90 days after the date of the enactment.	The VA would be required to begin implementing sections 2 and 3 of the bill on the date of the enactment.	
Office of the Inspector General (OIG) Report	Section 301 of the bill would require the VAOIG to submit a report the VA Secretary no later than 540 days following the publication of the interim final regulations implementing this section. The audit report will include results of the accuracy and timeliness of VA payments to non-VA health care providers as well as any recommendations, the IG may have.	No comparable provision.	
Termination of Expanded Authority for non-VA Care	Section 301 would terminate expanded authority to provide non-VA care on the date that is 2 years after the date on which the VA publishes the interim final regulations.	Sections 2 and 3 of the bill would terminate any hospital care or medical services furnished under the authority provided in Sections 2 and 3 at the end of the 2 years following the date of enactment.	
Reports to Congress	Section 301 of the bill would require VA to submit an interim report to Congress, not later than 90 days after the publication of interim final regulations. The interim report must include information on the number of eligible veterans and a description of the type of care and services furnished to eligible veterans. A final report to Congress would be required within 540 days after	Section 2 of the bill would require the VA to submit quarterly reports to Congress which will include quarterly data and information on: (1) The number of veterans who received care or services at non-VA facilities as authorized under Section 2; (2) The number of veterans who were eligible to receive care or services	

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
	the publication of the interim final regulations to address the feasibility and advisability of continuing to furnish non-VA care and services after 2 year authority sunsets.	pursuant to this section but who elected to continue waiting for an appointment at a VA facility; (3) The purchase methods used to provide the care and services at non-VA facilities, including the rate of payment for individual authorizations for such care and services; and (4) Any other matters as the Secretary determines appropriate.	
Filling Prescription Medications	Section 301 of the bill would require VA pharmacies and Consolidated Mail Order Pharmacies (CMOPs) to fill prescriptions of veterans.	No comparable provision.	Currently, prescriptions written by a VHA provider are processed and filled by the VHA facility or the assigned Consolidated Mail Outpatient Pharmacy (CMOP) for the preferred VAMC.
Reimbursement of Non-VA Providers Assigned to the Chief Business Office (CBO)	Section 302 of the bill would require the Secretary to transfer payment authority for hospital care, medical services, and other health care through non-VA providers, from the Veterans Integrated Service Networks (VISNs) and VAMCs to the Chief Business Office (CBO) of VHA. This transfer will be effective on October 1, 2014.	No comparable provision.	The VA's health care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs). Although policies and guidelines are developed at VA headquarters to be applied throughout the VA health care system, management authority for basic decision making and budgetary responsibilities are delegated to the VISNs. Although, VHA's Chief Business Office (CBO) oversees the non-VA care program claims processing activities are conducted at the VISN or VAMC level. Currently, in some VISNs, claims processing activities are centralized at

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
			the VISN level. In other VISNs non-VA care claims processing is the responsibility of each VAMC.
Transfer of Reimbursement Payments	Section 302 of the bill would require the VA, in each fiscal year that begins after the date of the enactment, to include in VHA's CBO budget amounts to pay for hospital care, medical services, and other health care provided through non- VA providers; and to exclude these amounts from the VISN and VAMC budgets.	No comparable provision.	Currently, congressionally appropriated medical care funds are allocated to the VISNs based on the Veterans Equitable Resource Allocation (VERA) system. VISNs in turn allocate the funds to each VAMC within the VISN. VAMC and VISNs use a portion of these VERA allocations to reimburse non-VA providers.
Enhanced Collaboration Between VA and the Indian Health Service (IHS)	Section 303 of the bill would require the VA in consultation with the Director of the Indian Health Service (IHS), to conduct outreach to each medical facility operated by an Indian tribe or tribal organization through a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to raise awareness of the ability of such facilities, Indian tribes, and tribal organizations to enter into agreements with the VA under which the VA reimburses such facilities, Indian tribes, or tribal organizations, for health care provided to veterans eligible for care at such facilities.	No comparable provision.	In December 2012, VA and the Indian Health Service entered into a reimbursement agreement for services provided to American Indian and Alaska Native Veterans. Under this agreement VA able to reimburse the Indian Health Service for direct care services provided to eligible American Indian and Alaska Native Veterans. The national agreement applies only to VA and IHS and does not directly apply to reimbursement between the VA and tribal health programs or urban Indian organizations. Under the agreement VA copayments do not apply to direct care services provided by IHS to eligible American Indian and Alaska Native Veterans.
Performance Metrics	Section 303 of the bill would require the VA to implement performance metrics	No comparable provision.	

