115TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
115–65

TO ELIMINATE THE SUNSET OF THE VETERANS CHOICE PROGRAM, AND FOR OTHER PURPOSES

MARCH 29, 2017.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. ROE of Tennessee, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 369]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 369) to eliminate the sunset of the Veterans Choice Program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. ELIMINATION OF SUNSET OF THE VETERANS CHOICE PROGRAM.

Section 101(p)(2) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note) is amended by striking all that follows "section 802" and inserting a period.

SEC. 2. ELIMINATION OF REQUIREMENT TO ACT AS SECONDARY PAYER FOR CARE RELATING TO NON-SERVICE-CONNECTED DISABILITIES AND RECOVERY OF COSTS FOR CERTAIN CARE UNDER CHOICE PROGRAM.

(a) IN GENERAL.—Section 101(e) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note) is amended—

(1) in the subsection heading, by striking "OTHER HEALTH-CARE PLAN" and inserting "RESPONSIBILITY FOR COSTS OF CERTAIN CARE";

(2) in paragraph (1), in the paragraph heading, by striking "TO SECRETARY" and inserting "ON HEALTH-CARE PLANS";

(3) by striking paragraphs (2) and (3);

(4) by redesignating paragraph (4) as paragraph (2); and

(5) by adding at the end the following new paragraph:

"(3) RECOVERY OF COSTS FOR CERTAIN CARE.—

"(A) IN GENERAL.—In any case in which an eligible veteran is furnished hospital care or medical services under this section for a non-service-connected disability described in subsection (a)(2) of section 1729 of title 38, United States Code, or for a condition for which recovery is authorized or with respect to which the United States is deemed to be a third party beneficiary under Public Law 87–693, commonly known as the 'Federal Medical Care Recovery Act' (42 U.S.C. 2651 et seq.), the Secretary shall recover or collect from a third party (as defined in subsection (i) of such section 1729) reasonable charges for such care or services to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

"(B) USE OF AMOUNTS.—Amounts collected by the Secretary under subparagraph (A) shall be deposited in the Medical Community Care account of the Department. Amounts so deposited shall remain available until expended.".

(b) CONFORMING AMENDMENT.—Paragraph (1) of such section is amended by striking "paragraph (4)" and inserting "paragraph (2)".

SEC. 3. AUTHORITY TO DISCLOSE CERTAIN MEDICAL RECORDS OF VETERANS WHO RECEIVE NON-DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE.

Section 7332(b)(2) of title 38, United States Code, is amended by adding at the end the following new subparagraph:

"(H)(i) To a non-Department entity (including private entities and other Federal agencies) that provides hospital care or medical services to veterans.

"(ii) An entity to which a record is disclosed under this subparagraph may not redisclose or use such record for a purpose other than that for which the disclosure was made.".

PURPOSE AND SUMMARY

H.R. 369 was introduced by Representative David P. Roe of Tennessee, the Chairman of the Committee on Veterans' Affairs, on January 9, 2017. H.R. 369, as amended, would: (1) remove the three-year sunset date for the Veterans Choice program; (2) make the Department of Veterans Affairs (VA) the primary payer for the Choice program; and (3) authorize VA to share medical record information with a public or private health care provider in order to provide care or treatment to a shared patient.

BACKGROUND AND NEED FOR LEGISLATION

Section 1. Elimination of sunset of the Veterans Choice Program

VA has been collaborating with medical providers in the community to provide timely, quality care to veteran patients since 1945. There are a variety of statutory authorities and programs that the Veterans Health Administration (VHA)—which operates and oversees the VA health care system—uses to refer veterans to community providers. The most recent community care program is the Choice program (hereinafter referred to as "Choice").

Choice was established by section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146) (the Act). Choice expanded the availability of community care to veteran patients by setting specific triggers that would require VA to give veterans the option of receiving care in the community rather than in a VA medical facility. In general, veterans are eligible to receive care through Choice if they are unable to secure an appointment at a VA medical facility within 30 days or if they reside more than 40 miles from the nearest VA medical facility. More than 1.2 million veterans have used Choice since its creation to receive needed care and, in fiscal year (FY) 2016, 23 percent of all of VA community care appointments resulted from the Choice program.

To fund Choice, section 802 of the Act created—and deposited $10 billion into—the Veterans Choice Fund and stipulated that Choice will sunset either when the money in the Choice fund is fully expended or three years after enactment of the Act. Since the law was enacted on August 7, 2014, three years after enactment of the Act would be August 7, 2017. At the time of the Act's passage, Congress expected that the money in the Veterans Choice Fund would be fully expended within three years. However, VA currently expects to have anywhere from $800 million to $1.2 billion left in the Veterans Choice Fund on August 7, 2017. Absent legislation to remove the current sunset date, Choice would end on August 7, 2017, and any funds remaining in the Veterans Choice Fund must then be returned to the Treasury.

