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Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230; P.L. 113-146)

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Summary

On August 7, 2014, President Obama signed the Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230; H.Rept. 113-564; P.L. 113-146). The Department of Veterans Affairs Expiring Authorities Act of 2014 (H.R. 5404; P.L. 113-175), the Consolidated and Further Continuing Appropriations Act, 2015 (H.R. 83; P.L. 113-235), the Construction Authorization and Choice Improvement Act (H.R. 2496; P.L. 114-19), and the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41) made amendments to some provisions in P.L. 113-146. The act, as amended, makes a number of changes to programs and policies of the Veterans Health Administration (VHA) within the Department of Veterans Affairs (VA) that aim to increase access to care outside the VA health care system. Among other things, the act establishes a new program (the Veterans Choice Program) that would allow the VA to authorize care for enrolled veterans through the Veterans Choice Program if they meet the following eligibility requirements:

1. attempts, or has attempted to schedule an appointment for the receipt of hospital care or medical services but is unable to schedule an appointment:
   I. within the wait-time goals of the VHA for the furnishing of care or services; *or*
   II. within a clinically appropriate period if such time frame is shorter than the wait-time goals of the VHA; *or*
2. resides more than 40 miles (based on distance traveled):
   I. if seeking primary care, from a VA medical facility including a community-based outpatient clinic (CBOC) that is able to provide the care sought and provided by a full-time primary care physician; *or*
   II. if not seeking primary care, from any VA medical facility including a community-based outpatient clinic (CBOC); *or*
3. resides in a state without a VA medical facility that provides (a) hospital care; (b) emergency medical services; and (c) surgical care, or more than 20 miles away from such a VA medical facility; *or*
4. resides within 40 miles of a VA medical facility and is required to travel by air, boat, or ferry to access such a facility; or faces a travel burden based on geographical challenges; or inaccessible roads or hazardous weather; or a medical condition that would prevent the veteran from travelling; or any other factor as determined by the VHA.

This report offers an overview of the provisions in the law, which requires, among other things:

- increased collaboration between the VA and facilities operated by the Indian Health Service or the Native Hawaiian Health Care System and requiring increased funding for graduate medical education training at the VA;
- the extension of Project ARCH (Access Received Closer to Home) within specified Veterans Integrated Service Networks (VISNs) for veterans in highly rural areas who are enrolled in VA health care for an additional two years;
- several studies to examine a variety of issues pertaining to VA's health care delivery system, and to explore ideas on how best to reform the system;
- imposition of penalties on VA employees who knowingly falsify data on patient wait times or health care quality measures; and limitations on VA employee and bonuses.

Contents

Introduction 1
Brief Legislative History 1
Provisions in the Veterans Access, Choice, and Accountability Act of 2014 2
Sec. 1. Short Title 3
Sec. 2. Definitions 3
Title I: Improvement of Access to Care from Non-Department of Veterans Affairs Providers 3
Sec. 101. Availability of Hospital Care and Medical Services through the Use of Non-VA Entities 3
Eligibility 3
Choice of Provider 5
Coordination of Care with Non-VA Entities 5
Authorization of Care by the VA 5
Electronic Waiting List 6
Care and Services Through Agreements 6
Rates of Reimbursement 6
VA as the Secondary Payer of Care 7
Veterans Choice Card 7
Information on Availability of Care 7
Follow-Up Care 8
Credentials of Providers 8
Copayments 8
Health Care Claims Processing 8
Medical Records 8
Tracking Missed Appointments 8
Implementing Regulations 9
Office of the Inspector General (OIG) Report 9
End Date of the Expanded Authority for Non-VA Care 9
Reports to Congress 9
Filling Prescription Medications 9
Wait-Time Goals of the VHA 9
Waiver of Certain Printing Requirements 10
Sec. 102. Enhancement of Collaboration between the VA and Indian Health Service 10
Sec. 103. Enhancement of Collaboration between the VA and the Native Hawaiian Health Care System 10
Sec. 104. Reauthorization and Modification of Project ARCH (Access Received Closer to Home) 11
Sec. 105. Prompt Payment 11
Sec. 106. Reimbursement of Non-VA Providers Assigned to the Chief Business Office (CBO) 12
Title II: Health Care Administrative Matters 12
Sec. 201. Independent Assessment of the VA Health Care Delivery Systems and Management Processes 12
Sec. 202. Commission on Care 12
Sec. 203. Technology Task Force on Review of Scheduling System and Software of the VA 13

Sec. 204. Improving Access to Mobile Vet Centers and Mobile Medical Centers 13
Sec. 205. Improved Performance Metrics for Health Care Provided by the VA 13
Sec. 206. Improved Transparency Concerning Health Care Provided by the VA 14
Sec. 207. Information for Veterans on the Credentials of VA Physicians 14
Sec. 208. Information in Annual Budget of the President on Hospital Care and Medical Services Furnished through the Expanded use of Contracts 15
Sec. 209. Prohibition on Falsification of Data Concerning Wait Times and Quality Measures at the VA 15
Title III: Health Care Staffing, Recruitment, and Training Matters 15
Sec. 301. Treatment of Staffing Shortage and Biennial Report on Staffing of VA Medical Facilities 15
Sec. 302. Extension and Modification of Certain Programs within the VA's Health Professionals Educational Assistance Program 16
Sec. 303. Clinic Management Training for Employees at VA Medical Facilities 16
Title IV: Health Care Related to Sexual Trauma 17
Sec. 401. Expansion of Eligibility for Sexual Trauma Counseling and Treatment to Veterans on Inactive Duty Training 17
Sec. 402. Provision of Counseling and Treatment for Sexual Trauma by the VA to Members of the Armed Forces 17
Sec. 403. Reports on Military Sexual Trauma 17
Title V: Other Health Care Matters 17
Sec. 501. Extension of Pilot Program on Assisted Living Services for Veterans with Traumatic Brain Injury 17
Title VI: Major Medical Facility Leases 18
Sec. 601. Authorization of Major Medical Facility Leases 18
Sec. 602. Budgetary Treatment of VA Major Medical Facilities Leases 18
Title VII: Other Veterans Matters 19
Sec. 701. Expansion of Marine Gunnery Sergeant John David Fry Scholarship 19
Sec. 702. Approval of Courses of Education Provided by Public Institutions of Higher Learning for Purposes of All-Volunteer Force Educational Assistance Program and Post-9/11 Educational Assistance Conditional on In-State Tuition Rate for Veterans 19
Secs. 703, 704, 705, and 706 20
Sec. 707. Removal of Senior Executives of the VA for Performance or Misconduct 20
Title VIII: Other Matters 21
Sec. 801. Appropriation of Amounts 21
Sec. 802. Veterans Choice Fund 22
Sec. 803. Emergency Designations 22

Tables

Table A-1. Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146 as Amended by P.L. 113-175 and P.L. 113-235): Implementation and Reporting Deadlines 23

Appendixes

Appendix. Veterans Access, Choice, and Accountability Act of 2014: Implementation and Reporting Deadlines 23

Contacts

Author Information 30

Introduction

In April 2014, Congress became aware of issues pertaining to delays in patient care and patient wait time manipulation at various Department of Veterans Affairs (VA) health care system facilities.[1] In response to these issues, in August 2014 Congress passed the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146). At the heart of this legislation is a temporary new program known as the "Veterans Choice Program," intended to increase eligible veterans' access to care through eligible non-VA providers and facilities. In addition, P.L. 113-146, as amended, provides additional funding to improve VA's physical infrastructure and to hire physicians and other medical professionals, including nurses, mental health professionals, and social workers. Lastly, among other things, the Veterans Access, Choice, and Accountability Act of 2014 requires the VA to enter into one or more contracts with a private sector entity or entities for an independent assessment in order to comprehensively examine the VA's ability to deliver high-quality health care to veterans now and into the future. As discussed in the next section, the act (P.L. 113-146) has been amended several times since it was enacted on August 7, 2014. This report begins with a brief overview of the legislative history that lead up to the enactment of the Veterans Access, Choice, and Accountability Act of 2014, and subsequent amendments to the act.

Brief Legislative History

In an attempt to address delays in patient care provided by the VA health care system and to provide veterans with timely access to care, among other things, the Senate and House introduced and passed several measures in May and June of 2014. 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.[2] 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.

On July 28, the Co-Chairmen of the Conference Committee, Senator Bernie Sanders and Representative Jeff Miller, announced that an agreement had been reached, and reported the measure. The conferees voted on the conference report (H.Rept. 113-564) on the same day.[3] The full House passed the Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230; H.Rept. 113-564) on July 30, and the Senate passed the conference measure on July 31. President Barack Obama signed the Veterans Access, Choice, and Accountability Act of 2014 into law (P.L. 113-146) on August 7, 2014.[4]

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[1] U.S. Congress, House Committee on Veterans' Affairs, *A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths',* 113th Cong., 2nd sess., April 9, 2014.

[2] 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.

[3] "Conference Report on H.R. 3230," *Congressional Record*, daily edition, vol.160 (July 28, 2014), pp. H6953-H6974; and U.S. Congress, Committee of Conference, *Veterans Access, Choice, and Accountability Act of 2014*, Report to Accompany H.R. 3230, 113th Cong., 2nd sess., July 28, 2014, H.Rept. 113-564 (Washington: GPO, 2013), pp. 3-81.

