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By Annie Shuppy
ashuppy@cq.com
202-650-6729

Veterans Health Agreement

This Fact Sheet deals with the conference agreement on **HR 3230**, Veterans Access, Choice and Accountability Act, which the House will consider July 30 under suspension of the rules.

The agreement increases veterans' access to health care in the wake of the Veterans Affairs (VA) Department scandal involving falsified appointment records that hid long wait times, allowing veterans to obtain health care at non-VA facilities if they live more than 40 miles from a VA clinic or can't get an appointment at a VA clinic within 30 days, and it increases the VA's capacity to provide services by providing expedited authority to hire more doctors and nurses and authorizing leases for the opening of 27 new VA health facilities.

To promote greater accountability, it authorizes the VA secretary to fire or demote VA Senior Executive Service employees based on their performance or misconduct, providing for a limited appeals process during which the employee would not be paid.

It includes $10 billion to pay for care at non-VA facilities and $5 billion for VA to hire more doctors, nurses and other health care professionals — all of which would be categorized as emergency spending. It also includes about $5 billion in offsets. CBO late Tuesday estimated that the agreement, on net, would increase the deficit by about $10 billion through FY 2024.

Section I

Background & Summary

After revelations this spring that some employees of the Veterans Affairs (VA) Department were falsifying wait-time records for veterans' medical appointments and keeping many patients on unofficial waitlists to create the appearance that they were reaching wait time targets, there was nearly universal support in Congress for overhauling the Veterans Health Administration (VHA) and for making the VA more accountable.

Former VA Secretary Eric Shinseki resigned in late May, shortly after the VA's inspector general reported that as many as 1,700 veterans at the Phoenix VA health facility were waiting for appointments outside of the clinic's official waiting list (with many waiting an average of 115 days for their first primary-care appointment). Moreover, the IG report noted that "inappropriate scheduling practices are a systemic problem nationwide." On June 9, the VA, under acting Secretary Sloan D. Gibson, released a review that found that 57,000 veterans nationwide waited more than 90 days for an appointment, while 64,000 others requested medical care but never made it onto a VA waiting list. The review also found that large numbers of VA schedulers were told by their superiors to falsify appointment requests and that such fraud was found at most VA health facilities.

The administration and VA began taking a number of steps to address the problems — including seeking to ensure that veterans could more quickly gain access to health care after the scandal revealed that the VHA did not have the capacity to meet the health care needs of all the veterans who were seeking care — while the FBI

began a criminal investigation as to whether VA hospital officials lied in order to receive performance bonuses tied to meeting wait-time goals.

On July 29, the Senate confirmed Bob McDonald as the new VA secretary. McDonald, the former head of Procter and Gamble and a former Army Ranger, has vowed to change the VA's management and improve its health care system.

Congressional Action & Conference

The House over the past few months passed a number of bills intended to increase accountability at the VA and provide greater access to health services for veterans, while the Senate passed a single, comprehensive measure to address the VA's issues.

To go to conference on the issue in mid-June, the House combined the text of two earlier House-passed VA health-care-related bills (**HR 4031** and **HR 4810**). The House measure would allow veterans for several years to get access to health care services at non-VA facilities if they lived more than 40 miles from a VA clinic or couldn't get an appointment to see a VA doctor within a certain time period, and it would give the VA secretary authority to fire or demote high-level VA officials for poor performance. The comprehensive Senate measure included similar provisions while also providing expedited authority to hire more VA doctors and nurses using unobligated VA funds, authorizing leases for new VA medical facilities, requiring that VA's patient-scheduling system be updated, establishing commissions on ways to improve the VA and expanding certain veterans education benefits.

Cost Concerns

During conference deliberations, the potential costs of both the House and Senate versions to provide greater access to non-VA health care services became the major focus and a cause of concern. The Congressional Budget Office (CBO) initially estimated that those provisions in the Senate version would cost $35 billion through FY 2019 and the House version $44 billion and that, under both measures, veterans could ultimately seek additional care costing the government at least $50 billion a year if the temporary access to non-VA care was allowed to continue. CBO later reduced those potential costs somewhat, but they still remained very high.

