

Health Care for Rural Veterans: The Example of Federally Qualified Health Centers

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Summary

The Department of Veterans Affairs (VA) is statutorily required to provide VA-enrolled veterans with access to timely and quality medical care. It does so through the nation's largest integrated health care delivery system. Despite the existence of this system, Congress remains concerned that veterans, in particular rural veterans, may not be able to access VA health services. Among veterans enrolled in VA health care, approximately 41% reside in rural or highly rural areas. Compared to urban veterans, rural veterans have higher prevalence of physical illness, lower health-related quality of life, and greater health care needs. Congress has demonstrated continuing interest in modifying VA delivery of care to expand access for rural veterans. Such interest has been demonstrated through report language, statutory mandates, appropriation of funds, and authorization of demonstration projects. In particular, Congress has encouraged the VA to collaborate with federally qualified health centers (FQHCs)—facilities that receive federal grants and are required to be located in areas where there are few providers, particularly rural areas.

The VA is generally a provider—rather than a financier—of health care services; however, the VA has statutory authority to reimburse non-VA providers for services that are not readily available within the VA's integrated health care delivery system. VA facilities may consider contracting with outside providers to provide services to rural veterans. One type of facility that the VA has contracted with in the past are FQHCs. Although FQHCs are one type of facility that the VA can collaborate with, FQHCs may be candidates for VA collaboration because, as a condition of receiving a federal grant, they must meet certain requirements that include providing specific types of services, maintaining health records, and meeting certain quality standards. These requirements, and the leverage that the federal government may have as a funding source, may facilitate VA-FQHC collaboration to provide care to veterans in rural areas.

The report discusses four scenarios under which an FQHC might provide health care services to veterans: (1) without reimbursement from the VA, (2) under the VA's fee basis care program, (3) under a contract for specific services, or (4) as a contractor-operated community-based outpatient clinic (a type of outpatient VA facility). Each of these scenarios is discussed because the scenario used for collaboration affects the considerations that may arise.

Some considerations that may arise during attempts to increase VA-FQHC collaboration include the costs of care to an FQHC, the VA, and veterans; the capacity of an FQHC to serve veterans in addition to its existing patients; and the compatibility of the VA and an FQHC in terms of the services available, quality initiatives, accreditation, and use of electronic health records.

To address these considerations and encourage VA-FQHC collaboration, there are a number of policy levers that Congress might use. These include oversight, an incentive fund, directed spending, statutory mandates, and watchful waiting. Congress may also consider a combination of these levers.

This report discusses considerations that may arise during possible attempts to increase VA-FQHC collaboration, and describes policy levers Congress might use to encourage VA-FQHC collaboration. These approaches might also be employed to encourage collaboration between the VA and other types of facilities that may serve rural veterans.

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Introduction

The Department of Veterans Affairs (VA) is statutorily required to provide VA-enrolled veterans (see **text box**) with access to timely and quality medical care.¹ It does so through the nation's largest integrated health care delivery system, with more than 150 VA medical centers (VAMCs), 800 community-based outpatient clinics (CBOCs), and a range of other types of facilities (e.g., nursing homes) that provide care to more than 6.3 million patients.² Despite this, Congress remains concerned that veterans, in particular rural veterans, may not be able to access VA health services. Among veterans enrolled in VA health care, approximately 41% reside in rural or highly rural areas.³

Rural-enrolled veterans share certain characteristics that influence access to and the need for care. Compared to urban veterans, rural veterans have higher prevalence of physical illness, lower health-related quality of life, and greater health care needs.⁴ Despite their greater need, rural veterans are less likely than urban veterans to use VA or private sector health care services.⁵ The disparity in use of health care may be due in part to longer driving distances to VA medical facilities experienced by many rural veterans, relative to their urban counterparts.⁶ VA primary care⁷ is available within a 30-minute drive for 91% of urban veterans, 38% of rural veterans, and 22% of highly rural veterans.⁸ Fewer than half (49%) of highly rural veterans live within 60 minutes of VA primary care.⁹

¹ 38 U.S.C. §7301.

² CRS Report R43179, *Veterans' Medical Care: FY2014 Appropriations*, by Sidath Viranga Panangala.