[4] While some provisions took effect on that same date, other provisions such as the new authority that would allow veterans to seek care from non-VA health care providers will not take effect until implementing regulations are issued.

On September 26, 2014, the Department of Veterans Affairs Expiring Authorities Act of 2014 (H.R. 5404; P.L. 113-175) was signed into law. Sections 408 and 409 of P.L. 113-175 made minor amendments to Sections 101, 102, 104, 105, 204, 206, 207, 301, 302, and 702 of the Veterans Access, Choice, and Accountability Act of 2014. On December 16, 2014, President Barack Obama signed into law the Consolidated and Further Continuing Appropriations Act, 2015 (H.R. 83; P.L. 113-235). Division I of this act contained the Military Construction and Veterans Affairs, and Related Agencies Appropriations Act, 2015. Section 242 of this act amended Section 101 of the Veterans Access, Choice, and Accountability Act of 2014. On May 22, 2015, the Construction Authorization and Choice Improvement Act (H.R. 2496; P.L. 114-19) was enacted into law. Section 3 of this act amended Section 101(b)(2)of the Veterans Access, Choice, and Accountability Act of 2014, as amended. Lastly, on July 31, 2015, the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41) was enacted into law. Title IV of this act contained the VA Budget and Choice Improvement Act. Sections 4004 and 4005 of this act amended and modified Sections 101 and 802 of the Veterans Access, Choice, and Accountability Act of 2014. The summary of selected provisions of the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146) provided in this report incorporates these amendments made by P.L. 113-175, P.L. 113-235, P.L. 114-19, and P.L. 114-41.

Provisions in the Veterans Access, Choice, and Accountability Act of 2014

The rest of this report provides a summary of selected provisions in the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146)—as amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (H.R. 5404; P.L. 113-175); the Consolidated and Further Continuing Appropriations Act, 2015 (H.R. 83; P.L. 113-235); the Construction Authorization and Choice Improvement Act (H.R. 2496; P.L. 114-19); and the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41)—by title and section. It does not attempt to analyze each of the provisions in the act in depth, but provides brief outlines of the matters addressed. The **Appendix** provides a table showing the numerous implementing and reporting deadlines required by P.L. 113-146 as amended by P.L. 113-175. Throughout this report, unless otherwise stated, the "Secretary" means the Secretary of Veterans Affairs, and the "VA" means the same. In addition, "this section" refers to matters addressed under that specific section of the act.

This report uses a number of acronyms, which are listed below.

CBO	Chief Business Office of the Veterans Health Administration
CBOC	Community Based Outpatient Clinic
DOD	Department of Defense
FQHCs	Federally Qualified Health Centers
GAO	Government Accountability Office
HHS	Department of Health and Human Services
IHS	Indian Health Service
MST	Military Sexual Trauma
NVCC	Non-VA Care Coordination
Project ARCH	Access Received Closer to Home

U.S.C.	United States Code
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISNs	Veterans Integrated Service Networks

Sec. 1. Short Title

This section provides the title of the bill as the "Veterans Access, Choice, and Accountability Act of 2014."

Sec. 2. Definitions

This section provides definitions of the terms used for the purposes of this act. These definitions refer to current law definitions provided in Title 38 U.S.C. for the terms "facilities of the Department," "hospital care," and "medical services."[5]

Title I: Improvement of Access to Care from Non-Department of Veterans Affairs Providers

At the core of this title is a new *temporary* program (the Veterans Choice Program) to provide hospital care and medical services to certain eligible veterans in non-VA facilities or through non-VA providers. The VA has 90 days from the date of enactment (i.e., November 5, 2014) to issue interim final regulations to implement major provisions of Section 101.[6]

Sec. 101. Availability of Hospital Care and Medical Services through the Use of Non-VA Entities

Eligibility

This section requires the VA to authorize non-VA care to veterans who are enrolled in the VA health care system, including a veteran enrolled in the VA health care system who 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; [7]

[5] 38 U.S.C. §1701. Under current law, the term "facilities of the Department" means facilities over which the Secretary has direct jurisdiction; other VA- contracted government facilities; and public or private facilities at which the Secretary provides recreational activities for patients receiving VA care. The terms "hospital care" and "medical services" have the meanings given such terms by 38 U.S.C. §1701(5) and §1701(6).

[6] For a discussion of implementation issues of the Veterans Choice Program, see CRS In Focus IF10224, *Implementation of the Veterans Choice Program (VCP)*, by Sidath Viranga Panangala.

[7] Prior to the passage of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41), veterans had to have been enrolled in the VA health care system as of August 1, 2014, or have to have served in a combat-theater and discharged or released from active duty during a five-year period prior to the enrollment date. With the enactment of P.L. 114-41, these criteria no longer applies.

If a veteran is enrolled in the VA health system, then veterans are eligible for Veterans Choice Program authorization if they meet one of the following four criteria:

(A) attempts, or has attempted to schedule an appointment for the receipt of hospital care or medical services but is unable to schedule an appointment

I. within the wait-time goals of the VHA for the furnishing of care or services; *or*

II. within a clinically appropriate period if such time frame is shorter than the wait-time goals of the VHA;[8]

or

(B) resides more than 40 miles (based on distance traveled),[9]

I. if seeking primary care, from a VA medical facility including a community-based outpatient clinic (CBOC) that is able to provide the care sought and provided by a full-time primary care physician;[10] *or*

II. if not seeking primary care, from any VA medical facility including a community-based outpatient clinic (CBOC); [11]

or

(C) resides in a state without a VA medical facility that provides (I) hospital care, and (II) emergency 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 provides hospital care; and (II) emergency medical services; and (III) surgical care rated by the Secretary as having a surgical complexity standard;[12]

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[8] As amended by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41).

[9] As amended by the Construction Authorization and Choice Improvement Act (H.R. 2496; P.L. 114-19). The VA would generally use driving distance when measuring the distance traveled from a veteran's place of residence to the nearest VA medical facility, instead of a geodesic or straight-line distance measurement. The VA will calculate a veteran's driving distance using geographic information system (GIS) software.

[10] As amended by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41). A veteran would be eligible for *primary care* through the Veterans Choice Program if the veteran *lives less than* 40 miles (as calculated based on distance traveled) from a VA medical facility, including a CBOC, if that facility is not able to provide the *primary care* sought by the veteran and cannot be provided by a full-time primary care physician. It should be noted that the VA is in the process of modifying its interim final rules (Department of Veterans Affairs, " Interim Final Rule - Expanded Access to Non-VA Care through the Veterans Choice Program," 79 *Federal Register* 65571 - 65587, November 5, 2014), and may through rulemaking, define how these latest eligibility criteria will be implemented.

[11] For a veteran *not seeking primary care*, the veteran would be eligible for care through the Veterans Choice Program system if the veteran lives more than 40 miles (as calculated based on distance traveled) from any VA medical facility. It should be noted that the VA is in the process of modifying its interim final rules (Department of Veterans Affairs, " Interim Final Rule - Expanded Access to Non-VA Care through the Veterans Choice Program," 79 *Federal Register* 65571 - 65587, November 5, 2014), and may through rulemaking, define how these latest eligibility criteria will be implemented.

[12] 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

or

(D) resides in a location, (*not including* a location in Guam, American Samoa or the Republic of the Philippines), that is 40 miles or less from a VA medical facility, including a CBOC;

and

(1) is required to travel by air, boat, or ferry to reach each VA medical facility, including a CBOC, that is 40 miles or less from the veteran's residence

or

(2) resides in a location, (*not including* a location in Guam, American Samoa, or the Republic of the Philippines), that is 40 miles or less from a VA medical facility, including a CBOC, and faces an unusual or excessive burden in accessing such a VA medical facility due to geographical challenges; *or* environmental factors, such as roads that are not accessible to the public, because of traffic, or hazardous weather; *or* a medical condition that impacts the veteran's ability to travel; or other factors, as determined by the VA.[13]

Choice of Provider

Eligible veterans authorized to receive care under this section could choose to receive care through any of the following non-VA entities or providers: Medicare providers, including any physician furnishing services under such program;[14] FQHCs;[15] DOD medical facilities; IHS facilities; and other health care providers that meet criteria established by the Secretary.[16]

Coordination of Care with Non-VA Entities

This section requires the VA to use the Non-VA Care Coordination (NVCC) program to coordinate care of eligible veterans with non-VA providers. It also requires the VA to ensure that appointments are scheduled within the wait-time goals of the VA.[17]

Authorization of Care by the VA

This section requires the VA to authorize care to eligible veterans. It also allows the veteran to elect whether he or she wants to receive care from non-VA entities. If the veteran does not elect to receive care from non-VA entities, the veteran could be provided with an appointment that exceeds the wait-time goals of the VA,[18] or the veteran will be placed on an electronic waiting

VA facility that has these programs.

[13] As amended by the Construction Authorization and Choice Improvement Act (H.R. 2496; P.L. 114-19).

[14] Title XIII of the Social Security Act ("Medicare") 42 U.S.C. §1395 et seq. Medicare providers include 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.

[15] These include FQHC Look-Alike facilities. For more details, see CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

[16] As amended by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41).

