HOUSE COMMITTEE ON VETERANS' AFFAIRS
Chairman Phil Roe, M.D.

Legislation to Establish a VA Care in the Community Program

TITLE I - IMPROVED ACCESS FOR VETERANS TO NON-DEPARTMENT OF VETERANS MEDICAL CARE

Section 101 would:

Require every eligible veteran (defined as a veteran who is enrolled in the VA healthcare system, and has been furnished care at VA on at least one occasion during the preceding two year period, or who has requested a first-time appointment at a VA medical facility) to be assigned to dedicated VA primary care provider (PCP) or patient aligned care team (PACT) to provide, manage, and coordinate care consistent with the goals of care agreed upon by the veteran and his/her provider/care team and allow for a veteran who resides in more than one location to be assigned to a PCP/PACT team at more than one location.

Section 102 would:

Establish a permanent VA Care in the Community Program to provide hospital care, medical services, and/or extended (nursing home) care to eligible veterans (defined as a veteran who is enrolled in the VA healthcare system, and has been furnished care at VA on at least one occasion during the preceding two year period or who has requested a first-time appointment at a VA medical facility) through contracts or agreements with network providers (to include Medicare providers, FQHCs, DOD, IHS, and academic affiliates).

- Require VA coordinate care for eligible veterans
- Require VA to establish regional networks of community providers and to enter into one or more contracts (including national contracts) for the purpose of managing the operations of the network and the delivery of care in the community
- If VA is unable to assign an eligible veteran to a PCP/PACT due to unavailability (as determined by VA), require VA to consult with the veteran regarding the availability of PCPs in the community via a network provider in the regional network the veteran resides in, or one adjacent, and allow the veteran to select a network provider for such care
    - Require VA to provide the veteran the option of being reassigned to a VA PCP/PACT if one becomes available after a veteran has been assigned to a network provider

Require VA to reevaluate a veteran's assignment to a network provider not earlier than one year after such assignment and annually thereafter

Authorize VA to furnish specialty care to an eligible veteran pursuant to a referral by the veterans PCP either in VA or in the network (with exceptions as determined by the Secretary)

Require VA to determine whether to furnish specialty care: (1) at a VA medical facility within reasonable distance of the veteran's residence (as determined by VA); (2) by a network provider that to the greatest extent possible is located in the regional network in which the veteran resides or one adjacent; or, (3) pursuant to an agreement with a network provider to provide such care at a VA medical facility or a VA provider to provide such care at a network facility.

In making such determination, require VA to prioritize VA medical facilities but take into account unusual/excessive travel burdens geographical challenges, environmental factors, the veteran's medical condition, other factors as determined by VA, and the recommendation of the veteran's PCP in VA or in the network.

Require VA to establish a process to review disagreements regarding the eligibility of a veteran to receive care or services from a network provider.

Require VA to ensure that an eligible veteran receives hospital, medical, or extended care services by a VA provider or a network provider selected by the veteran through the completion of an episode of care including, after consultation with VA, all specialty and ancillary services.

Require VA to provide case management, if determined by VA to be appropriate, to an eligible veteran who receives hospital, medical, or extended care services, from a network provider.

Require VA to reimburse network providers in accordance with Medicare rates with the exception of highly rural areas, Alaska, and states with all-payer models; authorize VA to enter into value-based reimbursement models; authorize VA to negotiate adjusted rates, to follow Medicare exceptions, to establish fee schedules, and to negotiate rates with a federal or tribal entity.

Establish a prompt payment standard for VA.

Require claims to be submitted 180 days after either care is provided or a network provider is paid by a contractor.

Require clean paper claims to be paid or denied not later than 45 days after receipt and clean electronic claims to be paid or denied no later than 30 days after receipt.

Require adjudication within 30 days of receipt when a claim is denied and additional information has been submitted.

Require interest payments for overdue claims.

Allow for recovery of overpayments through deductions of future payments or refunds from claimant.

Prohibit VA from requiring receipt of medical records as a requisite for payment.

Require a provider to attest that that care was provided prior to payment.

Require veterans to pay copayments for care in the community via a network provider if the veteran would be required to pay a copayment for care in a VA medical facility.

Require VA to ensure that network providers provide VA with medical records upon the completion of care and services and to the veteran upon request and require VA to submit relevant medical record information to network providers

Require VA to ensure medical record information is shared in an electronic format accessible to network providers via an Internet website and to provide network providers access to VA's electronic patient health record system.