The expiration of Choice this year could have a negative impact on access to care for veteran patients. VA's non-Choice community care account is not sufficiently resourced to absorb the additional demand for care resulting from Choice. Furthermore, during a Committee hearing on March 7, 2017, Secretary Shulkin testified that, "[the] looming expiration [of Choice] is a cause for concern among veterans, providers, and VA staff . . . [as] . . . [w]ithout Congressional action, veterans will have to face longer wait times for care." [1] The Secretary went on to claim that, if Choice is not extended past the current sunset date, it would be "a disaster for American veterans." [2] VA has already started halting referrals to Choice in anticipation of the program's expiration. Services that typically require months-long episodes of care, such as maternity and oncology care, are already experiencing significant impacts as they are likely to outlast the current sunset date. However, a "large number of veterans" are not going to be able to access Choice

[1] March, 8, 2017; Committee on Veterans' Affairs, U.S. House of Representatives, "Shaping the Future: Consolidating and Improving VA Community Care," https://veterans.house.gov/hearings/shaping-future-consolidating-and-improving-va-community-care.
[2] Ibid.

care "towards to end of April to May [2017]," should the program not be extended, per the Secretary's testimony in early March.[3]

To that end, Section 101 of the bill would remove the current August 7, 2017, sunset date for the Choice program, which would allow the program to continue operating until all of the money remaining in the Veterans Choice Fund is fully expended. The Committee recognizes that Choice, in its current form, is flawed and in need of improvement to ensure its optimal functioning for veterans, VA, community providers, and taxpayers alike. The Committee is strongly committed to the expeditious development of legislation to improve VA community care, in general, and Choice, in particular. However, the Committee also recognizes that veterans could be unduly harmed by the expiration of Choice on the current sunset date. Enactment of Section 101 of the bill would ensure that, as Congress moves forward with efforts to improve the provision of care in the community to veteran patients, veterans can continue to access needed care from Choice and continue to benefit from the full amount of money Congress appropriated into the Veterans Choice Fund for this intended purpose.

Section 2. Elimination of requirement to act as secondary payer for care relating to non-service connected disabilities and recovery of costs for certain care under Choice Program

Section 101(e) of the Act stipulates that VA is secondarily responsible for costs associated with non-service connected care provided pursuant to Choice. In other words, VA is a secondary payer for non-service connected care provided under Choice. This is different from standard protocol for VA's non-Choice community care programs wherein VA is the primary payer for both service-connected and non-service-connected care and collects reasonable charges from a veteran's third party insurer—where applicable—for non-service connected care. VA claims that the requirement for VA to be the secondary payer for Choice has created significant confusion for veterans and community providers and that making VA the primary payer under Choice, consistent with VA's other care in the community programs, would result in timelier and more consistent payments to community providers.[4]

Section 2 of the bill would eliminate the requirement for VA to act as the secondary payer for non-service connected care provided under Choice. While the Committee has continued concerns regarding VA's ability to efficiently and fully collect reimbursements from third parties, the Committee understands that the requirement for VA to be a secondary payer for non-service connected care has created unforeseen challenges that have impeded Choice care in certain instances. As such, the Committee is supportive of removing the secondary payer requirement to bring Choice fully in line with VA's other care in the community programs and to make Choice care more efficient.

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[3] Ibid.

[4] January 30, 2017, VA Office the Inspector General report 15–04673–333, "Review of the Implementation of the Veterans Choice Program," https://www.va.gov/oig/pubs/VAOIG-15-04673-333.pdf.

Section 3. Authority to disclose certain medical records of veterans who receive non-Department of Veterans Affairs health care

Since FY 2014, VA community care appointments have increased by 61 percent overall and by 41 percent as a percentage of total VA appointments.[5] In FY 2016 alone, 25.5 million appointments—or 30 percent of all VA appointments—occurred in the community rather than in VA medical facilities.[6] Given the dramatic increase in VA community care demand in recent years and the need to ensure that the care veterans receive in the community is coordinated and of the highest quality, the Committee believes that it is critically important for VA and community providers to be able to share pertinent medical record information about the veteran patients they are jointly treating.

Accordingly, Section 3 of the bill would authorize VA to share medical record information with a public or private health care provider in order to provide care or treatment to a shared patient but prohibit any subsequent re-disclosure of medical record information for a purpose other than that for which the original disclosure was made.The Committee believes this would improve the provision of care to veteran patients from both VA providers and community providers while also ensuring that personal patient information is safeguarded from inappropriate disclosure.

HEARINGS

There were no Subcommittee hearings held on H.R. 369.

On March 7, 2017, the full Committee held an oversight and legislative hearing that included a discussion of H.R. 369. The following witnesses testified:

The Honorable John McCain of Arizona, U.S. Senate; the Honorable David J. Shulkin M.D., Secretary of the U.S. Department of Veterans Affairs, who was accompanied by Baligh Yehia M.D., the Deputy Under Secretary for Health for Community Care for the Veterans Health Administration of the U.S. Department of Veterans Affairs; The Honorable Michael J. Missal, Inspector General of the U.S. Department of Veterans Affairs; and Randy Williamson, Health Care Director for the U.S. Government Accountability Office.

Statements for the record were submitted by:

The American Legion, the Disabled American Veterans, the Paralyzed Veterans of America, the Veterans of Foreign Wars of the United States, and TriWest Healthcare Alliance.

SUBCOMMITTEE CONSIDERATION

There was no Subcommittee markup of H.R. 369.

COMMITTEE CONSIDERATION

On March 8, 2017, the full Committee met in open markup session, a quorum being present, and ordered H.R. 369, as amended, favorably reported to the House of Representatives by voice vote. During consideration of the bill, the following amendment was considered and agreed to by voice vote:

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[5] January 11, 2017, MyVA Advisory Committee Meeting, Georgetown University, Washington, D.C.

[6] Ibid.

An Amendment to H.R. 369 offered by Representative Tim Walz of Minnesota, the Ranking Member of the Committee on Veterans' Affairs.

COMMITTEE VOTES

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, there were no recorded votes taken on amendments or in connection with ordering H.R. 369, as amended, reported to the House. A motion by Representative Tim Walz of Minnesota, the Ranking Member of the Committee on Veterans' Affairs, to report H.R. 369, as amended, 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 to extend and improve the Choice program.