[17] NVCC is an internal program to improve referral management practices. It was formerly known as "Fee Basis," "Purchased Care," or "Non-VA Care."

[18] As amended by Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175). As required by

list—which may be viewed by the veteran—maintained by the VA for an appointment for hospital care or medical services. If the veteran chooses to be seen by non-VA entities, the VA is required to authorize such care or services to the eligible veteran for a period of time specified by the Secretary; and notify the eligible veteran by electronic communication or in writing, describing the care or services that the veteran is eligible to receive.

Electronic Waiting List

This section requires the VA to maintain an electronic waiting list and allow each eligible veteran access to it either through the www.myhealth.va.gov or any successor website (or other digital channel).[19] The veteran could use the electronic waiting list to determine the average length of time an individual spends on the waiting list at each specific VA medical facility. The veteran could use this information to decide if they want to seek care from a non-VA entity.

Care and Services Through Agreements

This section requires the VA to enter into agreements for furnishing care and services to eligible veterans with the following entities: Medicare providers, including any physician furnishing services under such program;[20] FQHCs;[21] DOD medical facilities; IHS facilities; and other health care providers that meets criteria established by the Secretary.[22] This section defines the term ‘‘agreement’’ to include contracts, intergovernmental agreements, and provider agreements, as appropriate. Furthermore, this section stipulates that an agreement entered for furnishing care and services to eligible veterans cannot be treated as a federal contract for the acquisition of goods or services. This section also requires the Secretary to the maximum extent practicable to furnish care and services to eligible veterans using existing contracts or other processes available at VAMCs prior to entering into new agreements.[23]

Rates of Reimbursement

This section requires the Secretary to negotiate reimbursement rates for the furnishing of care and services with non-VA entities. Furthermore, this section places a limit on the reimbursement rate with several exceptions. In general, negotiated rates must 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 the Medicare reimbursement rate if the provider is furnishing care or services to an eligible veteran who resides in a highly rural area (defined as an area located in a county that has fewer than seven individuals residing in that county per square mile). Furthermore, in the State of Alaska, VA will be able to

law, wait-time goals of the VA were published on October 17, 2014. See Department of Veterans Affairs, “Wait-Time Goals of the Department for the Veterans Choice Program,” 79 *Federal Register* 62519-62520, October 17, 2014.

[19] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

[20] Title XIII of the Social Security Act (“Medicare”) 42 U.S.C. §1395 et seq. Medicare providers include 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.

[21] These include FQHC Look-Alike facilities. For more details, see CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

[22] As amended by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41)

[23] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

reimburse providers under the VA Alaska Fee Schedule, and in states with an "All-Payer Model" agreement, VA will calculate Medicare payments based on payment rates under such "All-Payer Model" agreements.[24] This section also exempts Medicare and Medicaid providers—during the period they are furnishing care to eligible veterans—from Federal Contract Compliance Programs of the Department of Labor that apply to federal contractors and subcontractors. Furthermore, this section stipulates that a non-VA health care entity may not collect an amount that is greater than the rate that was negotiated with the VA for care to eligible veterans. It also requires that the Secretary provide non-VA health care entities and providers with required information on policies and procedures with regard to billing, claims submission, and care authorization, among other things.

VA as the Secondary Payer of Care

This section of the act stipulates that the VA will generally be the secondary payer[25] for eligible veterans receiving care for nonservice-connected disabilities or conditions from specified non-VA health care entities. It further stipulates that the VA will pay for care or services that are not covered by the veteran's health insurance plan at an amount not to exceed the Medicare rate or a negotiated rate. Furthermore, before receiving hospital care or medical services, an eligible veteran is required to provide the Secretary information on any insurance policy or contract that the veteran has. For those veterans who are only enrolled in Medicare, Medicaid, or TRICARE, the VA will be the primary payer for care and services for nonservice-connected disabilities or conditions.[26]

Veterans Choice Card

This section stipulates that not later than 90 days after enactment the VA is required to provide each enrolled veteran with a card known as a "Veterans Choice Card." Among other things, as specified, 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.'' Furthermore, the act stipulates that the Secretary provide the eligible veteran with information clearly stating the circumstances under which the veteran may be eligible for care or services.

Information on Availability of Care

This section requires the Secretary to provide information on non-VA care to veterans when they enroll in the VA health care system, 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

[24] As amended by the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235). Maryland operates the nation's only all-payer hospital rate regulation system. Under Section 1814(b) (3) of the Social Security Act, the Centers for Medicare & Medicaid Services ("CMS") has exempted certain hospitals in Maryland from reimbursement under the national payment system and has allowed the state to set reimbursement rates payable by Medicare for applicable services that otherwise would be reimbursed under Medicare's Inpatient Prospective Payment System ("IPPS") and Outpatient Prospective Payment System ("OPPS"). On January 10, 2014, CMS and the State of Maryland jointly announced a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services. In the state of Maryland, VA will follow this reimbursement system.

[25] A secondary payer is an insurance carrier or program that is secondary to the primary insurance carrier or program.

[26] VA will be a secondary payer in situations that the veteran has private coverage or other health care coverage that is not Medicare, Medicaid or TRICARE.

within the current wait-time goals of the VHA for the delivery of such care or services, and when the veteran becomes eligible for hospital care or medical services under this act.

Follow-Up Care

This section requires non-VA care authorizations to include a complete episode of care, including all specialty and ancillary services deemed necessary as part of an episode of recommended treatment.[27]

Credentials of Providers

This section of the act requires participating non-VA providers to maintain the same or similar credentials and licenses as required of VA health care providers, and to submit verification at least annually.

Copayments

This section of the act requires veterans who are authorized to receive non-VA care to pay applicable copayment just as they would be assessed a copayment if treatment was provided in a VA facility. The non-VA health care provider or entity that furnishes the care or service will be required to collect the copayment directly from the eligible veteran.

Health Care Claims Processing

This section requires the Secretary 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. Regulations implementing such a claims processing system are to be published no later than 90 days after enactment of this act.

Medical Records

This section requires the VA to ensure that non-VA providers submit to the VA a copy of 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 (CPRS) maintained by the VA. It further stipulates that to the greatest extent possible the medical records submitted by non-VA providers or entities should be in an electronic format.[28]

Tracking Missed Appointments

This section of the act requires the Secretary to implement a mechanism to track missed appointments authorized under this section for eligible veterans to ensure that the VA does not pay for such care or services that were not furnished to an eligible veteran.

[27] Prior to the passage of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41), authorization for care through the Veterans Choice Program was limited for a period of 60 days per episode of care. With the enactment of P.L. 114-41, this criterion no longer applies.

[28] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

Implementing Regulations

This section of the act requires the VA to prescribe and publish interim final regulations no later than 90 days after the date of the enactment on the implementation of the new program to provide eligible veterans with care in non-VA facilities.

Office of the Inspector General (OIG) Report

This section of the act requires the VA Inspector General to issue an audit of care report to the Secretary on the expanded non-VA care authority. The report is required to be submitted no later than 30 days after the Secretary determines that 75% of amounts deposited in the "Veterans Choice Fund" (see section on "Sec. 802. Veterans Choice Fund" later in this report) have been exhausted.

End Date of the Expanded Authority for Non-VA Care

This section stipulates that the authority for the new expanded non-VA care program will end on a date when all the funds deposited in the "Veterans Choice Fund" (see section on "Sec. 802. Veterans Choice Fund" later in this report) are exhausted or on a date that is three years after the date of enactment, whichever comes first.

Reports to Congress

This section of the act requires the VA to submit reports to Congress on the expanded non-VA care authority. The Secretary is required 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 is required no later than 30 days after the date on which the Secretary determines that 75% of the amounts deposited in the "Veterans Choice Fund" are exhausted. The final report must include, among other things, an assessment and recommendations regarding the continuation of non-VA care and services under the new expanded authority.

Filling Prescription Medications

This section specifies that VA's current practice of filling prescriptions of veterans at VA pharmacies and/or Consolidated Mail Order Pharmacies (CMOPs), and the policies that allow the VA to pay for prescribed drugs provided for certain eligible veterans, will continue without any changes.