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
	for assessing the performance by the VA and the Indian Health Service under the memorandum of understanding entitled "Memorandum of Understanding between the Department of Veterans Affairs (VA) and the Indian Health Service (IHS)" in increasing access to health care, improving quality and coordination of health care, among other things.		
Report to Congress	Section 303 of the bill would require the VA in collaboration with IHS to report to Congress on the feasibility of including urban Indian organizations into the current VA-IHS reimbursement agreement. Additionally, the report should include feasibility of entering into reimbursement agreements with IHS facilities or clinics run by an Indian tribe or tribal organization for the treatment of non-American Indian veterans on a reimbursable basis. This report to Congress is due 180 days following enactment.	No comparable provision.	
Enhanced Collaboration Between Department Of Veterans Affairs and Native Hawaiian Health Care Systems	Section 304 of the bill would require the VA, in consultation with Papa Ola Lokahi and such other organizations involved in the delivery of health care to Native Hawaiians, to enter into contracts or agreements with Native Hawaiian health care systems that are in receipt of funds from the Secretary of Health and Human Services.	No comparable provision.	

Provision	Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 [H.R. 3230 as amended] "Senate Bill"	Veteran Access to Care Act of 2014 [House amendment to the Senate amendment to H.R. 3230][a] "House Bill"	Notes
Prompt Payment	Section 305 of the bill would establish that it is the Sense of Congress that the VA must comply with the Prompt Payment rule.	No comparable provision.	In general, the Prompt Payment rule ensures that federal agencies pay vendors in a timely manner. For more information on the rule see, http://www.fms.treas.gov/prompt/index.html

Source: Table prepared by the Congressional Research Service (CRS).

a. Version of the bill printed in U.S. Congress, House Committee On Rules, *Providing For Consideration Of The Bill (H.R. 4870) Making Appropriations For The Department Of Defense For The Fiscal Year Ending September 30, 2015, And For Other Purposes, And Providing For Consideration Of The Senate Amendments To The Bill (H.R. 3230) Making Continuing Appropriations During A Government*, Report to accompany H.Res. 628, 113th Cong., 2nd sess., June 17, 2014, H.Rept. 113-475.

b. See CRS Report R43029, *Health Care for Rural Veterans: The Example of Federally Qualified Health Centers*, by Elayne J. Heisler, Sidath Viranga Panangala, and Erin Bagalman, for aspects of the FQHCs that are most relevant to collaboration with the VA.

c. VA has assigned each of its medical centers an inpatient "surgical complexity" level—complex, intermediate or standard. Hospitals assigned a "complex" rating require special facilities, equipment and staff for difficult operations, such as cardiac surgery and craniotomies. Those with an "intermediate" rating may perform less complex surgeries, such as partial colon removal and complete joint replacement. Those with a "standard" rating may perform inpatient surgeries, such as hernia repair and ear, nose, and throat (ENT) surgeries. These measures were implemented May 7, 2010. If a VA hospital cannot provide a certain type of therapy or treatment to a patient, it will transfer the veteran to a VA facility that has these programs.

Author Contact Information

Sidath Viranga Panangala
Specialist in Veterans Policy
spanangala@crs.loc.gov, 7-0623