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. 369, as amended, does not contain any Congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 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. 369, as amended, 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. 369, as amended, 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, March 20, 2017.

Hon. PHIL ROE, M.D.,
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. 369, a bill to eliminate the sunset of the Veterans Choice Program, and for other purposes.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Ann E. Futrell.

Sincerely,

MARK P. HADLEY
(For Keith Hall, *Director*).

Enclosure.

H.R. 369—A bill to eliminate the sunset of the Veterans Choice Program, and for other purposes

The Veterans Choice Program (VCP), enacted on August 7, 2014, provided $10 billion to the Department of Veterans Affairs (VA) to pay for certain veterans to receive health care from participating providers in the private sector through the earlier of August 7, 2017, or the date when funds are exhausted. H.R. 369 would eliminate the sunset date of August 7, 2017, and allow VA to operate VCP until the $10 billion in funding is exhausted.

The bill also would require VA to act as the primary payer rather than a secondary payer for care provided under VCP. Currently, VA acts as primary payer only for those veterans who are receiving care for service-connected conditions. Under this provision, CBO expects that VA would cover more of the health care costs for veterans being treated for conditions that are not related to military service.

Through the end of fiscal year 2016, VCP spending totaled roughly $6.6 billion for health care appointments, Hepatitis C drugs, and other community care. In the January 2017 baseline, CBO estimates that VA would obligate all but $200 million of the remaining funds for VCP by August 7, 2017. Enacting H.R. 369 would allow VA to obligate and spend the $200 million that would otherwise be unavailable after August 7, 2017; such spending is classified as direct spending. (Since we prepared our current baseline, VA has released new information that indicates that as much as $1 billion of the funding for VCP could remain unobligated by August 7, 2017; to the extent that unobligated funds are higher than our baseline estimate, direct spending under this bill would also be higher.)

Because CBO estimates that enacting H.R. 369 would increase direct spending by $200 million over the 2017–2027 period, pay-as-you-go procedures apply. Enacting H.R. 369 would not affect revenues.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 369 AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON VETERANS' AFFAIRS ON MARCH 8, 2017

	By fiscal year, in millions of dollars—												
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2017–2022	2017–2027
	NET INCREASE IN THE DEFICIT												
Statutory Pay-As-You-Go Impact	0	200	0	0	0	0	0	0	0	0	0	200	200

CBO estimates that enacting H.R. 369 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

H.R. 369 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would impost no costs on state, local, or tribal governments.

The CBO staff contact for this estimate is Ann E. Futrell. The estimate was approved by H. Samuel Papenfuss, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 369, as amended, 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. 369, as amended.

STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to Article I, section 8 of the United States Constitution, H.R. 369, as amended, is authorized by Congress' power to "provide for the common Defense and general Welfare of the United States."

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that H.R. 369, as amended, 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.

STATEMENT ON DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee finds that no provision of H.R. 369, as amended, establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULEMAKING

Pursuant to section 3(i) of H. Res. 5, 115th Cong. (2017), the Committee estimates that H.R. 369, as amended, contains no directed rulemaking that would require the Secretary to prescribe regulations.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Elimination of sunset of the Veterans Choice Program

Section 1 of the bill would amend section 101(p)(2) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146) by striking "section 802" and inserting a period.

Section 2. Elimination of requirement to act as secondary payer for care relating to non-service connected disabilities and recovery of costs for certain care under Choice Program

Section 2(a) of the bill would amend section 101(e) of the Veterans Access, Choice, and Accountability Act of 2014:

(1) in the subsection heading, by striking "OTHER HEALTH-CARE PLAN" and inserting "RESPONSIBILITY FOR COSTS OF CERTAIN CARE";

(2) in paragraph (1) in the paragraph heading, by striking "TO SECRETARY" and inserting "ON HEALTH-CARE PLANS";

(3) by striking paragraphs (2) and (3);

(4) by redesignating paragraph (4) as paragraph (2); and

(5) by adding at the end a new paragraph entitled, "(3) RECOVERY OF COSTS FOR CERTAIN CARE". This new paragraph would stipulate that in any case in which an eligible veteran is furnished hospital care or medical services under this Section for a non-service connected disability or for a condition in which recovery is authorized or with respect to which the United States is deemed to be a third party beneficiary under the Federal Medical Care Recovery Act (Public Law 87–693), that the Secretary shall recover or collect from a third party reasonable charges for such care or services to the extent that the veteran or the provider of the care or services would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States and that the amounts collected by the Secretary under paragraph (A) are required to be deposited in the Medical Community Care account to remain available until expended.

Section 2(b) of the bill would provide a conforming amendment to paragraph (1) of section 101(e) of the Veterans Access, Choice, and Accountability Act of 2014, particularly by striking "paragraph (4)" and inserting, "paragraph (2)".

Section 3. Authority to disclose certain medical records of veterans who receive non-Department of Veterans Affairs health care

Section 3 of the bill would amend section 7332(b)(2) of title 38, U.S.C., by adding a new paragraph (H).

Section 7332(b)(2)(H) would authorize VA to disclose medical record information to a non-Department entity (including private entities and other Federal agencies) that provide hospital care or medical services to veterans and stipulate that such an entity may not redisclose or use the medical record information for a purpose other than that for which the disclosure was made.

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 (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

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 (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

VETERANS ACCESS, CHOICE, AND ACCOUNTABILITY ACT OF 2014

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TITLE I—IMPROVEMENT OF ACCESS TO CARE FROM NON-DEPARTMENT OF VETERANS AFFAIRS PROVIDERS

SEC. 101. EXPANDED AVAILABILITY OF HOSPITAL CARE AND MEDICAL SERVICES FOR VETERANS THROUGH THE USE OF AGREEMENTS WITH NON-DEPARTMENT OF VETERANS AFFAIRS ENTITIES.