Wait-Time Goals of the VHA

This section of the act defines "wait time goals of the Veterans Health Administration" as an appointment date that is not more than 30 days from the date that the veteran requested an appointment for care. If the Secretary notifies Congress no later than 60 days after enactment that the "wait-time goals of the Veterans Health Administration" are different than what is defined in this section, then the new wait time goals of the VHA will be the ones defined by the Secretary.[29]

[29] On October 17, 2014, the Department of Veterans Affairs published a notice in the *Federal Register* announcing VA's report on the wait-time goals for purposes of the Veterans Choice Program. The report provides that the goals of the Veterans Health Administration are as follows: "Unless changed by further notice in the Federal Register, the term

Waiver of Certain Printing Requirements

This section allows the Secretary to print material related to the Veterans Choice Program other than through the Government Printing Office (GPO).[30]

Sec. 102. Enhancement of Collaboration between the VA and Indian Health Service

This section requires the Secretary (in consultation with the IHS Director) to conduct outreach to each medical facility operated by an Indian Tribe or Tribal Organization[31] to make these facilities aware that they can enter into agreements with the VA under which the VA will reimburse these facilities for care provided to IHS beneficiaries who are also VA-enrolled veterans. This section also requires the Secretary and the IHS director to jointly establish and implement performance metrics that examine whether the existing MOU between the VA and IHS—"Memorandum of Understanding" between the Department of Veterans Affairs (VA) and the Indian Health Service (IHS)—is effective at, among other things, increasing access, improving quality and care coordination, and determining whether health promotion and disease prevention services are funded and available to beneficiaries under both health care systems. The section further requires that the Secretary and the IHS Director submit a report to Congress on the (1) feasibility of including Urban Indian Organizations in the current VA-IHS reimbursement agreement, (2) feasibility of including the direct care costs of treating non-American Indian veterans in agreements between the VA and IHS facilities or medical facilities operated by an Indian Tribe or Tribal Organization, and (3) possible effects of an agreement between the IHS-VA agreement to provide care to veterans at IHS facilities on access to services by IHS-beneficiaries. This report is due no later than 180 days after enactment.[32]

Sec. 103. Enhancement of Collaboration between the VA and the Native Hawaiian Health Care System

This section requires 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, receiving funds from the Secretary of Health and Human Services (HHS), to reimburse such systems for direct care services provided to eligible veterans (as specified in the particular contract or agreement).

'wait-time goals of the Veterans Health Administration' means not more than 30 days from either the date that an appointment is deemed clinically appropriate by a VA health care provider, or if no such clinical determination has been made, the date a Veteran prefers to be seen for hospital care or medical services. In the event a VA health care provider identifies a time range when care must be provided (e.g., within the next 2 months), VA will use the last clinically appropriate date for determining whether or not such care is timely. The Department anticipates that the Under Secretary for Health periodically will consider changes to the wait-time goals of the Veterans Health Administration as appropriate." See Department of Veterans Affairs, "Wait-Time Goals of the Department for the Veterans Choice Program," 79 *Federal Register* 62519-62520, October 17, 2014.

[30] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175). Section 501 of Title 44 of the United States Code requires that all printing for the executive departments and independent offices and establishments of the government be done through the Government Printing Office (GPO)

[31] For more information about the Indian Health Service, see CRS Report R43330, *The Indian Health Service (IHS): An Overview*, by Elayne J. Heisler.

[32] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

Sec. 104. Reauthorization and Modification of Project ARCH (Access Received Closer to Home)

This section reauthorizes and modifies the pilot program known as Project ARCH, which was established under Section 403 of the Veterans' Mental Health and Other Care Improvements Act of 2008 (P.L. 110-387). The three-year pilot program was set to expire on August 29, 2014.[33] This section authorizes Project ARCH for two years from the date of enactment of the act. This section stipulates in law the pilot sites as: VISN 1; VISN 6; VISN 15; VISN 18; and VISN 19.[34] This section of the act further stipulates that the Secretary must ensure that medical appointments for those veterans eligible to participate in Project ARCH are scheduled not later than 5 days after the date on which the appointment is requested and occur no later than 30 days after such date. This section allows the Secretary to use existing Project ARCH contracts or enter into new contracts.[35]

Sec. 105. Prompt Payment

This section states that it is the sense of Congress that the VA must comply with the Prompt Payment rule,[36] and requires VA to establish and implement a system to process and pay claims from non-VA providers for hospital care, medical services, and other health care services provided to eligible veterans. Furthermore, it requires the Government Accountability Office (GAO) to submit a report, no later than one year after the date of enactment, to Congress on the timeliness of payments by the VA to non-VA providers, among other things.[37]

[33] The Veterans' Mental Health and Other Care Improvements Act of 2008 (P.L. 110-387) was signed into law on October 10, 2008. Section 403 of this law required VA to conduct pilot programs during a three-year period to provide non-VA health care services through contractual arrangements to eligible veterans. This pilot program had an implementation date of 120 days after October 10, 2008. Soon after the law was enacted VA recognized that the pilot program could not be commenced in the 120 days of the law's enactment as required, and in March 2009, VA officials briefed House and Senate VA Committees on these implementation issues. The first challenge that VA shared with Congress was the statute's definition of highly rural. The statute uses driving distances to define a highly rural veteran whereas VA uses a Census Bureau definition and defines a highly rural veteran as a veteran who resides in a county with fewer than seven civilians per square mile. VA has developed its data systems based on the Census Bureau definition and uses these systems to identify highly rural veterans. The second challenge involved the term hardship which VA needs to define through regulations. The Caregiver and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) signed into law in May 2010 made technical corrections regarding hardship exception and the mileage standard. Those eligible to participate in Project ARCH include (1) veterans who are enrolled in the VA health care system as of the date of the commencement of the pilot program and meet the statutory definition of "covered Veterans", or (2) eligible but not enrolled Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) veterans who meet the statutory definition of "covered Veterans." Covered veterans are defined as those veterans residing in a Pilot VISN and are (1) more than 60 minutes away from the nearest VA health care facility providing primary care services, or (2) more than 120 minutes away from the nearest VA health care facility providing acute hospital care, or (3) more than 240 minutes away from the nearest VA health care facility providing tertiary care.

[34] The VA's health care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs). VISN offices oversee VA healthcare facilities community based outpatient clinics, nursing homes, and Vet Centers throughout the country.

[35] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

[36] 5 C.F.R. §1315. Also see, http://fms.treas.gov/prompt/regulations.html.

[37] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

Sec. 106. Reimbursement of Non-VA Providers Assigned to the Chief Business Office (CBO)

This section of the act requires the Secretary to transfer payment authority for hospital care, medical services, and other health care through non-VA providers, from the VISNs and VAMCs to the Chief Business Office (CBO) of VHA. This transfer will be effective on October 1, 2014. Furthermore, this section requires the VA, in each fiscal year that begins after the date of 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.

Title II: Health Care Administrative Matters

The major emphasis of this title is the requirement of several studies to examine a variety of issues pertaining to VA's health care delivery system, and to explore ideas on how best to reform the system.

Sec. 201. Independent Assessment of the VA Health Care Delivery Systems and Management Processes

This section requires the Secretary, no later than 90 days after enactment of the act, to contract with a private sector entity or entities to conduct an independent assessment of the hospital care, and medical services furnished in VA medical facilities. Among other things, the assessment must address current and projected demographics and unique health care needs of the patient population served by the VA; the VA's current and projected health care capabilities and resources; the appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the VA; the information technology strategies of the VA with respect to furnishing and managing health care; and the VA's processes for carrying out construction and maintenance projects at medical facilities and the medical facility leasing program. The Secretary is required to submit this assessment report to Congress and make it available to the public as well.

Sec. 202. Commission on Care

This section establishes a ''Commission on Care'' to undertake a comprehensive evaluation and assessment of veterans access to VA health care and strategically examine how best to organize the VHA. The ''Commission on Care'' will also examine how to locate health care resources and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this act. The Commission will be composed of 15 voting members, and the appointment of Commissioners will be made not later than one year after the date of the enactment of this act by the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the Majority Leader of the Senate, the Minority Leader of the Senate, and the President of the United States. In appointing these Commissioners, at least one of the Commissioners must represent a Veteran Service Organization (VSO) recognized by the Secretary for the representation of veterans; have experience as senior manager for a private integrated health care system with an annual gross revenue of more than $50,000,000; be familiar with government health care systems, including those systems of the DOD, IHS, and FQHCs; be familiar with the VHA but not be a current employee of the VHA; and be familiar with medical facility construction and leasing projects carried out by government entities and have experience

in the building trades, including construction, engineering, and architecture. The "Commission on Care" is required to submit to the President, through the Secretary, several reports on their findings. The final report should be submitted within 180 days of the initial commission meeting. This section requires the President to require the Secretary of Veterans Affairs and other heads of relevant executive departments and agencies to implement each recommendation included in the final report of the "Commission on Care," as specified.

Sec. 203. Technology Task Force on Review of Scheduling System and Software of the VA

This section requires the Secretary to conduct a review of the needs of the VA's scheduling system and scheduling software that is used to schedule appointments for veterans for hospital care, medical services, and other health care. The Secretary is required to use the free services of a technology task force for this purpose. Not later than 45 days after the date of the enactment of this act, the technology task force is required to submit to the Secretary and Congress a report setting forth the findings and recommendations of the technology task force regarding the needs of the VA with respect to the scheduling system and scheduling software. Furthermore, this section requires the Secretary to make the report public no later than 30 days after the receipt of the report, and implement the recommendations in the report that the Secretary considers feasible, advisable, and cost effective.

