The VA Budget and Choice Improvement Act

Section 1 would provide a short title of, "VA Budget and Choice Improvement Act."

Section 2 would require the Department of Veterans Affairs (VA) to develop a plan to consolidate all non-VA programs into a single program called the "Veterans Choice Program" and submit a report on the plan the House and Senate Committees on Veterans' Affairs by November 1, 2015. The plan would be required to include the following information: a standard method of providing non-VA care that incorporates the strengths of current individual non-VA care programs; non-VA care eligibility requirements for veteran patients and non-VA providers; a description of the non-VA care authorization process; a structured billing and reimbursement process; a reimbursement rate for non-VA providers; a process to ensure compliance with the Prompt Payment Act; a description of how VA plans to use existing non-VA infrastructure and networks; a description of how non-VA providers will have access to VA medical records and how VA will receive medical record submissions from those non-VA providers; and, how VA plans to ensure an efficient transition to the program.

Section 3 would require a dedicated appropriations account for non-VA care in each President's budget submitted to Congress beginning in fiscal year 2017.

Section 4 would allow VA to use $3.348 billion dollars from the Veterans Choice Fund to pay for non-VA care provided to veteran patients from May 1st to October 1st, 2015. Of that, VA would be allowed to use no more than $500 million dollars to cover the costs of Hepatitis C care. VA would be required to report to the House and Senate Committees on Veterans' Affairs and Appropriations every 14 days on how these authorized funds are used and for which program.

Section 5 would modify the existing Veterans Choice Program by: eliminating the requirement for a veteran to have been enrolled in the VA healthcare system by August 1, 2014; expanding the number of non-VA providers who are allowed to participate in the Program by allowing VA to include Medicaid providers and other providers as appropriate; allowing VA to waive the wait time criteria for a veteran in need of an appointment but unable to schedule one prior to 30 days based on clinical necessity; and, allowing veterans who live within 40 miles of a VA community-based outpatient clinic that does not have a full-time physician on staff to access primary care through the Program.

Section 6 would stipulate that VA may not use appropriated dollars to expand internal dialysis capabilities until independent analysis of the ongoing dialysis pilot program is complete and 180 days has lapsed following the date that VA has provided to the House and Senate Committees on Veterans' Affairs and Appropriations a report containing the independent analysis and a five-year dialysis investment plan.

Section 7 would amend the Internal Revenue Code by: exempting any employee with coverage under a health care program administered by DoD, to include TRICARE, or by VA from classification as an eligible employee of an applicable large employer for purposes of the employer mandate under the Patient Protection and Affordable Care Act to provide such employees with minimum essential health care coverage; and, provides that that a veteran who receives hospital care or medical services for a service-connected disability is not disqualified from participating in or contributing to a tax-preferred health savings account.

Section 8 would designate all sections of the Act, with the exception of section 7, as an emergency requirement.