(a) EXPANSION OF AVAILABLE CARE AND SERVICES.—

(1) FURNISHING OF CARE.—

(A) IN GENERAL.—Hospital care and medical services under chapter 17 of title 38, United States Code, shall be furnished to an eligible veteran described in subsection (b), at the election of such veteran, through agreements authorized under subsection (d), or any other law administered by the Secretary of Veterans Affairs, with entities specified in subparagraph (B) for the furnishing of such care and services to veterans.

(B) ENTITIES SPECIFIED.—The entities specified in this subparagraph are the following:

(i) Any health care provider that is participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including any physician furnishing services under such program.

(ii) Any Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B))).

(iii) The Department of Defense.

(iv) The Indian Health Service.

(v) Subject to subsection (d)(5), a health care provider not otherwise covered under any of clauses (i) through (iv).

(2) CHOICE OF PROVIDER.—An eligible veteran who makes an election under subsection (c) to receive hospital care or medical services under this section may select a provider of such care or services from among the entities specified in paragraph (1)(B) that are accessible to the veteran.

(3) COORDINATION OF CARE AND SERVICES.—The Secretary shall coordinate, through the Non-VA Care Coordination Program of the Department of Veterans Affairs, the furnishing of care and services under this section to eligible veterans, including by ensuring that an eligible veteran receives an appointment for such care and services within the wait-time goals of the Veterans Health Administration for the furnishing of hospital care and medical services.

(b) ELIGIBLE VETERANS.—A veteran is an eligible veteran for purposes of this section if—

(1) the veteran is enrolled in the patient enrollment system of the Department of Veterans Affairs established and operated under section 1705 of title 38, United States Code, including any such veteran who has not received hospital care or medical services from the Department and has contacted the Department seeking an initial appointment from the Department for the receipt of such care or services; and

(2) the veteran—

(A) attempts, or has attempted, to schedule an appointment for the receipt of hospital care or medical services under chapter 17 of title 38, United States Code, but is unable to schedule an appointment within—

(i) the wait-time goals of the Veterans Health Administration for the furnishing of such care or services; or

(ii) with respect to such care or services that are clinically necessary, the period determined necessary for such care or services if such period is shorter than such wait-time goals;

(B) resides more than 40 miles (as calculated based on distance traveled) from—

(i) with respect to a veteran who is seeking primary care, a medical facility of the Department, including a community-based outpatient clinic, that is able to provide such primary care by a full-time primary care physician; or

(ii) with respect to a veteran not covered under clause (i), the medical facility of the Department, including a community-based outpatient clinic, that is closest to the residence of the veteran;

(C) resides—

(i) in a State without a medical facility of the Department that provides—

(I) hospital care;

(II) emergency medical services; and

(III) surgical care rated by the Secretary as having a surgical complexity of standard; and

(ii) more than 20 miles from a medical facility of the Department described in clause (i); or

(D)(i) resides in a location, other than a location in Guam, American Samoa, or the Republic of the Philippines, that is 40 miles or less from a medical facility of the Department, including a community-based outpatient clinic; and

(ii)(I) is required to travel by air, boat, or ferry to reach each medical facility described in clause (i) that is 40 miles or less from the residence of the veteran; or

(II) faces an unusual or excessive burden in traveling to such a medical facility of the Department based on—

(aa) geographical challenges;

(bb) environmental factors, such as roads that are not accessible to the general public, traffic, or hazardous weather;

(cc) a medical condition that impacts the ability to travel; or

(dd) other factors, as determined by the Secretary.

(c) ELECTION AND AUTHORIZATION.—

(1) IN GENERAL.—In the case of an eligible veteran described in subsection (b)(2)(A), the Secretary shall, at the election of the eligible veteran—

(A) provide the veteran an appointment that exceeds the wait-time goals described in such subsection or place such eligible veteran on an electronic waiting list described in paragraph (2) for an appointment for hospital care or medical services the veteran has elected to receive under this section; or

(B)(i) authorize that such care or services be furnished to the eligible veteran under this section for a period of time specified by the Secretary; and

(ii) notify the eligible veteran by the most effective means available, including electronic communication or notification in writing, describing the care or services the eligible veteran is eligible to receive under this section.

(2) ELECTRONIC WAITING LIST.—The electronic waiting list described in this paragraph shall be maintained by the Department and allow access by each eligible veteran via www.myhealth.va.gov or any successor website (or other digital channel) for the following purposes:

(A) To determine the place of such eligible veteran on the waiting list.

(B) To determine the average length of time an individual spends on the waiting list, disaggregated by medical facility of the Department and type of care or service needed, for purposes of allowing such eligible veteran to make an informed election under paragraph (1).

(d) CARE AND SERVICES THROUGH AGREEMENTS.—

(1) AGREEMENTS.—

(A) IN GENERAL.—The Secretary shall enter into agreements for furnishing care and services to eligible veterans under this section with entities specified in subsection (a)(1)(B). An agreement entered into pursuant to this subparagraph may not be treated as a Federal contract for the acquisition of goods or services and is not subject to any provision of law governing Federal contracts for the acquisition of goods or services. Before entering into an agree-

ment pursuant to this subparagraph, the Secretary shall, to the maximum extent practicable and consistent with the requirements of this section, furnish such care and services to such veterans under this section with such entities pursuant to sharing agreements, existing contracts entered into by the Secretary, or other processes available at medical facilities of the Department.