Republicans also expressed reservations that the costs of the Senate bill were classified as emergency spending that is exempt from budget caps, compared with the House version, where costs would be subject to the availability of appropriations. Cost concerns were further heightened in mid-July when acting Secretary Gibson appeared before the Senate Veterans' Affairs Committee and said the administration was also asking for $17.6 billion in supplemental VA funding — including $8.2 billion to hire more medical staff, $1.2 billion for information technology and $6 billion for construction of new health care facilities.

Late last week, negotiations appeared to have collapsed after Senate Democrats and House Republicans exchanged proposals and House Veterans' Affairs Chairman Jeff Miller, R-Fla., convened a conference meeting that all Democrats but one boycotted. But with the monthlong August recess looming and lawmakers under great pressure to reach an agreement before they leave town, discussions between the parties continued, and over the weekend it was announced that an agreement had been reached.

Summary of Agreement on HR 3230

The agreement increases veterans' access to health care in the wake of the Veterans Affairs (VA) Department scandal involving falsified appointment records that hid long wait times, allowing veterans to obtain health care at non-VA health facilities if they live more than 40 miles from a VA health clinic or can't get an appointment at a VA clinic within 30 days, and it increases the VA's capacity to provide health care services by providing expedited authority to hire more doctors and nurses and by providing for leases for the opening of 27 additional VA health facilities across the nation.

To address the VA culture that resulted in the widespread falsification of appointment records and to make VA officials more accountable, it authorizes the VA secretary to fire or demote VA Senior Executive Service

employees based on their performance or misconduct, and it provides for a limited appeals process during which the employee would not be paid.

It includes $10 billion in mandatory appropriations to pay for care at non-VA facilities and $5 billion in mandatory appropriations for VA to hire more doctors, nurses and other health care professionals and improve VA's physical infrastructure — all of which would be categorized as emergency spending. According to congressional Veterans' Affairs committee leaders, it also includes about $5 billion in offsets.

A Congressional Budget Office (CBO) estimate released late Tuesday estimated that the agreement, on net, would increase the deficit by about $10 billion through FY 2024 (CBO's estimate did not, however, individually tally up the spending and offsets).

Access to Care

To provide the additional access to care, the agreement requires the VA to contract out with private medical providers and community health centers that accept Medicare, Department of Defense health facilities and Indian Health Service clinics. Only veterans who are part of the VA's health system as of Aug. 1 would be eligible, as well as any new veterans who enroll later who in the five years before enrollment actively served in a combat theater. Veterans would be given a Choice Card to prove their eligibility at non-VA health facilities; this authority to use non-VA facilities would expire after three years.

The agreement gives the VA expedited authority to hire more doctors and nurses. The VA's Inspector General would be required to annually identify the five VA health care occupations that have the largest staffing shortages.

It requires the VA to post online the wait times for scheduling appointments at VA medical facilities and for a VA technology task force to review how best to improve and updated its medical appointment scheduling system. It also requires an independent assessment of hospital care and medical services furnished in VA medical facilities and establishes a Commission on Care to examine veterans' access to health care from the VA and to recommend changes in departmental organization and health care delivery.

VA Personnel Management

In addition to giving the VA secretary authority to fire or demote SES employees, the agreement limits, but does not prohibit, VA's awarding of bonuses through FY 2024; prohibits the use of scheduling and wait-time metrics in determining employee bonuses; and requires the VA to establish disciplinary procedures for employees involved with knowingly submitting false data regarding wait times or health care quality.

Other Provisions

The agreement expands VA's authority to provide sexual trauma counseling and treatment to veterans who were assaulted during inactive-duty weekend drill training for the National Guard and Reserves, as well as for active-duty servicemembers.

It also expands certain educational benefits to the spouses of servicemembers who die in the line of duty, including those who died since the 9/11 terrorist attacks, and it requires colleges and universities to provide in-state tuition to veterans under the Post-9/11 GI Bill regardless of how long they have lived in the state.

References

All conferees signed the conference report (H Rept 113-564) except Sens. John McCain, R-Ariz., Tom Coburn, R-Okla., and Marco Rubio, R-Fla.