Sec. 204. Improving Access to Mobile Vet Centers and Mobile Medical Centers

This section of the act requires the VA to provide standardized requirements to improve access of veterans to telemedicine services, other health care services, and readjustment counseling services provided by mobile Vet Centers and mobile medical centers. The standardized requirements include the number of days each mobile vet center and mobile medical center is expected to travel per year; the number of locations and events each center is expected to visit per year; the number of appointments and outreach contacts each center is expected to conduct per year; and the method and timing of notifications given by each center to individuals in the area to which the center is traveling, including notifications informing veterans of the availability to schedule appointments at the center. This section also requires the Secretary, one year after enactment, to submit an annual report (no later than September 30 of each year) to Congress outlining the recommended improvements for access to telemedicine, health care services, and readjustment counseling services through mobile Vet Centers and mobile medical centers, as well as data on the use of mobile Vet Centers and mobile medical centers.[38]

Sec. 205. Improved Performance Metrics for Health Care Provided by the VA

This section of the act requires the Secretary to ensure that scheduling and wait-time metrics or goals are not used as factors in evaluating employee performance for purposes of determining whether to pay performance awards to the following categories of employees: directors, associate directors, assistant directors, deputy directors, chiefs of staff, and clinical leads of VA medical centers; and directors, assistant directors, and quality management officers of VISNs. Furthermore, no later than 30 days after enactment, the Secretary is required to modify the

[38] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

performance plans of the directors of the VA medical centers and the directors of the VISNs to ensure that performance plans are based on the quality of care received by the veterans, as specified. This section further stipulates that the Secretary must not include performance goals in the performance plans of VISN and medical center Directors that might provide incentives for not authorizing non-VA care furnished through non-VA entities.

Sec. 206. Improved Transparency Concerning Health Care Provided by the VA

This section requires the VA, no later than 90 days after the date of enactment, to publish in the *Federal Register*, and on a publicly accessible Internet website of each VA medical center, the wait-times for the scheduling of an appointment in that facility by a veteran for the receipt of primary care, specialty care, and hospital care and medical services based on the general severity of the condition of the veteran. Furthermore, whenever the wait-times for the scheduling of such an appointment changes, the Secretary is required to publish the revised wait-times on a publicly accessible Internet website of each VA medical center no later than 30 days after such a change; and in the *Federal Register* no later than 90 days after such change. This section also requires the Secretary to develop and make available to the public a comprehensive, machine-readable data set containing all applicable patient safety, quality of care, and outcome measures for health care provided by VA and tracked by the VA. Furthermore, at least once a year the VA is required to update the data. This section further stipulates that the Secretary must enter into an agreement with the Secretary of Health and Human Services (HHS) to provide VA hospital data on patient quality and outcomes as specified in order for it to be made available through the Hospital Compare Internet website of the Department of Health and Human Services (HHS). This section also requires the Government Accountability Office (GAO) to conduct a review, no later than three years after enactment of this act, of publicly available safety and quality metrics.[39]

Sec. 207. Information for Veterans on the Credentials of VA Physicians

This section requires the VA to improve the information available to veterans regarding residency training in the "Our Doctors" data set located on each VAMCs website. This section requires the VA to publish on its website the following information: name of the facility at which each VA physician underwent residency training, and identifying whether a physician is a physician in residency. Furthermore, this section stipulates that for those veterans undergoing surgical procedures, the VA is to provide them information on the education and training of the surgeon as well as the licensure, registration, and certification of the surgeon. This section of the act also requires the GAO to report to Congress on VA's Patient Centered Community Care program (PCCC) and requires the Secretary to submit a plan to Congress and to GAO in response to GAO's findings and recommendations, and to implement such recommendation no later than 90 days after submitting the report.[40]

[39] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

[40] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

Sec. 208. Information in Annual Budget of the President on Hospital Care and Medical Services Furnished through the Expanded use of Contracts

This section requires that VA's annual congressional budget submissions include information pertaining to the number of veterans who received hospital care and medical services under the new expanded authority under Section 101 of P.L. 113-146; the amount expended by the VA on furnishing care and services under Section 101; the amount requested for the costs of furnishing care and services under Section 101; the number of veterans that the VA estimates will receive hospital care and medical services under Section 101 during the fiscal year of the budget request; and the number of VA employees on paid administrative leave at any point during the fiscal year preceding the fiscal year in which such budget request is submitted.

Sec. 209. Prohibition on Falsification of Data Concerning Wait Times and Quality Measures at the VA

This section of the act requires the Secretary to establish, no later than 60 days after enactment, policies that will impose penalties on VA employees who knowingly falsify data on patient wait-times or health care quality measures or knowingly request other VA employees to falsify such data.

Title III: Health Care Staffing, Recruitment, and Training Matters

The provisions of this title together aim to address the clinical workforce shortages in the VA health care system, and bolster recruitment and retention programs of the VA.

Sec. 301. Treatment of Staffing Shortage and Biennial Report on Staffing of VA Medical Facilities

This section requires the Inspector General (IG) to determine, and the Secretary to publish in the *Federal Register*, not later than September 30 annually, a list of the five VHA occupations, among the health professions listed in 38 U.S.C. §7401, that have the largest staffing shortages as calculated over the five year period that precedes the determination.[41] The section also specifies that the first determination be made and published not later than 180 days after enactment. The section also authorizes the Secretary to use the IG's determination to recruit and directly appoint qualified personnel in one of the identified occupations in the fiscal year that follows the report.

The section requires the Secretary to establish medical residency programs or to ensure that currently operating medical residency programs have sufficient positions at any VA facility that has a shortage or is located in a health professional shortage area as designated by the Department of Health and Human Services.[42] The subsection further requires that the Secretary allocate the residency positions among the occupations that the IG determined to be in shortage in the most

[41] The act adds a new §7412 to Subchapter 1 of Chapter 74 of title 38 U.S.C.

[42] The act adds a new §7302(e) to title 38 U.S.C. For more information about health professional shortage areas, see http://www.hrsa.gov/shortage/index.html.

recent report and must also give priority to residency positions in primary care, mental health, and any other specialty that the Secretary deems appropriate. The section also specifies that during the five-year period beginning on the day that is one year after enactment, the Secretary is required to increase the number of medical residency positions at VA facilities by up to 1,500 positions giving priority to medical facilities that do not, at the time of enactment, have a medical residency program and are located in a community that has a high concentration of veterans. Finally, the section requires that, on October 1 beginning in 2015 and continuing through 2019, the Secretary submit a report to the Committees on Veterans' Affairs in the House and Senate on VA graduate medical education that includes certain specified elements.

The section amends the priority of the VA's *Scholarship Program of Health Professionals Educational Assistance Program to Certain Providers* to give priority to individuals who are in the final year of education or training in an occupation that the IG identified in its most recent determination as having a large staffing shortage.

The section also requires, not later than 180 days after enactment and not later than December 31 of each even-numbered year thereafter until 2024, that the Secretary submit to the Committees on Veterans' Affairs in the House and Senate a report that assesses staffing at each VHA facility. The report will also include assessments of the appropriateness of certain specified elements related to VA staffing, including but not limited to staffing levels, patient panel size,[43] workloads, and wait times in certain fields; staffing models used in these specified fields; succession planning at the VA, and the number of health providers who have left the VA during the two years that precede the report's submission, including the reason they have left the VA, among other things.[44]

Sec. 302. Extension and Modification of Certain Programs within the VA's Health Professionals Educational Assistance Program

This section extends authorization of the VA scholarship program until December 31, 2019. It also modifies the Education Debt Reduction program to increase the amount that the VA could pay in total to a participant, over a five-year period, from $60,000 to $120,000. It also increases the amount that could be paid in the fourth and fifth years from $12,000 to $24,000 per year. Finally, the section eliminates the requirement that VA education debt reduction payments may not exceed the amount of principal and interest that a participant owes during a single year.[45]

Sec. 303. Clinic Management Training for Employees at VA Medical Facilities

This section of the act requires the Secretary to commence a clinic management training program, no later than 180 days after the date of enactment of this act, to provide in-person, standardized education on systems and processes for health care practice management and scheduling to all appropriate employees at VA medical facilities. Among other things, the training must include how to manage the schedules of VA health care providers; training on the appropriate number of appointments that a health care provider should conduct on a daily basis, based on specialty; training on how to determine whether there are enough available appointment slots to manage

[43] Generally the number of patients for a full-time physician provider.

[44] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

[45] §408 of P.L. 113-175 further amends the Education Debt Reduction Program to permit the VA to directly make payments to the entities that hold the eligible individual's loans. As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

demand for different appointment types and mechanisms for alerting management of insufficient slots; training on how to properly use the VA appointment scheduling system including any new scheduling system; training on how to optimize the use of technology; and training on how to properly use VA's physical plant space to ensure efficient flow and privacy for patients and staff. The training program must end on the date that is two years after the date on which the clinic management training program commences. After the termination of the program the Secretary is required to provide training materials and update them regularly.

Title IV: Health Care Related to Sexual Trauma

This title liberalizes eligibility for VA sexual trauma counseling, care, and services to certain veterans and servicemembers.

Sec. 401. Expansion of Eligibility for Sexual Trauma Counseling and Treatment to Veterans on Inactive Duty Training

This section provides VA with the authority to provide counseling, care, and services to veterans, and certain other servicemembers who may not have veteran status, who experienced sexual trauma while serving on active duty for training or inactive duty for training.[46]

Sec. 402. Provision of Counseling and Treatment for Sexual Trauma by the VA to Members of the Armed Forces

This section amends Section 1720D of title 38, U.S.C., and allows the Secretary in consultation with the Secretary of Defense to provide counseling and treatment for sexual trauma victims in the Armed Forces (including members of the National Guard and Reserve components on active duty) without an initial consultation and referral from DOD.

Sec. 403. Reports on Military Sexual Trauma

This section requires the Secretary to submit various reports to Congress on Military Sexual Trauma.