(B) AGREEMENT DEFINED.—In this paragraph, the term "agreement" includes contracts, intergovernmental agreements, and provider agreements, as appropriate.

(2) RATES AND REIMBURSEMENT.—

(A) IN GENERAL.—In entering into an agreement under paragraph (1) with an entity specified in subsection (a)(1)(B), the Secretary shall—

(i) negotiate rates for the furnishing of care and services under this section; and

(ii) reimburse the entity for such care and services at the rates negotiated pursuant to clause (i) as provided in such agreement.

(B) LIMIT ON RATES.—

(i) IN GENERAL.—Except as provided in clause (ii), rates negotiated under subparagraph (A)(i) shall not be more than the rates paid by the United States to a provider of services (as defined in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u))) or a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d))) under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for the same care or services.

(ii) EXCEPTION.—

(I) IN GENERAL.—The Secretary may negotiate a rate that is more than the rate paid by the United States as described in clause (i) with respect to the furnishing of care or services under this section to an eligible veteran who resides in a highly rural area.

(II) HIGHLY RURAL AREA DEFINED.—In this clause, the term "highly rural area" means an area located in a county that has fewer than seven individuals residing in that county per square mile.

(III) OTHER EXCEPTIONS.—With respect to furnishing care or services under this section in Alaska, the Alaska Fee Schedule of the Department of Veterans Affairs will be followed, except for when another payment agreement, including a contract or provider agreement, is in place. With respect to care or services furnished under this section in a State with an All-Payer Model Agreement under the Social Security Act that became effective on January 1, 2014, the Medicare payment rates under clause (i) shall be calculated based on the payment rates under such agreement.

(C) LIMIT ON COLLECTION.—For the furnishing of care or services pursuant to an agreement under paragraph (1),

an entity specified in subsection (a)(1)(B) may not collect any amount that is greater than the rate negotiated pursuant to subparagraph (A)(i).

(3) CERTAIN PROCEDURES.—

(A) IN GENERAL.—In entering into an agreement under paragraph (1) with an entity described in subparagraph (B), the Secretary may use the procedures, including those procedures relating to reimbursement, available for entering into provider agreements under section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)) and participation agreements under section 1842(h) of such Act (42 U.S.C. 1395u(h)). During the period in which such entity furnishes care or services pursuant to this section, such entity may not be treated as a Federal contractor or subcontractor by the Office of Federal Contract Compliance Programs of the Department of Labor by virtue of furnishing such care or services.

(B) ENTITIES DESCRIBED.—The entities described in this subparagraph are the following:

(i) In the case of the Medicare program, any provider of services that has entered into a provider agreement under section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)) and any physician or other supplier who has entered into a participation agreement under section 1842(h) of such Act (42 U.S.C. 1395u(h)); and

(ii) In the case of the Medicaid program, any provider participating under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.).

(4) INFORMATION ON POLICIES AND PROCEDURES.—The Secretary shall provide to any entity with which the Secretary has entered into an agreement under paragraph (1) the following:

(A) Information on applicable policies and procedures for submitting bills or claims for authorized care or services furnished to eligible veterans under this section.

(B) Access to a telephone hotline maintained by the Department that such entity may call for information on the following:

(i) Procedures for furnishing care and services under this section.

(ii) Procedures for submitting bills or claims for authorized care and services furnished to eligible veterans under this section and being reimbursed for furnishing such care and services.

(iii) Whether particular care or services under this section are authorized, and the procedures for authorization of such care or services.

(5) AGREEMENTS WITH OTHER PROVIDERS.—In accordance with the rates determined pursuant to paragraph (2), the Secretary may enter into agreements under paragraph (1) for furnishing care and services to eligible veterans under this section with an entity specified in subsection (a)(1)(B)(v) if the entity meets criteria established by the Secretary for purposes of this section.

(e) [OTHER HEALTH-CARE PLAN] *RESPONSIBILITY FOR COSTS OF CERTAIN CARE.*—

(1) SUBMITTAL OF INFORMATION [TO SECRETARY] *ON HEALTH-CARE PLANS.*—Before receiving hospital care or medical services under this section, an eligible veteran shall provide to the Secretary information on any health-care plan described in [paragraph (4)] *paragraph (2)* under which the eligible veteran is covered.

[(2) DISCLOSURE OF INFORMATION TO NON-DEPARTMENT ENTITY.—Notwithstanding section 5701 of title 38, United States Code, for purposes of furnishing hospital care or medical services to an eligible veteran under this section, the Secretary shall disclose to the entity specified in paragraph (1)(B) of subsection (a) with which the Secretary has entered into an agreement described in such subsection—

[(A) whether the eligible veteran is covered under a health-care plan described in paragraph (4); and

[(B) whether the hospital care or medical services sought by the eligible veteran is for a medical condition that is related to a non-service-connected disability described in paragraph (3)(C).

[(3) CARE FOR WHICH THE DEPARTMENT IS SECONDARILY RESPONSIBLE.—

[(A) IN GENERAL.—If an eligible veteran is covered under a health-care plan described in paragraph (4) and receives hospital care or medical services for a non-service-connected disability described in subparagraph (C), such health-care plan shall be primarily responsible for paying for such care or services, to the extent such care or services is covered by such health-care plan, and the Secretary shall be secondarily responsible for paying for such care or services in accordance with subparagraph (B)(ii).