Section II

Expand Access to Care

This section summarizes the provisions of the conference agreement on **HR 3230**, Veterans Access, Choice and Accountability Act, that are intended to increase veterans' access to health care.

The agreement allows veterans who live more than 40 miles from a VA health clinic or can't get an appointment at a VA clinic within 30 days to receive health care at non-VA medical facilities, and it increases the VA's capacity to provide health care services by providing expedited authority to hire more doctors and nurses and by providing for leases for the opening of 27 additional VA health facilities across the nation.

The measure includes $10 billion to pay for care at non-VA facilities and $5 billion for VA to hire more doctors, nurses and other health care professionals and improve VA health care facilities. The Congressional Budget Office (CBO) estimates that the expanded veterans access and VA hiring authority would result in $13.2 billion in spending through FY 2019, while the additional VA facility leases would result in $1.3 billion in outlays through FY 2021.

Care From Non-VA Facilities

To ensure that veterans quickly have access to health care services while the VA increases its own capacity to provide care, the agreement allows certain eligible veterans to receive health care services from non-VA providers, with the VA to pay for that care. The VA already has certain limited authority to contract with non-VA providers. The measure's expanded authority for non-VA care would expire after three years.

Under the measure, the VA could contract with Medicare providers, federally qualified health centers, Defense Department health facilities and the Indian Health Service. The VA would be required to coordinate this care through its Non-VA Care Coordination Program, and payment rates for non-VA care generally would be limited to Medicare rates, unless the services are provided to veterans living in highly rural locations.

The agreement appropriates $10 billion to pay for the care provided to veterans at non-VA facilities, with that funding to be deposited into a Veterans Choice Fund created in the Treasury. Of the total, $300 million could be used for administrative expenses.

It requires the VA to submit to Congress numerous reports to document program implementation, its establishment and success in meeting program goals, veterans' utilization of and satisfaction in the care and services delivered by non-VA medical facilities, and the VA's expenditures in reimbursing non-VA entities for such care.

Eligibility

Veterans generally would be eligible to use non-VA facilities if they live more than 40 miles from the nearest VA health clinic, or if they face a wait time of more than 30 days for an appointment to see a VA doctor or other VA medical professional.

Veterans living fewer than 40 miles from a VA facility also could use non-VA facilities if, to get to the VA facility, they must travel by air, boat or ferry to reach the VA facility or they face an usual or excessive burden because of geographic challenges. This exception would not apply to veterans and facilities in Guam, American Samoa or the Philippines.

Only veterans who are part of the VA's health system as of Aug. 1 would be eligible to receive VA-paid care at a non-VA facility, as well as any new veterans that enroll later who in the five years before enrollment served in active duty in a combat theater.

In their statement of managers, conferees state that in calculating the distance from a nearest VA medical facility it is their expectation that VA will use geodesic distance, or the shortest distance between two points. They also state that they do not intend the 40-mile eligibility criteria to preclude veterans who reside closer than 40 miles from a VA facility from accessing care through non-VA providers, particularly if the VA facility that the veteran resides near provides limited services.

Alternate Wait-Time Goals

The agreement allows the VA to alter its appointment wait-time goals if it submits a report to Congress within 60 days. The new goals would replace the 30-day goal used to determine eligibility under the non-VA care program.

Process to Receive Non-VA Care

To receive medical services at a non-VA health care facility, eligible veterans would select an accessible provider from among the Medicare system, federally qualified health centers, the Defense Department or the Indian Health Service and notify the VA. The VA would be required to ensure that an eligible veteran receives an appointment at the non-VA facility within the wait-time goals.

If a veteran is eligible for such non-VA care, he or she would be informed electronically by the VA about the care or services he or she is authorized to receive. The veteran also could choose to be notified by letter.

The measure requires veterans to disclose to the VA any information on other health care plans prior to receiving non-VA coverage, and it provides that other health care plans would be primarily responsible for non-service-connected care. In these cases, providers would be responsible for seeking reimbursement from the non-VA health care plans.

The agreement directs the VA to use cooperative agreements with non-VA facilities that were entered into under other provisions of law, to the greatest extent possible. These could include patient-centered community care contracts and intergovernmental agreements with federally qualified health centers, the Defense Department and the Indian Health Service.