Title V: Other Health Care Matters

This title extends the Assisted Living Pilot Program for Veterans with Traumatic Brain Injury until October 6, 2017.

Sec. 501. Extension of Pilot Program on Assisted Living Services for Veterans with Traumatic Brain Injury

This section extends the pilot program established by Section 1705 of the National Defense Authorization Act (NDAA) for Fiscal Year 2008 (P.L. 110-181) through October 6, 2017. Section 1705 required the Secretary, in collaboration with DOD's Defense and Veterans Brain Injury Center (DVBIC), to carry out a five-year pilot program to assess the effectiveness of providing assisted living (AL) services to eligible veterans with traumatic brain injury (TBI). The AL-TBI

[46] The act amends §1720D of title 38, U.S.C.

pilot program was established for implementation between April 2008 and June 2013 and was administered through contracts with residential living programs designed to accommodate the needs of patients with TBI.

Title VI: Major Medical Facility Leases

This title authorizes the VA to carry out specified major medical facility leases and requires the VA to comply with current laws and policies governing obligations for major medical facility leases.

Sec. 601. Authorization of Major Medical Facility Leases

This section of the act authorizes medical facility leases (requested by the VA in its FY2014 congressional budget submission) at the following locations: (1) Albuquerque, NM, for an amount of $9,560,000; (2) Brink, NJ, for an amount of $7,280,000; (3) Charleston, SC, for an amount of $7,070,250; (4) Cobb County, GA, for an amount of $6,409,000; (5) Honolulu, HI, for an amount of $15,887,370; (6) Johnson County, KS, for an amount of $2,263,000; (7) Lafayette, LA, for an amount of $2,996,000; (8) Lake Charles, LA, for an amount of $2,626,000; (9) New Port Richey, FL, for an amount of $11,927,000; (10) Ponce, PR, for an amount of $11,535,000; (11) San Antonio, TX, for an amount of $19,426,000; (12) San Diego, CA, for an amount of $11,946,100; (13) Tyler, TX, for an amount of $4,327,000; (14) West Haven, CT, for an amount of $4,883,000; (15) Worcester, MA, for an amount of $4,855,000; (16) Cape Girardeau, MO, for an amount of $4,232,060; (17) Chattanooga, TN, for an amount of $7,069,000; (18) Chico, CA, for an amount of $4,534,000; (19) Chula Vista, CA, for an amount of $3,714,000; (20) Hines, IL, for an amount of $22,032,000; (21) Houston, TX, for an amount of $6,142,000; (22) Lincoln, NE, for an amount of $7,178,400; (23) Lubbock, TX, for an amount of $8,554,000; (24) Myrtle Beach, SC, for an amount of $8,022,000; (25) Phoenix, AZ, for an amount of $20,757,000; (26) Redding, CA, for an amount of $8,154,000; and (27) Tulsa, OK, for an amount of $13,269,200.[47] This section also stipulates specific lease requirements for the leased clinic located in Tulsa, OK.[48]

Sec. 602. Budgetary Treatment of VA Major Medical Facilities Leases

This section requires the Secretary to record the full cost of the contractual obligation at the time a contract is executed either in an amount equal to total payments required under the full term of the lease; or equal to an amount sufficient to cover the first-year lease payments and any specified cancellation costs in the event that the lease is terminated before its full term. Furthermore, this section requires the VA to provide a detailed analysis of how such lease is expected to comply with Office of Management and Budget (OMB) Circular A–11 and Section 1341 of title 31, U.S.C. in a prospectus for a proposed lease, and requires the VA to submit to Congress the following information: (1) notice of the intent to enter into a lease; (2) a copy of the proposed lease; (3) an explanation of any difference between the prospectus and the lease submitted under this subsection; and (4) a scoring analysis demonstrating compliance with OMB Circular A–11.

[47] 38, U.S.C. §8104 requires that VA major medical facility leases, defined as "a lease for space for use as a new medical facility at an average annual rent of more than $1 million," be specifically authorized by law.

[48] These facilities are community based outpatient clinics (CBOCs). A VHA CBOC is a health care site that is geographically distinct and separate from a parent medical facility and may be a site that is VA-operated and/or contracted.

This information must be submitted to Congress not less than 30 days before entering into a major medical facility lease.

Title VII: Other Veterans Matters

This section broadly address several areas including veterans education benefits, spending offsets, and provides authority for the removal or transfer of Senior Executive Service (SES) employees of the VA for performance or misconduct and requires expedited review of such actions.

Sec. 701. Expansion of Marine Gunnery Sergeant John David Fry Scholarship

This section expands eligibility for the Marine Gunnery Sergeant John David Fry Scholarship program to the spouse of an individual who, on or after September 11, 2001, dies in the line of duty while serving on active duty as a member of the Armed Forces.[49] Under this section a spouse would be entitled to the scholarship until the earlier of 15 years following the servicemember's death or remarriage. A similarly circumstanced spouse is currently eligible for educational assistance under the Survivors' and Dependents' Educational Assistance program (DEA). This section requires the spouse to make an irrevocable election to receive benefits under either the scholarship or DEA. The amendment is effective for terms beginning after December 31, 2014.[50]

Sec. 702. Approval of Courses of Education Provided by Public Institutions of Higher Learning for Purposes of All-Volunteer Force Educational Assistance Program and Post-9/11 Educational Assistance Conditional on In-State Tuition Rate for Veterans

This section requires the Secretary to disapprove a course at a public institution of higher learning (IHL) if the IHL charges tuition and fees above the in-state rate for that course to a qualifying Post-9/11 GI Bill or All-Volunteer Force Educational Assistance Program (MGIB-AD)[51] participant who is living in the state in which the IHL is located.[52] However, the public IHL may require the qualifying participant to demonstrate intent to establish residency, by a means other than physical presence, in order to qualify for in-state tuition. The course disapproval only applies to the Post-9/11 GI Bill and MGIB-AD. Qualifying Post-9/11 GI Bill and MGIB-AD participants are those who were discharged or released from a period of not fewer than 90 days of service in the *active military, naval, or air service* less than three years before the date of enrollment in said

[49] The Post-9/11 GI Bill provides educational assistance payments to eligible individuals enrolled in approved programs. Prior to the enactment of P.L. 113-146 the Marine Gunnery Sergeant John David Fry Scholarship program provided eligibility for the Post-9/11 GI Bill for the children of individuals who, on or after September 11, 2001, died in the line of duty while serving on active duty as a member of the Armed Forces.

[50] For more information on the Post-9/11 GI Bill, see CRS Report R42755, *The Post-9/11 Veterans Educational Assistance Act of 2008 (Post-9/11 GI Bill): Primer and Issues*, by Cassandria Dortch. For more information on DEA, see CRS Report R42785, *GI Bills Enacted Prior to 2008 and Related Veterans' Educational Assistance Programs: A Primer*, by Cassandria Dortch.

[51] The Post-9/11 GI Bill and MGIB-AD provide educational assistance payments to eligible individuals enrolled in approved programs. For more information on MGIB-AD, see CRS Report R42785, *GI Bills Enacted Prior to 2008 and Related Veterans' Educational Assistance Programs: A Primer*, by Cassandria Dortch.

[52] The Secretary may waive this requirement.

course and to their Post-9/11 GI Bill-eligible dependents and survivors.[53] If a course is disapproved, the qualifying participant cannot be approved for subsequent courses at the same IHL if continuously enrolled. This section is effective for terms beginning after July 1, 2015.[54]

Secs. 703, 704, 705, and 706

These sections of the act, respectively: extend the authorization period that requires the VA pension benefits for veterans and survivors who are residing in Medicaid-approved nursing homes to be reduced to $90 per month; extend the authorization period in which fees are charged from certain veterans for obtaining home-loan guarantees from the VA; limit the amount of awards or bonuses paid to VA employees; and extend the authorization period in which VA is required to obtain data from the Internal Revenue Service (IRS) and the Social Security Administration (SSA) to verify the income of VA pension applicants.

Sec. 707. Removal of Senior Executives of the VA for Performance or Misconduct

This section of the act provides the VA Secretary with new authority to remove senior executives from the department. The new authority and procedures created under this section apply to members of the Senior Executive Service (SES) in the VA, as well as individuals in certain leadership positions specific to the VA and commonly referred to as "Title 38 employees."[55] The new authority will be added to Title 38 of the U.S.C., which currently contains a set of adverse action procedures for employees appointed under that title, and is in addition to the authority the Secretary currently has to remove members of the SES under Title 5 of the U.S.C.[56]

If the Secretary determines that the performance of a senior executive warrants removal or that the individual has engaged in misconduct that warrants removal, he can invoke the authority provided in this section and remove a senior executive in one of two ways. First, the Secretary may remove the executive from the civil service entirely (i.e., from federal service). Second, the Secretary may transfer the executive into a position at any grade on the General Schedule (GS)

[53] The term "active military, naval, or air service," as defined in 38 U.S.C. §101(24), includes *active duty*. The term "active duty," as defined in 38 U.S.C. §101(21), is not equivalent to that defined in 38 U.S.C. §3301(1) or 38 U.S.C. §3002.

[54] As amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175).