Prohibit VA from using funds to issue separate identification cards solely for the purpose of this program and require VA to ensure that the veterans identification card includes sufficient information to act as an identification card for the furnishing of care via a network provider.

Require VA to ensure network providers can submit prescriptions on the VA formulary to VA pharmacies using methods similar to how network providers submit prescriptions to retail pharmacies.

Require VA to use quality standards used by CMS to track the quality of network providers.

Require VA to conduct periodic (but not less often than once every three years) capacity and commercial market assessments of each VISN and VA medical facility

Require each assessment to identify gaps in care at each VISN/VA medical facility and how such gap could be filled via network providers, changes in how care is furnished at such VISN/VA medical facility, or building or realigning VA resources or personnel.

Require VA to develop a plan to allocate funds in the Community Care account.

Section 103 would:

Authorize VA to enter into provider agreements to deliver hospital care, medical services, or extended (nursing home) care to veteran patients when furnishing such care at VA facilities is impractical/inadvisable because of a veteran's medical condition, travel, and/or nature of the care/services required and such care is not available by a community provider under a traditional Federal Acquisition Regulation (FAR) based contract or medical sharing agreement; limit such provider agreements to $5 million in the case of a provider who furnishes homemaker/home health aide services and to $2 million otherwise; require VA to establish a process to certify eligible providers, to allow

for termination of provider agreements, and to ensure provider agreements meet certain terms and conditions and quality standards; and, stipulate that provider agreements are not subject to competitive procedures and are exempted from any provision of law that Medicare providers are exempted from but are subject to the Civil Rights Act of 1964 and all laws regarding integrity, ethics, or fraud.

Section 104 would:

Modify VA's authority to enter into agreements with State Veterans Homes by stipulating that such agreements are not subject to competitive procedures or laws that Medicare providers are exempt from but are subject to all laws regarding integrity, ethics, fraud, and that would protect against employment discrimination.

Section 105 would:

Require VA to ensure the system VA uses to receive, process, and pay claims from community providers includes the ability to submit information electronically, the ability to automatically adjudicate claims, a centralized claims database that is accessible nationwide, integration with other relevant VA information technology systems, the ability of a community provider to ascertain the status of their pending claim, and a claim review system similar that used by Medicare to determine the accuracy/appropriateness of payments and ensure program integrity and oversight; require VA to ensure the claims processing system established above meets all federal information protection laws and certain protection, security and privacy requirements; and, authorize VA to enter into a contract for the purpose of carrying out this section.

Section 106 would:

Require the permanent VA Care in the Community program to be funded out of the Community Care account established by P.L. 114-41 and stipulate that remaining funds, if any, in the Veterans Choice Fund would be transferred to the Community Care account one year after enactment.

Section 107 would:

Terminate VA's existing care in the community programs and authorities upon commencement of the permanent VA Care in the Community program (pursuant to section 108, summarized below).

Section 108 would:

Require VA to commence the implementation of the permanent VA Care in the Community Program no later than one year after enactment via interim final regulations after certifying to HVAC/SVAC that each community care provider and VA employee is trained to furnish care under such program and establishing standard, written guidance with respect to the policies and procedures of such program.

Section 201 would:

Require, as of January 1, 2019, VA to reimburse an ambulance provider (or other emergency transport service) for providing transportation to a veteran for purposes of receiving emergency medical care at a community facility if the request for transportation was made as a result of the sudden onset of a medical condition of such

a nature that it meets the prudent layperson standard and the veteran is transported to the most appropriate medical facility.

Section 202 would:

Require VA to share medical record information with a public or private health care provider in order to provide care or treatment to a shared patient and to a third party in order to recover/collect reasonable charges for care furnished to a veteran for a non-service connected disability with the stipulation that such sharing must be in accordance with relevant health record privacy laws (including HIPPA).

Section 203 would:

Eliminate the current requirement for VA to offset a veteran's copayment with amounts recovered from the veteran's third party insurance.

Section 204 would:

Include automatic data processing and information technology improvements as a Medical Care Collection Fund expense allowed in the billing, auditing, and collecting of such revenues.

Section 205 would:

Require VA to track productivity and standardize performance metrics in terms of nationally-recognized relative value units (RVUs).

Section 206 would:

Allow VA providers to provide telemedicine services to a veteran, regardless of where the veteran or the provider are physically located.