³ U.S. Department of Veterans Affairs (VA), Veterans Health Administration (VHA), Office of Rural Health (ORH), *Fact Sheet: Information about the Office of Rural Health and Rural Veterans*, April 2012, http://www.ruralhealth.va.gov/docs/ORH_GeneralFactSheet_April2012.pdf. The VA uses a three-tier classification system for population density: urban, rural, and highly rural. The system is based partly on the U.S. Census definitions of urban and rural; however, the VA divides the Census-designated rural areas into two categories, rural and highly rural (i.e., counties with fewer than 7 civilian residents per square mile). The VA designation of highly rural areas is similar to the designation that the Health Resources and Services Administration (HRSA) uses when giving priority to "sparsely populated areas" in competition for Federally Qualified Health Center sites; see 42 U.S.C. §254b(p) and discussion in CRS Report R42433, *Federally Qualified Health Centers*, by Elaine J. Heisler.

⁴ VA, VHA, ORH, *About Rural Veterans*, <http://www.ruralhealth.va.gov/about/rural-veterans.asp>, accessed January 9, 2014. Many of the issues that rural veterans face are similar to the health care needs and access issues that all rural populations face. See, for example, United States Department of Agriculture, Economic Research Service, "Amber Waves June 2010—Findings—Rural Populations Have Higher Rates of Chronic Disease," press release, June 2010, <http://www.ers.usda.gov/AmberWaves/June10/Findings/RuralPopulationsDisease.htm>.

⁵ VA, VHA, ORH, *About Rural Veterans*, <http://www.ruralhealth.va.gov/about/rural-veterans.asp>, accessed January 9, 2014.

⁶ The VA provides travel benefits to veterans and provides grants to Veterans Service Organizations that transport veterans; see U.S. Government Accountability Office, *Additional Steps Needed to Strengthen Beneficiary Travel Program Management and Oversight*, GAO-13-632, June 15, 2013, <http://www.gao.gov/products/GAO-13-632>.

⁷ The VA has adapted the Institute of Medicine's (IOM's) definition of primary care, which defines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." See Department of Veterans Affairs, Veterans Health Administration, *Primary Care Standards*, VHA Directive 2012-011, April 11, 2012.

⁸ Alan N. West et al., "Defining 'Rural' for Veterans' Health Care Planning," *The Journal of Rural Health*, no. 26 (2010), p. 301–309.

⁹ Ibid.

VA-Enrolled Veterans

Not all veterans are eligible to enroll in the VA. In general, eligibility for enrollment in VA health care operates through a system of eight priority groups, based on veteran status, presence of service-connected disabilities or exposures, income, and/or other factors, such as status as a former prisoner of war or receipt of a Purple Heart. Once enrolled in the VA health care system, a veteran remains enrolled and does not have to reapply, even if the veteran's priority group changes (due, for example, to a change in income). Veteran status is established by active-duty status in the U.S. Armed Forces and an honorable discharge or release from active military service. Generally, persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed two years of active duty or the full period of their initial service obligation to be eligible for VA health care benefits. Servicemembers discharged at any time because of service-connected disabilities are not held to this requirement. Veterans returning from combat operations are eligible to enroll for five years from the date of discharge without having to satisfy a means test or demonstrate a service-connected disability. A service-connected disability is a disability that was incurred or aggravated in the line of duty in the U.S. Armed Forces (38 U.S.C. §101 (16)). The VA determines whether veterans have service-connected disabilities and, for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability (38 C.F.R. §§4.1-4.31). Veterans who are eligible on the basis of exposure include those veterans who may have been exposed to Agent Orange during the Vietnam War or veterans who may have diseases potentially related to service in the Gulf War.

Source: CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala and Erin Bagalman.

Note: This report focuses on veterans who are enrolled in VA health care; throughout the report “veteran” refers to VA-enrolled veterans unless otherwise specified.

Congress has demonstrated continuing interest in modifying VA delivery of care to expand access for rural veterans. Such interest has been demonstrated through report language, statutory mandates, appropriation of funds, and authorization of demonstration projects. For example, in a 1999 conference report, Congress “urge[d] the VA to partner with existing [health care facilities] to provide outpatient primary and preventive health care services to area veterans in their home communities.”¹⁰ In 2006 Congress established the VA’s Office of Rural Health (ORH) to coordinate efforts to improve health care for rural veterans.¹¹ In 2010 Congress established several demonstration projects that aimed to improve care for rural veterans.¹² In 2011, the VA initiated the Congressionally-mandated pilot project called Project ARCH (Access Received Closer to Home), which required contracts with private providers to a variety of health care services to rural veterans.¹³ Congress has also repeatedly appropriated funds for activities to improve health care for rural veterans.¹⁴

This report explores one of these approaches to providing care for VA-enrolled veterans, particularly rural veterans, who do not live near a VA facility: VA collaboration with non-VA facilities. In areas where the veteran population is too small to support a VA facility, the total population may be large enough to support other types of facilities; thus, the VA might collaborate

¹⁰ “Conference Report on H.R. 2684 Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2000,” *Congressional Record*, October 13, 1999, p. H10005.