[55] Title 38 U.S.C. employees covered by the act include "any individual who occupies an administrative or executive position and who was appointed under section 7306(a) or section 7401(1) of this title." Section 7306(a) of Title 38 establishes positions for administrative officials in the office of the under secretary for health, including several assistant undersecretaries for health, a director of physical assistant services, a director of nursing services, and several other administrative directors whose appointments are considered necessary to suit the needs of the department. Section 7401(1) includes "physicians, dentists, podiatrists, chiropractors, optometrists, registered nurses, physician assistants, and expanded-function dental auxiliaries."

[56] The act retains the Secretary's current authority for removing a member of the SES or a Title 38 employee. Under his current authority, the Secretary could instigate a removal for a member of the SES under 5 U.S.C. §3592, which allows him to remove a senior executive for unsatisfactory performance. In other circumstances, the Secretary could remove a member of the SES using adverse action procedures under 5 U.S.C. §7543 "for reasons of misconduct, neglect of duty, malfeasance, or failure to accept a directed reassignment or to accompany a position in a transfer of function." For individuals in the VA-specific positions created under Title 38, another set of adverse action procedures is available to the Secretary under that title (38 U.S.C. §§7461 *et seq.*).

"for which the individual is qualified and that the Secretary determines appropriate."[57] Under the second scenario, the individual would be compensated at the established rate for that position.[58]

If the Secretary chooses to remove an individual using this new authority, the Secretary must submit notice to the Senate and House Veterans' Affairs Committees within 30 days of the removal or transfer. The notice must contain the reasons for removal or transfer.

A removal or transfer made under this section would also be subject to a new set of expedited appeal procedures if the senior executive chose to appeal the Secretary's decision. First, the individual would have up to seven days to appeal the Secretary's decision to the Merit Systems Protection Board (MSPB). While the appeal is ongoing, the individual is not eligible for compensation, including pay, awards, bonuses, and other benefits.

Once the MSPB receives the appeal, the agency is to refer it to an administrative judge for review, and the judge has up to 21 days following the date of the appeal to issue a decision. To assist the MSPB in accomplishing the expedited review, the act instructs the Secretary to provide to the MSPB and the reviewing administrative judge "such information and assistance as may be necessary to ensure an appeal under this subsection is expedited." The administrative judge's decision is final and may not be subject to further appeal.

If the judge cannot issue a decision in the case within the required 21-day period, the Secretary's decision to remove or transfer the senior executive would become final. If such an instance were to occur, the MSPB must submit a report to the Senate and House Veterans' Affairs Committees explaining why the decision was not issued within 21 days.

This section also requires MSPB to establish a process to conduct these expedited reviews within 14 days of enactment of the act. The MSPB issued an interim final rule to comply with this requirement on August 19, 2014.[59] The rule is effective as of the date of issuance. Also within 14 days of enactment, the MSPB is required to report to the Committees on Veterans' Affairs in the Senate and House on their planned actions for expedited reviews. This report is to provide a description of the resources the MSPB expects will be necessary to conduct the reviews, including a description of any additional resources that may be necessary for the agency to fulfill its new responsibilities.

Title VIII: Other Matters

Sec. 801. Appropriation of Amounts

This section, among other things, authorizes and appropriates $5 billion for the VA to hire primary care and specialty care physicians and to hire other medical staff, including the following: physicians; nurses; social workers; mental health professionals; and other health care professionals as the Secretary considers appropriate. This funding will also be available for the maintenance and operation of VHA facilities including leases and minor construction.

[57] The General Schedule is the pay scale on which many white-collar employees in the civil service are compensated.

[58] Under current law, if an individual is removed from the SES for performance reasons, he or she is generally guaranteed placement into a GS-15 position and may be eligible to receive pay that is higher than what would otherwise have been allotted for that position. See 5 U.S.C. §3594(c)(1)(B).

[59] Merit Systems Protection Board, "Practices and Procedures; Appeal of Removal or Transfer of Senior Executive Service Employees of the Department of Veterans Affairs," 79 *Federal Register* 48941-48946, August 19, 2014; and Merit Systems Protection Board, "Practices and Procedures," 79 *Federal Register* 63031-63032, October 22, 2014.

Sec. 802. Veterans Choice Fund

This section establishes in the Treasury a new fund known as the "Veterans Choice Fund" and the Secretary will administer this fund. This section authorizes and appropriates $10 billion to be deposited in the Veterans Choice Fund, and this amount will be available until expended to implement only the provisions in Section 101. This section also stipulates that no more than $300 million of this amount shall be used for administrative expenses to implement Section 101.

The Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41) authorizes approximately $3.35 billion from the $10 billion deposited in the Veterans Choice Fund to be used for care outside the VA health care system, including $500 million of this amount for costs associated with prescription medications for the treatment of Hepatitis C.[60] This authority expires on October 1, 2015.

Sec. 803. Emergency Designations

This section designates this act as an emergency requirement, and exempts it from budget enforcement rules.[61]

[60] Care outside the VA health care system (care provided in the community) includes care provided under the following statutory authorities (excluding the Veterans Choice Program): 38 U.S.C. §1703—non-VA medical care authority; 38 U.S.C. §1703note—Pilot Program Of Enhanced Contract Care Authority For Health Care Needs Of Veterans In Highly Rural Areas also known as Project ARCH (Access Received Closer to Home); 38 U.S.C. §1725—emergency care for nonservice-connected conditions; 38 U.S.C. §1728—emergency care for service-connected conditions; 38 U.S.C. §8111—sharing of health care resources with DOD and IHS; 38 U.S.C. §8153—contracts for health-care resources negotiated under this authority with institutions affiliated with VA under 38 U.S.C. §7302, including medical practice groups and other approved entities associated with affiliated institutions.

[61] Congress may exempt the budgetary effects of a provision in legislation from certain enforcement procedures by designating such provision as an emergency requirement. Under the existing budget enforcement rules, if a provision is so designated, the spending and revenue effects projected to result from that provision are not counted for purposes of enforcing the budget procedures. For more information see, CRS Report R41564, *Emergency Designation: Current Budget Rules and Procedures*, by Bill Heniff Jr.

Appendix. Veterans Access, Choice, and Accountability Act of 2014: Implementation and Reporting Deadlines

Table A-1. Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146 as Amended by P.L. 113-175 and P.L. 113-235): Implementation and Reporting Deadlines

Section of P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235	Brief Description	Implementation and/or Reporting Deadline[a]
Section 101(k)	The Secretary is required to implement an efficient nationwide system for processing and paying bills or claims for authorized care and services under the Veterans Choice Program.	The Secretary is required to prescribe regulations for the implementation of a claims processing system no later than November 5, 2014.
	The Secretary is required to submit to the House and Senate Committees on Veterans' Affairs a quarterly report on the accuracy claims processing system.	Reports are due to the Committees no later than 20 days after the end of a quarter.
Section 101(n)	The Secretary is required to prescribe and publish interim final regulations on the implementation of Veterans Choice Program.	The Secretary is required to publish regulations in the *Federal Register* for the implementation of Veterans Choice Program no later than November 5, 2014.
Section 101(o)	The Inspector General of the VA is required to submit audit report to the Secretary.	The Inspector General's report is due no later than 30 days after the Secretary determines that 75% of the funds in the Veterans Choice Fund have been exhausted.
Section 101(p)	The authority to provide care and services under the Veterans Choice Program.	The authority for the Veterans Choice Program expires on August 7, 2017, or when funds in the Veterans Choice Fund have been exhausted—whichever occurs first.
		The Secretary is required to publish in the *Federal Register* and on the VA website a notice indicating expiration of the Veterans Choice Program. The Secretary is required to publish this notice 30 days before the funds are exhausted or no later than July 8, 2017.
Section 101(q)	The Secretary is required to submit to the House and Senate Committees on Veterans' Affairs a report on the furnishing of care and services under the Veterans Choice Program.	The initial report is due no later than February 3, 2015, and the final report is due no later than 30 days after the Secretary determines that 75% of the funds in the Veterans Choice Fund have been exhausted.

Section of P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235	Brief Description	Implementation and/or Reporting Deadline[a]
Section 101(s)	The Secretary is required to publish a report stating the actual wait-time goals of the VHA.	The Secretary is required to publish in the *Federal Register* and on a website a report stating the actual wait-time goals of the Veterans Health Administration no later than October 6, 2014.
Section 102(c)	The Secretary and the Director of the Indian Health Service are jointly required to submit a report to Congress regarding the enhancement of collaboration between the VA and Indian Health Service.	The report is due to Congress no later than February 3, 2015.
Section 105(c)	The Government Accountability Office (GAO) is required to submit a report to Congress on the timeliness of payments by the VA for hospital care, medical services, and other health care furnished by non-VA health care providers.	The report is due to Congress no later than August 7, 2015.
Section 201(a)	The Secretary is required to enter into one or more contracts with a private sector entity or entities to conduct an independent assessment of the hospital care, medical services, and other health care furnished in VA medical facilities.	Contracts are required to be entered into no later than November 5, 2014. The assessment needs to be completed no later than July 3, 2015.
Section 201(d)	The program integrator is required to report the results of the independent assessment to the Secretary, the House and Senate Committees on Veterans' Affairs, and the Commission on Care.	The program integrator is required to report the results within 60 days of the assessment's conclusion. The Secretary is required to publish the results of the independent assessment in the *Federal Register* and the VA website no later than 30 days after receiving the report.
Section 202(a)	Certain Members of the Congress holding leadership positions and the President are required to appoint a "Commission on Care" Majority of voting members of the "Commission on Care" appointed.	The Full Commission on Care needs to be established no later than August 7, 2015. A majority of the members of the Commission on Care must be appointed by February 18, 2015.

