110TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
110–817

RURAL VETERANS ACCESS TO CARE ACT

AUGUST 1, 2008.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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

R E P O R T

[To accompany H.R. 1527]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 1527) to amend title 38, United States Code, to allow highly rural veterans enrolled in the health system of the Department of Veterans Affairs to receive covered health services through providers other than those of the Department, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

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69–006

AMENDMENT

The amendment is as follows:
Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Rural Veterans Access to Care Act".

SEC. 2. PILOT PROGRAM OF ENHANCED CONTRACT CARE AUTHORITY FOR HEALTH CARE NEEDS OF VETERANS IN HIGHLY RURAL AREAS.

(a) IN GENERAL.—Section 1703 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(e)(1) The Secretary shall conduct a pilot program which permits highly rural veterans—

"(A) who are enrolled in the system of patient enrollment established under section 1705(a) of this title, and

"(B) who reside within Veterans Integrated Service Network 1, 15, 18, and 19,

to elect to receive covered health services for which such veterans are eligible through a non-Department health-care provider.

"(2) The election under paragraph (1) shall be made by submitting an application to the Secretary in accordance with such regulations as the Secretary prescribes. The Secretary shall authorize such services to be furnished to the veteran pursuant to contracting with such a provider to furnish such services to such veteran.

"(3) For purposes of this subsection, a highly rural veteran is one who—

"(A) resides in a location that is—

"(i) more than 60 miles driving distance from the nearest Department health-care facility providing primary care services, if the veteran is seeking such services;

"(ii) more than 120 miles driving distance from the nearest Department health-care facility providing acute hospital care, if the veteran is seeking such care; or

"(iii) more than 240 miles driving distance from the nearest Department health-care facility providing tertiary care, if the veteran is seeking such care; or

"(B) in the case of a veteran who resides in a location less than the distance indicated in clause (i), (ii), or (iii) of subparagraph (A), as applicable, experiences such hardship or other difficulties in travel to the nearest appropriate Department health-care facility that such travel is not in the best interest of the veteran, as determined by the Secretary pursuant to regulations prescribed for purposes of this subsection.

"(4) For purposes of this subsection, a covered health service is any hospital care, medical service, rehabilitative service, or preventative health service authorized to be provided by the Secretary under this chapter or any other provision of law.

"(5) For purposes of this subsection, a health-care provider is any qualified entity or individual furnishing a covered health service.

"(6) In meeting the requirements of this subsection, the Secretary shall develop the functional capability to provide for the exchange of medical information between the Department and non-Department health-care providers.

"(7) This subsection shall apply to covered health services provided during the 3-year period beginning on the 120th day after the date of the enactment of this subsection.

"(8) Not later than the 30th day after the close of each year of the period described in paragraph (7), the Secretary shall submit a report to the Committees of Veterans' Affairs of the House of Representatives and the Senate a report which includes—

"(A) the Secretary's assessment of the program under this subsection, including its cost, volume, quality, patient satisfaction, benefit to veterans, and any other findings and conclusions of the Secretary with respect to such program, and

"(B) any recommendations that the Secretary may have for—

"(i) continuing the program,

"(ii) extending the program to other or all service regions of the Department, and

"(iii) making the program permanent.".

(b) EFFECTIVE DATE.—The Secretary of Veterans Affairs shall implement the amendment made by subsection (a) not later than the 120th day after the date of the enactment of this Act.

Amend the title so as to read:

A bill to amend title 38, United States Code, to direct the Secretary of Veterans Affairs to conduct a pilot program to permit certain highly rural veterans enrolled in the health system of the Department of Veterans Affairs to receive covered health services through providers other than those of the Department.

PURPOSE AND SUMMARY

H.R. 1527 was introduced by Representative Jerry Moran of Kansas on March 14, 2007. H.R. 1527, as amended, would require the Department of Veterans Affairs (VA) to conduct a three-year demonstration project in Veterans Integrated Service Networks (VISNs) 1, 15, 18, and 19 to allow highly rural veterans enrolled in VA health care to receive covered services through non-VA providers.

The bill would define a highly rural veteran as one who resides 60 miles from VA primary care services, 120 miles from the nearest VA facility providing acute hospital care, or more than 240 miles from the nearest VA facility providing tertiary care.

The bill would require VA to develop the functional capability to exchange medical information between VA and non-VA providers in the pilot.

The bill would direct the VA to submit a report to Congress upon the conclusion of the first year of the pilot, and each year thereafter, that includes an assessment of the program cost, volume, quality, patient satisfaction, and benefit to veterans; and, any recommendations for continuation, extension, or for making the program permanent.