¹¹ Section 212 of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (P.L. 109-461) established the VA’s Office of Rural Health (ORH).

¹² The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) authorizes, among other things, several demonstration projects related to care for veterans in rural areas.

¹³ This program was authorized in Section 403 of the Veterans’ Mental Health and Other Care Improvements Act of 2008 (P.L. 110-387, enacted on October 10, 2008).

¹⁴ See, for example, Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (P.L. 110-329); Consolidated Appropriations Act, 2010 (P.L. 111-117), Consolidated Appropriations Act, 2012 (P.L. 112-74), and Consolidated and Further Continuing Appropriations Act, 2013 (P.L. 113-6).

with existing non-VA facilities to provide care for veterans. Federally qualified health centers (FQHCs)—outpatient facilities that provide health care in underserved areas—are presented as an example of entities that might collaborate with the VA.¹⁵ One of four different payment mechanisms may be used in this collaboration and these four scenarios are presented separately. Which of the four mechanisms is used is important for the subsequent discussion of considerations that might arise when the VA and FQHCs are deciding whether to collaborate, as well as for discussing policy levers available to Congress.

The report focuses on FQHCs because they provide outpatient primary care in underserved (often rural) areas; as such, they may be located in areas where rural veterans live and are currently used by veterans. For example, a VA-commissioned study estimated that FQHCs located in the District of Columbia, Maryland, Northern Virginia, and eastern West Virginia served approximately 6,500 veterans in 2009.¹⁶ The VA also has a recent history of contracting with FQHCs and of exploring mechanisms to increase its collaboration with FQHCs; specifically, the aforementioned commissioned report included recommendations to increase collaboration and the VA has 52 contracts with FQHCs for the provision of certain counseling services in rural communities where access to a VA facility is limited.¹⁷ (See **Appendix A**.)

FQHCs may also be candidates for VA collaboration because they currently receive federal grants and therefore must meet certain requirements that include providing specific types of services, maintaining certain records, and meeting certain quality standards. These requirements, and the leverage that the federal government may have as a funding source, may facilitate VA-FQHC collaboration to provide care to veterans in rural areas.¹⁸

This report focuses on considerations that may affect decisions to collaborate or not. It assumes that readers are familiar with both the VA and FQHCs. Where relevant, background information is included to assist the readers with understanding the consideration discussed. More comprehensive background information on the VA and FQHCs is included in **Appendix B** and **Appendix C**. In addition, readers can access other CRS products that describe the VA health care system and FQHCs in greater depth.¹⁹ CRS Report R42747, *Health Care for Veterans: Answers to*

¹⁵ This is one of many options available. For example, under 38 U.S.C. §8111, the VA is authorized to enter into agreements to share health care resources with the Department of Defense (DOD); this provision may be used to establish Community Based Outpatient Clinics (CBOCs) at DOD facilities using personnel from DOD, VA, or both. Congress has also required the VA to coordinate with the Indian Health Service; see 25 U.S.C. §1645; see also description of Sec. 154 in CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*, by Elayne J. Heisler; and U.S. Department of Veteran's Affairs, "VA and Indian Health Service Announce National Reimbursement Agreement," press release, December 6, 2012.

¹⁶ National Association of Community Health Centers and Atlas Research, *Collaboration with Rural Community Health Centers VISN 5*, Task 4: Final Report, June 2011.

¹⁷ This number is as of the date of this CRS report's publication.

¹⁸ Rural areas may also have "rural health clinics," which are outpatient facilities that provide primary care services to rural populations. Unlike FQHCs these facilities do not receive federal grants; instead they are designated as "rural health clinics" and made eligible for a higher Medicare payment rate. Although this designation gives the federal government some leverage over rural health clinics, they are not required to meet FQHC requirements, such as the requirement to provide specific services or to meet quality assurance standards. For more information on rural health clinics, see Center for Medicare & Medicaid Services, "Rural Health Clinic Fact Sheet," January 2013, <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf>.

¹⁹ CRS products on Benefits for Veterans, including the VA health care system, can be accessed at <http://www.crs.gov/pages/subissue.aspx?cliid=2179>.