[(B) RESPONSIBILITY FOR COSTS OF CARE.—In a case in which the Secretary is secondarily responsible for paying for hospital care or medical services as described in subparagraph (A)—

[(i) the health care provider that furnishes such care or services pursuant to an agreement described in subsection (a) shall be responsible for seeking reimbursement for the cost of such care or services from the health-care plan described in paragraph (4) under which the eligible veteran is covered; and

[(ii) the Secretary shall be responsible for promptly paying only the amount that is not covered by such health-care plan, except that such responsibility for payment may not exceed the rate determined for such care or services pursuant to subsection (d)(2).

[(C) NON-SERVICE-CONNECTED DISABILITY DESCRIBED.—A non-service-connected disability described in this subsection is a non-service-connected disability (as defined in section 101 of title 38, United States Code)—

[(i) that is incurred incident to a veteran's employment and that is covered under a workers' compensation law or plan that provides for payment for the cost

of health care and services provided to the veteran by reason of the disability;

[(ii) that is incurred as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations insurance;

[(iii) that is incurred as the result of a crime of personal violence that occurred in a State, or a political subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such crime;

[(iv) that is incurred by a veteran—

[(I) who does not have a service-connected disability; and

[(II) who is entitled to care (or payment of the expenses of care) under a health-care plan; or

[(v) for which care and services are furnished under this section to a veteran who—

[(I) has a service-connected disability; and

[(II) is entitled to care (or payment of the expenses of care) under a health-care plan.]

[(4)] *(2)* HEALTH-CARE PLAN.—A health-care plan described in this paragraph—

(A) is an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement not administered by the Secretary of Veterans Affairs, under which health services for individuals are provided or the expenses of such services are paid; and

(B) does not include any such policy, contract, agreement, or similar arrangement pursuant to title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.) or chapter 55 of title 10, United States Code.

(3) RECOVERY OF COSTS FOR CERTAIN CARE.—

(A) IN GENERAL.—In any case in which an eligible veteran is furnished hospital care or medical services under this section for a non-service-connected disability described in subsection (a)(2) of section 1729 of title 38, United States Code, or for a condition for which recovery is authorized or with respect to which the United States is deemed to be a third party beneficiary under Public Law 87–693, commonly known as the "Federal Medical Care Recovery Act" (42 U.S.C. 2651 et seq.), the Secretary shall recover or collect from a third party (as defined in subsection (i) of such section 1729) reasonable charges for such care or services to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

(B) USE OF AMOUNTS.—Amounts collected by the Secretary under subparagraph (A) shall be deposited in the

Medical Community Care account of the Department. Amounts so deposited shall remain available until expended.

(f) VETERANS CHOICE CARD.—

(1) IN GENERAL.—For purposes of receiving care and services under this section, the Secretary shall, not later than 90 days after the date of the enactment of this Act, issue to each veteran described in subsection (b)(1) a card that may be presented to a health care provider to facilitate the receipt of care or services under this section.

(2) NAME OF CARD.—Each card issued under paragraph (1) shall be known as a "Veterans Choice Card".

(3) DETAILS OF CARD.—Each Veterans Choice Card issued to a veteran under paragraph (1) shall include the following:

(A) The name of the veteran.

(B) An identification number for the veteran that is not the social security number of the veteran.

(C) The contact information of an appropriate office of the Department for health care providers to confirm that care or services under this section are authorized for the veteran.

(D) Contact information and other relevant information for the submittal of claims or bills for the furnishing of care or services under this section.

(E) The following statement: "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.".

(4) INFORMATION ON USE OF CARD.—Upon issuing a Veterans Choice Card to a veteran, the Secretary shall provide the veteran with information clearly stating the circumstances under which the veteran may be eligible for care or services under this section.

(g) INFORMATION ON AVAILABILITY OF CARE.—The Secretary shall provide information to a veteran about the availability of care and services under this section in the following circumstances:

(1) When the veteran enrolls in the patient enrollment system of the Department under section 1705 of title 38, United States Code.

(2) When the veteran attempts to schedule an appointment for the receipt of hospital care or medical services from the Department but is unable to schedule an appointment within the wait-time goals of the Veterans Health Administration for the furnishing of such care or services.

(3) When the veteran becomes eligible for hospital care or medical services under this section under subparagraph (B), (C), or (D) of subsection (b)(2).

(h) FOLLOW-UP CARE.—In carrying out this section, the Secretary shall ensure that, at the election of an eligible veteran who receives hospital care or medical services from a health care provider in an episode of care under this section, the veteran receives such hospital care and medical services from such health care provider through the completion of the episode of care, including all specialty and ancillary services deemed necessary as part of the treat-

ment recommended in the course of such hospital care or medical services.

(i) PROVIDERS.—To be eligible to furnish care or services under this section, a health care provider must—

(1) maintain at least the same or similar credentials and licenses as those credentials and licenses that are required of health care providers of the Department, as determined by the Secretary for purposes of this section; and

(2) submit, not less frequently than once each year during the period in which the Secretary is authorized to carry out this section pursuant to subsection (p), verification of such licenses and credentials maintained by such health care provider.

(j) COST-SHARING.—

(1) IN GENERAL.—The Secretary shall require an eligible veteran to pay a copayment for the receipt of care or services under this section only if such eligible veteran would be required to pay a copayment for the receipt of such care or services at a medical facility of the Department or from a health care provider of the Department pursuant to chapter 17 of title 38, United States Code.

(2) LIMITATION.—The amount of a copayment charged under paragraph (1) may not exceed the amount of the copayment that would be payable by such eligible veteran for the receipt of such care or services at a medical facility of the Department or from a health care provider of the Department pursuant to chapter 17 of title 38, United States Code.