BACKGROUND AND NEED FOR LEGISLATION

Approximately 39 percent of enrolled veterans utilizing the VA health care system live in rural areas. It is a challenge for these veterans to access VA health care services because of their geographic distance from VA facilities and limited transportation services.

VA is undertaking a number of initiatives to help veterans in rural areas gain better access to health care services. Central to this effort is the expansion of community-based outpatient care. VA is scheduled to activate 44 new clinics over the next 15 months. This would increase VA's network of independent and community-based clinics to 782, an addition of more than 100 clinics over the past five years. VA is also expanding readjustment counseling services through community-based Vet Centers. Today, VA operates 232 Vet Centers and will open an additional 39 centers across the country by the end of 2009. Additionally, VA is expanding its telehealth and telemedicine programs, which are using new technology to bring doctors to their patients, rather than patients to their doctors.

In 2007, pursuant to the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Public Law 109–461) VA established an Office of Rural Health (ORH). The purpose of the ORH is to develop policies to provide the best solutions to the challenges of providing rural health care and innovative practices to support the unique needs of veterans residing in rural areas. In June 2008,

a Rural Health Advisory Committee was created to advise the Secretary on health care issues facing enrolled veterans in rural areas.

The Committee recognizes and commends the steps VA is taking to improve care and services for veterans in rural and highly rural areas. However, we remain concerned that there are still barriers to accessing VA care for veterans in highly rural areas and there is a need to expand opportunities for veterans living the farthest away from VA facilities to receive needed primary care locally in non-VA facilities.

Current law authorizes VA to provide fee-for-service care in a veteran's local community when the treating facility cannot provide the required care or because of geographical inaccessibility. However, the decision to utilize such care is left to the facility providing the care.

H.R. 1527, as amended, would require VA to conduct a three-year demonstration project to allow enrolled highly rural veterans in four VISNs with large rural populations to receive covered services through non-VA providers. To ensure continuity of care, the legislation would require VA to develop the functional capability to exchange veterans' medical information between VA and non-VA providers in the pilot. To effectively implement the pilot program, the Committee also expects the Secretary to establish regulations for payment that would be consistent with the authorized allowable reimbursement rate VA currently has established of 70 percent of the applicable Medicare rate.

The Committee believes that this pilot program would support VA's efforts to improve care and services for veterans who reside in rural areas.

HEARINGS

On April 26, 2007, the Subcommittee on Health held a legislative hearing on a number of bills introduced during the 110th Congress, including H.R. 1527. The following witnesses testified: The Honorable Stevan Pearce of New Mexico; The Honorable Ginny Brown-Waite of Florida; The Honorable Solomon P. Ortiz of Texas; The Honorable Steven R. Rothman of New Jersey; The Honorable Hilda L. Solis of California; The Honorable Tom Latham of Iowa; The Honorable Jason Altmire of Pennsylvania; The Honorable Jerry Moran of Kansas; The Honorable Bob Filner of California; Ms. Shannon Middleton, Deputy Director for Health, Veterans Affairs and Rehabilitation Commission, The American Legion; Mr. Kimo S. Hollingsworth, National Legislative Director, American Veterans (AMVETS); Mr. Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans; Mr. Carl Blake, National Legislative Director, Paralyzed Veterans of America; Mr. Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars of the United States; Mr. Richard F. Weidman, Executive Director for Policy and Government Affairs, Vietnam Veterans of America; Gerald M. Cross, M.D., FAAFP, Acting Principal Deputy Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs, accompanied by Mr. Walter A. Hall, Assistant General Counsel, U.S. Department of Veterans Affairs. Those submitting statements for the record included: the American Academy of Neurology, and The Honorable Rubén Hinojosa of Texas.

SUBCOMMITTEE CONSIDERATION

On July 10, 2008, the Subcommittee on Health met in open markup session and ordered favorably forwarded to the full Committee H.R. 1527, as amended, by voice vote. During consideration of the bill the following amendment was considered: An amendment in the nature of a substitute by Mr. Moran of Kansas to create a pilot program and establish the four VISNs where the pilot program will be conducted as VISNs 1, 15, 18 and 19, was agreed to by voice vote.

COMMITTEE CONSIDERATION

On July 16, 2008, the full Committee met in an open markup session, a quorum being present, and ordered H.R. 1527, as amended, reported favorably to the House of Representatives, by voice vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report the legislation and amendments thereto. There were no record votes taken on amendments or in connection with ordering H.R. 1527 reported to the House. A motion by Mr. Buyer of Indiana to order H.R. 1527, as amended, reported favorably to the House of Representatives was agreed to by voice vote.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the descriptive portions of this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee's performance goals and objectives are reflected in the descriptive portions of this report.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARKS AND TAX AND TARIFF BENEFITS

H.R. 1527 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e), or 9(f) of rule XXI of the Rules of the House of Representatives.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate on H.R. 1527 prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate for H.R. 1527 provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 31, 2008.