Veterans Choice Card

Enrolled veterans must be provided by the VA with a "Veterans Choice Card," which would be presented to non-VA health care providers to prove the veteran's eligibility to receive VA-reimbursed medical services, and which would contain identifying information and contact information for authorization and claims procedures. The card must also include information for veterans regarding the care and services that are available through use of the card.

The VA must issue the cards to enrolled veterans within 90 days of enactment. In their statement of managers, conferees say they do not intend for any delays that may occur in the production of the Veterans Choice Cards to delay the implementation of the non-VA health care program.

Limit on Follow-Up Care

Under the non-VA care system created by the agreement, follow-up care generally would be limited to 60 days per episode of care.

Conferees, however, in their statement of managers say they recognize that certain chronic conditions may require episodes of care beyond 60 days and that they expect the VA to authorize additional episodes of care sufficient to complete the veteran's needed treatment or to maintain a quality of life during a terminal illness.

Payment Procedures

The VA would be required to supply information to providers on applicable policies and procedures for submitting bills or claims. Veterans would be required to pay a copayment for hospital care or medical services at non-VA facilities only if they would have been required to pay a copayment for the receipt care and services at a VA medical facility.

The agreement directs the VA to implement an efficient nationwide system for processing and paying bills or claims for authorized care and services at non-VA facilities, and to issue regulations for such a system

within 90 days of enactment. It provides that VA should comply with existing federal "prompt payment" in making payments to non-VA facilities.

The agreement directs the VA to transfer, by Oct. 1, authority for paying for non-VA hospital care, medical services and other health care to the Chief Business Office of the Veterans Health Administration, a move intended to centralize non-VA care oversight. It also requires the Chief Business Office to work with the Office of Clinical Operations and Management to ensure that care and services are provided in a manner that is "clinically appropriate" and in the best interest of the veterans.

For purposes of determining whether a payment is limited to Medicare rates, the measure defines "highly rural location" as an area located in a county that has fewer than seven individuals residing per square mile.

Associated Access Authorities

The agreement requires the VA, in consultation with the Indian Health Service, to conduct more outreach to Indian Health Service tribal health programs to ensure they are aware that they can negotiate reimbursement agreements. It also directs the VA to enter into contracts or agreements with the Native Hawaiian health care systems for reimbursement of direct care services provided to eligible veterans.

It also extends for two years the Access Received Close to Home (ARCH) pilot program, which is intended to provide health care access closer to home through contracts with non-VA providers. According to the VA, five pilot areas have been established in Maine, Virginia, Kansas, Arizona and Montana. The measure requires appointments with non-VA providers in the program to be scheduled within five days of the provider accepting a referral from VA, and requires that those veterans receive care within 30 days of when the appointment was made.

Reports & Other Provisions

The measure directs the VA inspector general to report on accuracy and timeliness of payments. It also requires the VA to report on program utilization, including a description of the types of care and services furnished to veterans.

In response to reports of the VA not paying claims from non-VA providers in a timely manner, the agreement requires the Government Accountability Office (GAO) to report on the timeliness of payments by VA for non-VA care and services.

As part of the VA's annual budget submission, the measure requires details regarding cost and participation of veterans in the new non-VA care program.

Labor Department Treatment

The measure prevents any non-VA provider from being treated as a federal contractor or subcontractor by the Labor Department's Office of Federal Contract Compliance Programs during the period in which the entity furnishes care.

VA Health Care Staffing & Capacity

To increase the VA's capacity to provide health care services to veterans, the agreement provides $5 billion for the VA to hire additional doctors, nurses and other health care professionals and to improve its health care facilities. It specifically calls for the hiring of primary care and speciality care physicians within the VA.

Hiring Authority & Retention

The measure requires the VA's inspector general to annually identify the five occupations of health care providers with the largest staffing shortages in VA's health system, and it authorizes VA to utilize direct, expedited appointment authority to fill those openings. The VA, no later than Dec. 31 and then on a biennial basis through 2024, must report to Congress on staffing levels at each VA medical facility.