(3) COLLECTION OF COPAYMENT.—A health care provider that furnishes care or services to an eligible veteran under this section shall collect the copayment required under paragraph (1) from such eligible veteran at the time of furnishing such care or services.

(k) CLAIMS PROCESSING SYSTEM.—

(1) IN GENERAL.—The Secretary shall provide for an efficient nationwide system for processing and paying bills or claims for authorized care and services furnished to eligible veterans under this section.

(2) REGULATIONS.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall prescribe regulations for the implementation of such system.

(3) OVERSIGHT.—The Chief Business Office of the Veterans Health Administration shall oversee the implementation and maintenance of such system.

(4) ACCURACY OF PAYMENT.—

(A) IN GENERAL.—The Secretary shall ensure that such system meets such goals for accuracy of payment as the Secretary shall specify for purposes of this section.

(B) QUARTERLY REPORT.—

(i) IN GENERAL.—The Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a quarterly report on the accuracy of such system.

(ii) ELEMENTS.—Each report required by clause (i) shall include the following:

(I) A description of the goals for accuracy for such system specified by the Secretary under subparagraph (A).

(II) An assessment of the success of the Department in meeting such goals during the quarter covered by the report.

(iii) DEADLINE.—The Secretary shall submit each report required by clause (i) not later than 20 days after the end of the quarter covered by the report.

(l) MEDICAL RECORDS.—

(1) IN GENERAL.—The Secretary shall ensure that any health care provider that furnishes care or services under this section to an eligible veteran submits to the Department a copy of any medical record related to the care or services provided to such eligible veteran by such health care provider for inclusion in the electronic medical record of such eligible veteran maintained by the Department upon the completion of the provision of such care or services to such eligible veteran.

(2) ELECTRONIC FORMAT.—Any medical record submitted to the Department under paragraph (1) shall, to the extent possible, be in an electronic format.

(m) TRACKING OF MISSED APPOINTMENTS.—The Secretary shall implement a mechanism to track any missed appointments for care or services under this section by eligible veterans to ensure that the Department does not pay for such care or services that were not furnished to an eligible veteran.

(n) IMPLEMENTATION.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall prescribe interim final regulations on the implementation of this section and publish such regulations in the Federal Register.

(o) INSPECTOR GENERAL REPORT.—Not later than 30 days after the date on which the Secretary determines that 75 percent of the amounts deposited in the Veterans Choice Fund established by section 802 have been exhausted, the Inspector General of the Department shall submit to the Secretary a report on the results of an audit of the care and services furnished under this section to ensure the accuracy and timeliness of payments by the Department for the cost of such care and services, including any findings and recommendations of the Inspector General.

(p) AUTHORITY TO FURNISH CARE AND SERVICES.—

(1) IN GENERAL.—The Secretary may not use the authority under this section to furnish care and services after the date specified in paragraph (2).

(2) DATE SPECIFIED.—The date specified in this paragraph is the date on which the Secretary has exhausted all amounts deposited in the Veterans Choice Fund established by section 802**[**, or the date that is 3 years after the date of the enactment of this Act, whichever occurs first.**]**.

(3) PUBLICATION.—The Secretary shall publish such date in the Federal Register and on an Internet website of the Department available to the public not later than 30 days before such date.

(q) REPORTS.—

(1) INITIAL REPORT.—Not later than 90 days after the publication of the interim final regulations under subsection (n), the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the furnishing of care and services under this section that includes the following:

(A) The number of eligible veterans who have received care or services under this section.

(B) A description of the types of care and services furnished to eligible veterans under this section.

(2) FINAL REPORT.—Not later than 30 days after the date on which the Secretary determines that 75 percent of the amounts deposited in the Veterans Choice Fund established by section 802 have been exhausted, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the furnishing of care and services under this section that includes the following:

(A) The total number of eligible veterans who have received care or services under this section, disaggregated by—

(i) eligible veterans described in subsection (b)(2)(A);

(ii) eligible veterans described in subsection (b)(2)(B);

(iii) eligible veterans described in subsection (b)(2)(C); and

(iv) eligible veterans described in subsection (b)(2)(D).

(B) A description of the types of care and services furnished to eligible veterans under this section.

(C) An accounting of the total cost of furnishing care and services to eligible veterans under this section.

(D) The results of a survey of eligible veterans who have received care or services under this section on the satisfaction of such eligible veterans with the care or services received by such eligible veterans under this section.

(E) An assessment of the effect of furnishing care and services under this section on wait times for appointments for the receipt of hospital care and medical services from the Department.

(F) An assessment of the feasibility and advisability of continuing furnishing care and services under this section after the termination date specified in subsection (p).

(r) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to alter the process of the Department for filling and paying for prescription medications.

(s) WAIT-TIME GOALS OF THE VETERANS HEALTH ADMINISTRATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), in this section, the term "wait-time goals of the Veterans Health Administration" means not more than 30 days from the date on which a veteran requests an appointment for hospital care or medical services from the Department.

(2) ALTERNATE GOALS.—If the Secretary submits to Congress, not later than 60 days after the date of the enactment of this

Act, a report stating that the actual wait-time goals of the Veterans Health Administration are different from the wait-time goals specified in paragraph (1)—

(A) for purposes of this section, the wait-time goals of the Veterans Health Administration shall be the wait-time goals submitted by the Secretary under this paragraph; and

(B) the Secretary shall publish such wait-time goals in the Federal Register and on an Internet website of the Department available to the public.

(t) WAIVER OF CERTAIN PRINTING REQUIREMENTS.—Section 501 of title 44, United States Code, shall not apply in carrying out this section.