Hon. BOB FILNER,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1527, the Rural Veterans Access to Care Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sunita D'Monte.

Sincerely,

PETER H. FONTAINE
(For Peter R. Orszag, Director).

Enclosure.

H.R. 1527—Rural Veterans Access to Care Act

Summary: H.R. 1527 would require the Department of Veterans Affairs (VA) to implement a pilot program that would pay for certain veterans who are enrolled in the VA health care program to receive medical care outside the VA system. The program would be carried out over a three-year period in four specific Veterans Integrated Services Networks (VISNs), which are regional networks of medical facilities. CBO estimates that implementing H.R. 1527 would cost about $1.6 billion over the 2009–2013 period, assuming appropriation of the necessary amounts.

Enacting the bill also could affect direct spending for Medicare, but CBO estimates any such effects would not be significant. Enacting the bill would not affect revenues.

H.R. 1527 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 1527 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans benefits and services).

	By fiscal year in millions of dollars—					
	2009	2010	2011	2012	2013	2009–2013
CHANGES IN SPENDING SUBJECT TO APPROPRIATION [1]						
Estimated Authorization Level	210	440	685	235	0	1,570
Estimated Outlays	190	415	660	280	25	1,570

[1] In addition to the effects on spending subject to appropriation shown in this table, CBO estimates that enacting H.R. 1529 could increase direct spending, but that any such changes would be less than $500,000 a year.

Basis of estimate: For this estimate, CBO assumes that the legislation will be enacted near the end of fiscal year 2008, that the estimated amounts will be appropriated for each year, and that outlays will follow historical spending patterns for the VA medical services program.

Spending subject to appropriation

H.R. 1527 would require VA to implement a pilot program to pay for certain enrollees to receive medical care outside the VA system. The program would be carried out over a three-year period—from February 2009 through January 2012—in VISNs 1, 15, 18, and 19. Those VISNs include states in various parts of the country, including the northeast, central, southwest, and northwest. Under the bill, enrollees could elect to receive health care through non-VA providers and VA would pay for such care if:

- The enrollee requires primary care and lives more than 60 miles driving distance from the nearest VA facility providing such care,
- The enrollee requires acute hospital care and lives more than 120 miles driving distance from the nearest VA facility providing such care,
- The enrollee requires tertiary care and lives more than 240 miles driving distance from the nearest VA facility providing such care, or
- The enrollee does not meet the criteria above but has difficulty traveling to VA facilities, as determined by the Secretary of the VA.

VA has indicated that the department would implement the pilot program required under the bill in the same fashion as its current fee-basis program. Under that program, VA has the authority to contract with health care providers outside the VA system to provide pre-approved services for certain veterans. VA negotiates the price of such services and pays the providers. Thus, under the pilot program, CBO assumes that VA will provide the required services through contracts with private health care providers, and that VA will pay the full cost of such care.

Data from VA indicate that about 800,000 veterans in VISNs 1, 15, 18, and 19 would be eligible for the pilot program. (That figure combines both current enrollees in the VA health system and veterans that are currently not enrolled.) Of that total, about 300,000 are currently using some VA-provided health care. Of the remainder, CBO estimates that about 200,000 might choose to receive care in 2009 through the pilot program.

CBO expects that, under the bill, eligible veterans would receive about 95 percent of their health care through VA. After adjusting for inflation and an estimated 10 percent increase in health care costs (care provided at non-VA facilities is generally more expensive than care provided at VA facilities), CBO estimates that in 2009 the department would spend an average of roughly $5,000 per new patient under the pilot program and less than $3,500, on average, for existing patients that participate in this pilot program. Those averages account for the different usage patterns of veterans, with some enrollees in the new program receiving only primary care, acute care, or tertiary care, and others receiving a combination of those three types of care.

Using the above estimates of per-patient costs, and assuming appropriation of sufficient amounts to cover all those who choose to use the program, implementing it could cost as much as $2 billion a year, CBO estimates. However, because the proposed pilot program is temporary, CBO expects that not all eligible veterans would be able to enroll in the program during the three-year period, and that local health care providers would hesitate to invest in expanded facilities to accommodate veterans. Accounting for a slow, incremental take-up of the temporary benefit, CBO estimates that costs would rise from almost $200 million in 2009 to $660 million in 2011 (costs fall sharply in 2012 because the program would expire that year).