It requires the VA to establish medical residency programs, or to ensure that sufficient residency positions exist at facilities with programs in specialties facing a shortage of physicians or located in a community that is

designated as a health professional shortage area. It increases by up to 1,500 the number of graduate medical education residents over a five-year period, with a priority for primary care, mental health and other specialties as VA determines is appropriate.

Health Professionals Educational Assistance Program

The agreement extends through Dec. 31, 2019, VA's authority to operate the Health Professionals Educational Assistance Program, under which it provides student loan debt reduction payments to VA health care professionals as thereby serves and a VA personnel recruitment and retention tool.

It increases the cap on debt reduction payments that the VA may make to individual participants — from $60,000 to $120,000 overall, and from $12,000 to $24,000 on a per-year basis. The statement of managers notes that those increases would bring VA's program in line with other similar federal programs and ensure that VA has the authority to provide appropriate incentives to attract health care professionals.

In distributing assistance under the program, the measure requires VA to give priority to medical students who are pursuing a specialty that has been identified by VA's IG as experiencing a shortage.

"Our Doctors" Database

The agreement directs VA to improve the information available to veterans regarding residency training in the “Our Doctors” database that is located on each VA medical facility's website. It requires VA to provide to veterans information on the credentials of the surgeon performing a procedure prior to the veteran receiving surgery through the VA. The statement of managers says that those websites currently contain very limited information on VA doctors and other VA health care providers.

Mobile Access to Care

The agreement requires the VA to standardize requirements for the operation of its mobile vet centers and mobile medical units in order to improve veterans' access to health care services in rural areas.

The statement of managers notes that there are currently 70 mobile vet centers around the country providing readjustment counseling and information resources to veterans in rural areas but that regional managers determine how they are utilized. As of March 2013, VA also operated eight mobile medical units to increase access to care for rural veterans.

The measure requires the VA to standardize the number of days the mobile units are expected to be in use and the number of locations they would visit. It directs the VA to report annually on mobile unit access, including recommendations on how they can be used to improve access to telemedicine in rural areas.

VA Organizational Reviews & Assessments

The agreement requires an independent, comprehensive assessment of VA's health care system — including its leadership, the hospital care and medical services provided by the VA and its current and projected health care capabilities and resources, veterans' access to care and their projected demographics and unique needs, VA staffing and productivity standards and information technology strategies, and medical construction and maintenance.

Conferees in their statement of managers say they expect that the assessment will produce outcomes that identify improvement areas outlined both qualitatively and quantitatively, taking into consideration Department of Veterans Affairs' directives and industry benchmarks from outside the federal government. They state that the recommendations for how to address identified improvement areas relating to structure, accountability, process changes, technology, capabilities and usage, staff compliance, training effectiveness and other relevant drivers of performance are expected to better inform the Commission on Care in its work.

Commission on Access to Care

The agreement establishes a presidentially appointed, 15-member Commission on Access to Care, which would examine veterans' access to health care and assess how best to organize the VHA, locate health care resources and deliver health care to veterans.

The commission would be required to report initial findings and recommendations within 90 days of its first meeting and to provide a final report within 180 days of the first meeting. It would also include a

representative familiar with medical facility construction and would examine how the VA's physical infrastructure affects care.

Conferees in their statement of managers also urge the commission to consider looking at the relationship and communication structure between the VHA and the Veterans Benefits Administration. Conferees say they are concerned that the two administrations do not communicate and that they lack synergy to ensure that veterans' benefits and services are rendered in a timely, safe and veteran-focused manner.

Other VA Health Activities

Technology Task Force

The measure requires the VA to review, through a technology task force, the needs of the department with respect to its medical scheduling system and scheduling software. Within 45 days of enactment, it must propose specific actions that the VA can take to improve its scheduling software and determine whether an existing off-the-shelf system would meet the VA's needs. The VA would also be required to implement any feasible, advisable and cost-effective recommendations made by the task force within one year of receiving the task force's report.

Conferees in the statement of managers say they expect the VA to use the Northern Virginia Technology Task Force to implement this review. That task force previously provided a pro bono review for Arlington National Cemetery.

Wait Time Lists

The agreement requires the VA to publish wait-time goals for scheduling an appointment in the Federal Register and on each medical center's public website within 90 days of enactment. It also requires the VA to publish current wait times for appointments in primary and specialty care at each VA medical center.

