Improving Veterans Care in the Community Act of 2016 (S. 3401)
Section-by-Section

Section 1: Short Title
The bill is called the "Improving Veterans Care in the Community Act of 2016."

Section 2: Sense of Congress
This section expresses the Sense of Congress that the Department of Veterans Affairs (VA) should be the primary means by which eligible veterans access health care, and that the VA needs a simple tool by which it can send veterans into the community for medical care and services. Veterans should be sent into the community for care when it is in the best medical interest of the veteran, or when the veteran does not have access to a VA medical facility (or one that has the service the veteran needs) without an undue travel burden.

Section 3: Establishment of the VA's Care in the Community Program
This section consolidates all of the existing non-VA care programs, including the Choice Program, into one program called the "Care in the Community Program." The measure protects all of the ways in which a veteran may be sent into the community for care today and expands eligibility for rural veterans who need specialty care.

There are certain circumstances when the VA may use the new Care in the Community Program to provide vets care:

- Distance
    - All of the current distance requirements for the Veterans Choice Program are carried over to the Care in the Community Program.
    - Additionally, if a veteran requires care or services that are not available at the VA facility or facilities within 40 miles of the veteran, s/he may be sent to a local facility through the Care in the Community Program.
- Wait Times
    - Under the Veterans Choice Program, veterans are eligible for non-VA care if they have to wait more than 30 days for an appointment. This 30-day rule is carried over until the VA, through the rulemaking process, establishes wait time standards that are specialty-specific.
- Medical Interest of the Veteran
    - Although we carry over many of the current means by which a veteran may currently receive non-VA care, we specify that a veteran should be able to use Care in the Community whenever his or her doctors at the VA believe that it is in the person's best interest medically.

Section 3 also requires the VA to educate veterans on the Care in the Community Program. The VA needs to explain the following details to veterans: 1) how the program works; 2) how veterans become eligible for the program; and 3) who is responsible for payment when the veteran uses the program.

Additionally, Section 3 requires a Government Accountability Office (GAO) report on the performance of the Third Party Administrators (TPAs). In Idaho, that is Tri West and Health Net. Although we do not prohibit the VA from contracting with third parties outright, we ask the GAO to assess: 1) the performance of the TPAs; 2) the overlap between the TPAs and the VA staff having to perform the same duties as the TPAs; and 3) given the overlap in function, how much it would cost to implement the Care in the Community Programs without the TPAs.

This section does not change eligibility for the VA overall, it just changes eligibility for use of the Care in the Community program by veterans who are eligible for care through the VA by making it easier for veterans to utilize community care.

Section 4: Authorization of Use of Certain Amounts Appropriated to the Veterans Choice Fund for other Non-Department of Veterans Affairs Care

Section 4 consolidates all of the funding for the separate non-VA care programs into one funding source, the Medical Services Account. Further, this section allows the account to be used to pay for the Care in the Community Program as well as disability examinations that are provided by non-VA providers.

Section 5: Interdisciplinary Panel on Clinical Appeals Process

Section 5 requires the VA to establish an interdisciplinary panel that would develop a clinical appeals process to resolve disputes regarding VA health care. This process must be comprehensive and fair, similar to the process that is currently in place in the private sector and in other federal agencies. The VA must allow veterans the chance to have an external review.

Section 6: Comptroller General Reports on the Department of Veterans Affairs

S. 3401 requires several GAO reports within a year of enactment. These reports are to be used to guide the implementation of the Care in the Community Program. In addition to the GAO report required under Section 3, these are the four reports required:

- A report on how to improve the clinical operations of the Veterans Health Administration (VHA) and how to ensure that clinical staff perform to the top of their licenses;

- A report on the travel benefit program, how it can be improved to be more timely, and if Congress should revise the program's eligibility;
- A report on the structure and management of the VA's office of Congressional and Legislative Affairs;
- A report on payment responsibility for Care in the Community, including who should be the primary payer (the veteran, the VA, private insurance, Medicare or Medicaid) and in which circumstances.

Section 7: Creation of the Veterans Health Administration Payment and Access Commission

S. 3401 authorizes the creation of a Veterans Health Administration Payment and Access Commission (VHAPAC) similar to the MedPAC that exists for Medicare. This commission will submit to Congress an annual report examining all the emerging issues within VHA health care and the impact VHA services are having on the country's health care industry as a whole.