Direct spending

Enacting H.R. 1527 could affect spending for Medicare, if community-based providers of health care would seek to recover costs from those programs before billing VA. However, under the current fee-basis program, VA pays for the entire cost of care, and CBO assumes the same would be true for the pilot program. Thus, for this estimate, CBO expects that any direct spending effects would be insignificant. (If VA chooses to implement this pilot program differently, Medicare could become the primary payer for veterans in this program, thus increasing direct spending significantly for that program.)

Intergovernmental and private-sector impact: H.R. 1527 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Estimate prepared by: Federal Costs: Sunita D'Monte; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Daniel Frisk.

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

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 1527 prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act would be created by H.R. 1527.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for H.R. 1527 is provided by article I, section 8 of the Constitution of the United States.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or

accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

This section would provide the short title of H.R. 1527 as the "Rural Veterans Access to Care Act."

Section 2. Pilot program of enhanced contract care authority for health care needs of veterans in highly rural areas

This section would amend section 1703 of title 38, United States Code, by inserting a requirement that the VA establish a 3-year pilot program allowing highly rural veterans residing in VISNs 1, 15, 18, and 19 to receive covered health services through a provider outside of the VA. A "highly rural" veteran would be defined as a veteran who lives more than 60 miles driving distance from the nearest VA facility providing primary care services; more than 120 miles from the nearest VA facility providing acute hospital care; or more than 240 miles from the nearest VA facility providing tertiary care.

Additionally, veterans who fail to meet these distance requirements but are subject to hardship or difficulty in travel to the nearest appropriate VA facilities may be eligible for the program at the determination of the Secretary. The Secretary would also be directed to develop the functional capability to share medical information with non-departmental providers. The 3-year pilot would be effective 120 days following enactment and the Secretary would be required to submit an annual assessment of the program to the Committee.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

SECTION 1703 OF TITLE 38, UNITED STATES CODE

§ 1703. Contracts for hospital care and medical services in non-Department facilities

(a) * * *

* * * * * * *

(e)(1) The Secretary shall conduct a pilot program which permits highly rural veterans—

(A) who are enrolled in the system of patient enrollment established under section 1705(a) of this title, and

(B) who reside within Veterans Integrated Service Network 1, 15, 18, and 19,

to elect to receive covered health services for which such veterans are eligible through a non-Department health-care provider.

(2) The election under paragraph (1) shall be made by submitting an application to the Secretary in accordance with such regulations

as the Secretary prescribes. The Secretary shall authorize such services to be furnished to the veteran pursuant to contracting with such a provider to furnish such services to such veteran.

(3) For purposes of this subsection, a highly rural veteran is one who—

(A) resides in a location that is—

(i) more than 60 miles driving distance from the nearest Department health-care facility providing primary care services, if the veteran is seeking such services;

(ii) more than 120 miles driving distance from the nearest Department health-care facility providing acute hospital care, if the veteran is seeking such care; or

(iii) more than 240 miles driving distance from the nearest Department health-care facility providing tertiary care, if the veteran is seeking such care; or

(B) in the case of a veteran who resides in a location less than the distance indicated in clause (i), (ii), or (iii) of subparagraph (A), as applicable, experiences such hardship or other difficulties in travel to the nearest appropriate Department health-care facility that such travel is not in the best interest of the veteran, as determined by the Secretary pursuant to regulations prescribed for purposes of this subsection.

(4) For purposes of this subsection, a covered health service is any hospital care, medical service, rehabilitative service, or preventative health service authorized to be provided by the Secretary under this chapter or any other provision of law.

(5) For purposes of this subsection, a health-care provider is any qualified entity or individual furnishing a covered health service.

(6) In meeting the requirements of this subsection, the Secretary shall develop the functional capability to provide for the exchange of medical information between the Department and non-Department health-care providers.

(7) This subsection shall apply to covered health services provided during the 3-year period beginning on the 120th day after the date of the enactment of this subsection.

(8) Not later than the 30th day after the close of each year of the period described in paragraph (7), the Secretary shall submit a report to the Committees of Veterans' Affairs of the House of Representatives and the Senate a report which includes—

(A) the Secretary's assessment of the program under this subsection, including its cost, volume, quality, patient satisfaction, benefit to veterans, and any other findings and conclusions of the Secretary with respect to such program, and

(B) any recommendations that the Secretary may have for—

(i) continuing the program,

(ii) extending the program to other or all service regions of the Department, and

(iii) making the program permanent.

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