It also requires the VA to maintain an electronic waiting list that each eligible veteran could access through www.myhealth.va.gov or any successor website. It would determine the place of the veteran on the waiting list and the average length of time an individual spends on the waiting list, disaggregated by medical facility and type of care or service.

Facility Leases

The agreement authorizes the VA to enter into 27 major leases to establish new VA medical facilities in 17 specified states, plus Puerto Rico. It requires the funding prospectus of a proposed lease to include a detailed analysis of how the lease is expected to comply with Office of Management and Budget (OMB) Circular A-11 and the Anti-Deficiency Act. It also requires notice to Congress 30 days prior to entering into such a lease.

CBO estimates that this authority, which would be effective for the opening of new facilities beginning in FY 2017, would result in $1.3 billion in spending through FY 2024.

The conferees, writing in the explanatory statement, state that they would like the VA to consider savings through standardized design elements such as prefabricated components and panelized structures.

Section III

VA Personnel Management

This section summarizes the provisions of the conference agreement on **HR 3230**, Veterans Access, Choice and Accountability Act, that deal with Veterans Affairs (VA) Department employee performance and accountability issues.

The agreement gives the VA secretary expanded authority to fire or demote senior VA executives, and it limits the appeals process for those individuals. It also caps the amount of bonuses the VA may pay each year and prohibits the VA from using scheduling and wait-time metrics as factors in determining performance awards, and it requires the VA to establish penalties for employees who knowingly submit false appointment wait-time data.

SES Firing Authority

The agreement authorizes the VA secretary to fire, remove or demote any VA employee from the Senior Executive Service (SES) if the secretary determines that the performance of the individual warrants such removal — such as for poor performance or misconduct.

Under the measure, the individual would have an opportunity to appeal the secretary's decision with the Merit System Protection Board (MSPB), which would have to conduct an expedited review and render its decision within 21 days. The expedited review must be conducted by an administrative judge at the MSPB, and if the administrative judge does not conclude the review within 21 days, then the removal or demotion would be final. No appeal is permitted beyond the administrative judge (including no second-level review by the MSPB's three-person board). Within 14 days of enactment, the MSPB must submit to Congress a plan on how it would implement the expedited reviews.

During the appeal, the employee would not be paid or receive federal benefits if he or she had been fired and would only receive the pay and benefits commensurate with his or her downgraded position if demoted.

The VA would be required to notify Congress within 30 days of removing or demoting an SES employee.

Under current law, there are greater restrictions on the ability of agency heads to fire or demote SES employees, and such employees are entitled to certain rights, including at least 30 days advance written notice, at least seven days to reply, representation by an attorney or other representative, a written decision from the agency involved and more extensive appeal rights to the MSPB. The measure would allow the VA to immediately remove SES career appointees, notwithstanding a 120-day moratorium under current law after the appointment of the head of the agency.

Bonuses & Performance Measures

The agreement limits, but does not prohibit, the paying of VA awards or bonuses through FY 2024. For the next 10 years, cumulative awards would be capped at $360 million per year. Conferees in their statement of managers say that it is their expectation that this cap will not disproportionately affect lower-wage VA employees.

However, the measure prohibits the use of scheduling and wait-time metrics as factors in determining performance awards for certain VA employees. Investigations of the VA scandal have revealed that performance bonuses tied to achieving shorter appointment wait-time goals for veterans may have created an incentive for many employees at VA facilities to falsify wait-time records or create the secret waiting lists.

It also requires the VA to remove any performance goals for employees of Veterans Integrated Service Networks and VA medical centers that could discourage the payment of veterans claims for non-VA health care, and it modifies the performance plans of the directors of those service networks and VA medical centers to ensure that the plans are based on the quality of care received by veterans — including reviews and recommendations by the VA's inspector general and the Commission on Access to Care.

Penalties for Falsifying Data

The measure requires the VA to establish policies that create disciplinary procedures and penalties for employees who knowingly falsify data concerning appointment wait times or quality measures, or who knowingly require another employee to submit false data. These procedures must be established within 60 days of enactment.