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TITLE 38, UNITED STATES CODE

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PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 73—VETERANS HEALTH ADMINISTRATION - ORGANIZATION AND FUNCTIONS

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SUBCHAPTER III—PROTECTION OF PATIENT RIGHTS

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§ 7332. Confidentiality of certain medical records

(a)(1) Records of the identity, diagnosis, prognosis, or treatment of any patient or subject which are maintained in connection with the performance of any program or activity (including education, training, treatment, rehabilitation, or research) relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia which is carried out by or for the Department under this title shall, except as provided in subsections (e) and (f), be confidential, and (section 5701 of this title to the contrary notwithstanding) such records may be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b).

(2) Paragraph (1) prohibits the disclosure to any person or entity other than the patient or subject concerned of the fact that a special written consent is required in order for such records to be disclosed.

(b)(1) The content of any record referred to in subsection (a) may be disclosed by the Secretary in accordance with the prior written consent of the patient or subject with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed in regulations prescribed by the Secretary.

(2) Whether or not any patient or subject, with respect to whom any given record referred to in subsection (a) is maintained, gives written consent, the content of such record may be disclosed by the Secretary as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient or subject in any report of such research, audit, or evaluation, or otherwise disclose patient or subject identities in any manner.

(C)(i) In the case of any record which is maintained in connection with the performance of any program or activity relating to infection with the human immunodeficiency virus, to a Federal, State, or local public-health authority charged under Federal or State law with the protection of the public health, and to which Federal or State law requires disclosure of such record, if a qualified representative of such authority has made a written request that such record be provided as required pursuant to such law for a purpose authorized by such law.

(ii) A person to whom a record is disclosed under this paragraph may not redisclose or use such record for a purpose other than that for which the disclosure was made.

(D) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient or subject, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(E) To an entity described in paragraph (1)(B) of section 5701(k) of this title, but only to the extent authorized by such section.

(F)(i) To a representative of a patient who lacks decision-making capacity, when a practitioner deems the content of the given record necessary for that representative to make an informed decision regarding the patient's treatment.

(ii) In this subparagraph, the term "representative" means an individual, organization, or other body authorized under section 7331 of this title and its implementing regulations to give informed consent on behalf of a patient who lacks decision-making capacity.

(G) To a State controlled substance monitoring program, including a program approved by the Secretary of Health and Human Services under section 399O of the Public Health Service Act (42 U.S.C. 280g-3), to the extent necessary to prevent misuse and diversion of prescription medicines.

(H)(i) To a non-Department entity (including private entities and other Federal agencies) that provides hospital care or medical services to veterans.

(ii) An entity to which a record is disclosed under this subparagraph may not redisclose or use such record for a purpose other than that for which the disclosure was made.

(3) In the event that the patient or subject who is the subject of any record referred to in subsection (a) is deceased, the content of any such record may be disclosed by the Secretary only upon the prior written request of the next of kin, executor, administrator, or other personal representative of such patient or subject and only if the Secretary determines that such disclosure is necessary for such survivor to obtain benefits to which such survivor may be entitled, including the pursuit of legal action, but then only to the extent, under such circumstances, and for such purposes as may be allowed in regulations prescribed pursuant to section 7334 of this title.

(c) Except as authorized by a court order granted under subsection (b)(2)(D), no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against, or to conduct any investigation of, a patient or subject.

(d) The prohibitions of this section shall continue to apply to records concerning any person who has been a patient or subject, irrespective of whether or when such person ceases to be a patient.

(e) The prohibitions of this section shall not prevent any interchange of records—

(1) within and among those components of the Department furnishing health care to veterans, or determining eligibility for benefits under this title; or

(2) between such components furnishing health care to veterans and the Armed Forces.

(f)(1) Notwithstanding subsection (a) but subject to paragraph (2), a physician or a professional counselor may disclose information or records indicating that a patient or subject is infected with the human immunodeficiency virus if the disclosure is made to (A) the spouse of the patient or subject, or (B) to an individual whom the patient or subject has, during the process of professional counseling or of testing to determine whether the patient or subject is infected with such virus, identified as being a sexual partner of such patient or subject.

(2)(A) A disclosure under paragraph (1) may be made only if the physician or counselor, after making reasonable efforts to counsel and encourage the patient or subject to provide the information to the spouse or sexual partner, reasonably believes that the patient or subject will not provide the information to the spouse or sexual partner and that the disclosure is necessary to protect the health of the spouse or sexual partner.

(B) A disclosure under such paragraph may be made by a physician or counselor other than the physician or counselor referred to in subparagraph (A) if such physician or counselor is unavailable by reason of absence or termination of employment to make the disclosure.

(g) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined, in the case of a first offense, up to the maximum amount provided under section 5701(f) of this title for a first offense under that section and, in the case of a subsequent offense, up to the maximum amount

provided under section 5701(f) of this title for a subsequent offense under that section.

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MINORITY VIEWS

We interpret section 1 of H.R. 369 as amended, as granting the VA Secretary the authority to spend only the remaining funds in the Veterans Choice Fund under section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act).[1] Section 1 does not grant authorization to appropriate funds in section 802 of the Choice Act, or grant the VA Secretary the authority to obligate funds for the Veterans Choice Program under section 101 of the Choice Act from other existing medical care accounts including the separate account for medical community care established under section 4003 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015.[2]

We are pleased that our amendment to H.R. 369 was considered and adopted in full Committee markup. This showing of bipartisanship demonstrates that when we work together as a Committee, we can champion meaningful policies that help our veterans.

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[1] P.L. 113–146
[2] P.L. 114–41