Section of P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235	Brief Description	Implementation and/or Reporting Deadline[a]
Section 202(b)	The Commission on Care is required to submit an interim and final report to the President, through the Secretary.	The Interim report is due no later than 90 days after the date of the initial meeting of the Commission on Care, and a final report not later than 180 days after the date of the initial meeting.
Section 202(g)	The President is required to submit a report to the House and Senate Committees on Veterans' Affairs and other appropriate committees on the recommendations contained in the Commission on Care report.	The report to the committees is due no later than 60 days after the President receives a report from the Commission on Care.
Section 203(a)	The Secretary is required to use a technology task force to conduct a review of the VA's patient scheduling system.	No specific deadline.
Section 203(b)	The technology task force is required to submit a report to the Secretary, the House and Senate Committees on Veterans' Affairs, regarding the needs of the VA with respect to the scheduling system and scheduling software.	The technology task force report is required no later than September 21, 2014. The Secretary is required to publish the technology task force report in the *Federal Register* and on the VA website no later than 30 days after receipt of the report.
Section 203(c)	The Secretary is required to implement the recommendations of technology task force report that the Secretary considers are feasible, advisable, and cost effective.	The Secretary is required to implement the recommendations no later than one year after receipt of the report.
Section 204(b)	The Secretary is required to submit a report to the House and Senate Committees on Veterans' Affairs on access to care through VA mobile vet centers and mobile medical centers.	The Secretary is required to submit the report no later than August 7, 2015, and no later than September 30 of each year thereafter.
Section 205(b)	The Secretary is required to modify the performance plans of the directors of the VAMCs and VISNs.	The Secretary is required to modify the performance plans no later than September 06, 2014.
Section 206(a)	The Secretary is required to publish the wait-times for the scheduling of an appointment at each VAMC for the receipt of primary care, specialty care, and hospital care and medical services based on the general severity of the condition of the veteran.	The Secretary is required to publish this information in the *Federal Register* and on a publicly accessible website no later than November 05, 2014. Whenever the wait-times for scheduling an appointment changes, the Secretary is required to publish the revised wait-times not later than 30 days after such change; and in the *Federal Register* by not later than 90 days after such change.

Section of P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235	Brief Description	Implementation and/or Reporting Deadline[a]
Section 206(b)	The Secretary is required to develop and make available to the public a comprehensive database containing patient safety, quality of care, and outcome measures for health care provided by the VA.	The Secretary is required to establish this database no later than February 3, 2015.
Section 206(c)	The Secretary is required to enter into an agreement with the Secretary of Health and Human Services for the provision of information to be available on the Hospital Compare Internet website.	The Secretary is required to enter into an agreement no later than February 3, 2015.
Section 206(d)	The Government Accountability Office (GAO) is required to conduct a review of the safety and quality metrics made publicly available by the VA.	The GAO is required to conduct the review no later than August 7, 2017.
Section 207(c)	The Government Accountability Office (GAO) is required to submit a report to the House and Senate Committees on Veterans' Affairs on the oversight of the credentialing of physicians under the Patient-Centered Community Care initiative as well the Veterans Choice Program.	The GAO report is required no later than August 7, 2016.
	The Secretary is required to submit a report to GAO and to the House and Senate Committees on Veterans' Affairs, a plan to address any findings and recommendations of the GAO report.	The plan is required no later than 30 days after the submittal of the GAO report.
		Secretary is required to implement the plan no later than 90 days after the submittal of the GAO report.
Section 209	The Secretary is required to establish policies that would impose penalties including termination of employees who knowingly submits false data concerning wait times for health care or quality measures or requires others to do so.	Secretary is required to implement these policies and penalties no later than October 6, 2014.
Section 301(a)	The VA Inspector General is required to determine, and the Secretary is required to publish the five medical occupations for which there are the largest staffing shortages throughout the VA.	The Secretary is required to publish in the *Federal Register* the VA Inspector General's determination, no later than February 3, 2015, and by September 30 each year thereafter.

Section of P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235	Brief Description	Implementation and/or Reporting Deadline[a]
Section 301(b)	The Secretary is required to submit a report to the House and Senate Committees on Veterans' Affairs on graduate medical education residency positions at VA medical facilities.	The Secretary is required to submit this report on October 1 each year beginning 2015 and ending 2019.
Section 301(d)	The Secretary is required to submit a report to the House and Senate Committees on Veterans' Affairs assessing the staffing needs of each VA medical facility.	The Secretary is required to submit this report no later than February 3, 2015, and no later than December 31 of each even-numbered year thereafter until 2024.
Section 303(a)	The Secretary is required to implement a clinic management training program to provide in-person, standardized education on systems and processes for health care practice management and scheduling to all appropriate employees.	The Secretary is required to implement this clinic management training program no later than February 3, 2015.
Section 401	The act provides eligibility for sexual trauma counseling and treatment to veterans on inactive duty training.	Veterans on inactive duty training could receive services beginning August 7, 2014.
Section 402	The Secretary may, in consultation with the Secretary of Defense, provide sexual trauma counseling and treatment to members of the Armed Forces (including members of the National Guard and Reserves) on active duty.	Members of the Armed Forces (including members of the National Guard and Reserves) on active duty may receive services beginning August 7, 2015.
Section 403(a)	The Secretary is required to submit a report to the House and Senate Committees on Veterans' Affairs on VA services available for military sexual trauma.	The report on the treatment and services available from the VA for military sexual trauma is required to be submitted no later than April 28, 2016.
Section 403(b)	The Department of Veterans Affairs-Department of Defense Joint Executive Committee is required to submit a report to the House and Senate Committees on Veterans' Affairs on the transition of military sexual trauma treatment from DOD to VA.	The report on the transition of military sexual trauma treatment from DOD to VA must be submitted no later than April 28, 2016, and annually thereafter until September 30, 2021.
Section 501	Extension of Pilot Program on Assisted Living Services for Veterans with Traumatic Brain Injury.	The Assisted Living-Traumatic Brain Injury pilot will provided services to eligible veterans through contracts with private sector community-based and transitional rehabilitation programs from September 30, 2014, until October 6, 2017.

Section of P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235	Brief Description	Implementation and/or Reporting Deadline[a]
Section 601(b)	The Secretary is required to determine the most cost effective option over a 30-year life cycle for a CBOC in Tulsa, Oklahoma.	If the Secretary determines the most cost effective option is to construct a new CBOC the Secretary may request authority for a major medical facility project in Tulsa, Oklahoma, from Congress, and submit a detailed cost-benefit analysis no later than 90 days after making such a determination.
Section 602	The Secretary is required to submit reports to the House and Senate Committees on Veterans' Affairs on the budgetary treatment of VA major medical facilities leases.	The Secretary is required to submit a report no less than 30 days before entering into a major medical facility lease and no more than 30 days after entering into a major medical facility lease.
Section 701	The act expands eligibility for the Marine Gunnery Sergeant John David Fry Scholarship program to the spouse of an individual who, on or after September 11, 2001, dies in the line of duty while serving on active duty as a member of the Armed Forces.	This is effective for terms beginning after December 31, 2014.
Section 702	The act requires the Secretary to disapprove a course at a public institution of higher learning (IHL) if the IHL charges tuition and fees above the in-state rate for that course to a qualifying Post-9/11 GI Bill or All-Volunteer Force Educational Assistance Program (MGIB-AD) participant who is living in the state in which the IHL is located.	This is effective for terms beginning after July 1, 2015.
Section 707	The act creates a new statute, 38 U.S.C. 713, which sets forth new rules for the removal or transfer of Senior Executive Service employees of the Department of Veterans Affairs (covered SES employees) for performance or misconduct and requires expedited review of such actions by the Merit Systems Protection Board.	The act requires the Merit Systems Protection Board to develop and to put into effect expedited procedures for processing appeals filed pursuant to 38 U.S.C. 713 no later than August 21, 2014.
Section 801(d)	The Secretary is required submit a report to the House and Senate Veterans' Affairs Committees and Appropriations Committees, on how the VA has obligated the $5 billion that was authorized and appropriated to increase veterans access to care through the hiring of physicians and other medical staff and by improving VA's physical infrastructure.	The Secretary is required to submit the report no later than August 7, 2015.

Section of P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235	Brief Description	Implementation and/or Reporting Deadline[a]
Section 802(c)	The Secretary is required to submit a report to the House and Senate Veterans' Affairs and Appropriations Committees if the Secretary plans to use more than $300 million from the Veterans Choice Fund for administrative purposes to implement the Veterans Choice Program.	No specific deadline.

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

a. Certain dates were calculated based on the number of days prescribed in P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235. Where the number of days is dependent upon certain preceding actions, only the number of days as indicated in the statute is presented. For example, if a report is due 90 days after an initial meeting, then only "90 days" is indicated.

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