Management Training

To prevent the types of improper management practices that have occurred at VA health care facilities, the measure directs the VA to implement a clinic management training program to provide in-person, standardized education on health care management to all VA managers and health care providers.

The program must include training on managing the schedules of VA health care providers, the appropriate number of appointments for a VA provider on a daily basis and the proper use of VA's appointment scheduling system. The VA would be required to carry out the program for two years and to update training materials on an ongoing basis.

Section IV

Miscellaneous Health Care & Other Provisions

This section summarizes the provisions of the conference agreement on **HR 3230**, Veterans Access, Choice and Accountability Act, that deal with other Veterans Affairs (VA) Department health care programs, education benefits and other authorities — including sexual trauma treatment and services.

Sexual Trauma Provisions

The agreement expands the VA's authority to provide sexual trauma counseling and treatment to active-duty servicemembers and certain reservists assaulted when not on active duty.

Under the measure, the VA would be authorized to provide counseling, care and services to individuals who do not have veterans status but who experienced sexual trauma while serving on inactive duty for training — such as members of the National Guard and Reserve who are assaulted during weekend drill training.

In addition, active-duty servicemembers would be permitted to directly seek counseling and treatment from the VA for sexual trauma that occurred while on active duty, and they would no longer be required to initially be seen by Defense health professionals and receive a referral from the Defense Department.

The measure directs the VA-Defense Department Joint Executive Committee to conduct an annual assessment for the next five years of the processes and procedures regarding the transition of care from the Defense Department to the VA for individuals who have experienced military sexual trauma. The VA also would be required to submit a report to Congress on treatment available to male veterans who experience male sexual trauma.

VA Education Benefits

The agreement expands the Marine Gunnery Sergeant John David Fry Scholarship to include surviving spouses of members of the armed forces who died in the line of duty after Sept. 10, 2001. Eligibility for those education benefits would be limited to 15 years after the date of the servicemember's death or the date that the surviving spouse remarries, whichever is earlier. The spouse would be required to choose between assistance from this scholarship or from survivors' educational assistance under Chapter 35 of the U.S. Code.

The measure effectively requires public universities and colleges that participate in the Post-9/11 GI bill to provide in-state tuition to veterans and dependents using those GI bill benefits, regardless of how long they have lived in the state.

The conferees in their statement of managers note that while some states currently assist all or certain veterans by recognizing them as in-state students for purposes of attending a public educational institution, regardless of how long they have lived in that state where the college is located, many states require transitioning veterans to meet stringent residency requirements before they can be considered in-state residents.

Specifically, the agreement requires the VA to disapprove courses of education provided by public universities and colleges that charge more than the in-state resident rate for veterans within three years of when they were discharged from military service, irrespective of the veteran's current state of residence, if the veteran is living in the state where the college is located while pursuing that course of education. Colleges would, however, be allowed to require veterans to demonstrate an intent to eventually establish residency in that state.

TBI and Other Provisions

The agreement extends for three years — to Oct. 6, 2017 — the VA's pilot program for veterans with traumatic brain injury (TBI). The program's current authority expires Sept. 30.

The Assisted Living Pilot Program for Veterans with Traumatic Brain Injury, established by the 2008 defense authorization law, provides 24-hour assisted living help to veterans with TBI in order to enhance their quality of life and promote community integration.

Offsets

The measure also includes a number of provisions that help to partially offset the cost of the agreement — including limits on VA bonuses through FY 2024 and the expectation that Medicare payments would be reduced through the expanded access to non-VA medical facilities.

Other offsets that would raise federal receipts include:

- **VA Pensions & Medicaid** — Extends through FY 2024 the $90 limit on monthly VA pension or death pension payments that veterans or surviving spouses may receive if they also receive Medicaid-covered nursing home care. This authority is currently scheduled to expire at the end of FY 2016.
- **VA Housing Loan Fees** — Extends through FY 2024 the authority of the VA to collect fees for VA-guaranteed housing loans.
- **Income Verification** — Extends through FY 2024 the VA's authority to obtain income information from the IRS or the Social Security Administration to verify need-based VA benefits. This authority is currently scheduled to expire at the end of FY 2016.