Frequently Asked Questions, by Sidath Viranga Panangala and Erin Bagalman, and CRS Report R43179, *Veterans' Medical Care: FY2014 Appropriations*, by Sidath Viranga Panangala, provide an overview of the VA health care system, particularly the system for providing outpatient primary care, and CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler, describes, amongst other things, how FQHCs are designated and funded, the services they are required to provide, and the health records they are required to keep.

After a discussion of considerations, the report presents some selected policy levers available to Congress should they be interested in encouraging such collaboration.

FQHC Care for Veterans: Four Scenarios

The VA is statutorily required to provide VA-enrolled veterans with access to timely and quality medical care,²⁰ which may sometimes involve using non-VA providers such as FQHCs. An FQHC might provide health care services to veterans under four scenarios: (1) without reimbursement from the VA, (2) under the VA's fee basis care program, (3) under a contract for specific services, or (4) as a contractor-operated community-based outpatient clinic (CBOC). Which of these four scenarios is used is relevant for the considerations that will be discussed later in the report (see "Potential Considerations for VA-FQHC Collaboration"). In addition, who is in charge of deciding whether to initiate collaboration and the terms of such collaboration, differs in these scenarios. Specifically, a VA decision to enter into a contract with an FQHC (such as is discussed in scenarios 3 and 4) is determined at the facility level.²¹

Care Without VA Reimbursement

An FQHC may provide health care services for veterans without reimbursement from the VA. Every FQHC is required (1) to provide care to all individuals regardless of their ability to pay for services and (2) to collect reimbursements for the cost of these services, either from the patient or from a third party payer.²² Each FQHC must also establish a fee schedule that takes into account local rates for health care services and the costs that the FQHC incurs providing services. The FQHC is then required to establish a separate discounted fee schedule, which is then further discounted or waived based on a patient's ability to pay. Ability to pay is determined by the patient's income relative to the federal poverty level. The statute requires that individuals with incomes above 200% of the federal poverty level pay full charges, while individuals with incomes at or below 100% of the federal poverty level pay only nominal fees.²³

²⁰ 38 U.S.C. §7301.

²¹ Overall, VA decision-making authority and budgetary responsibility are somewhat decentralized such that decisions about collaboration may be influenced by considerations at multiple levels within the agency. While policies and guidelines developed at VA headquarters are applied throughout the VA health care system, basic decision-making authority is delegated to 21 geographically defined Veterans Integrated Service Networks (VISNs). (See **Figure B-1** in **Appendix B** for a map of the VISNs.) Within each VISN, some authority—which may include decision making on collaboration—is further delegated to facility directors.

²² An FQHC must seek reimbursement from third party payers such as private health insurers, Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP). The VA is not considered a third party payer for this purpose; therefore, an FQHC is not required to seek reimbursements from the VA. Instead, an FQHC would seek reimbursement directly from the veteran (or a third party payer if available).

²³ 42 C.F. R. §51c.303(f) and Section 330(k)(3)(G)(i) of the Public Health Service Act (PHSA).

Fee Basis Care

The VA may reimburse non-VA providers such as FQHCs for specific authorized health care services rendered to specific veterans on a fee-for-service basis (commonly referred to as Fee Basis Care).²⁴ This program does not represent a formal collaborative relationship between the VA and a particular FQHC. Fee Basis Care is authorized under the following circumstances: (1) when a clinical service cannot be provided at a VA medical center (VAMC); (2) when a veteran is unable to access VA health care facilities due to geographic inaccessibility; or (3) in emergencies when delays could lead to life-threatening situations.²⁵

Although fee basis care may include inpatient care, emergency care, medical transportation, and dental services, it is used predominantly to provide outpatient care.²⁶ The Fee Basis Care Program Office at the local VAMC pre-authorizes outpatient fee basis care if the care is determined to be appropriate, the veteran is eligible for the program, and an appropriate justification has been provided. Once outpatient fee basis care has been authorized, the veteran selects a provider and receives the service. The non-VA provider (e.g., an FQHC) then sends a claim to the Fee Basis Care Program Office at the authorizing VAMC. After the claim is reviewed and processed, the non-VA provider (e.g., an FQHC) receives payment electronically.²⁷

Contracts for Specific Services

The VA has statutory authority to contract with non-VA providers such as FQHCs to deliver health care services to veterans in a specific geographic area or veterans requiring a specific set of services.²⁸ The VA generally purchases health care services that may not be readily available at VAMCs; examples include radiation therapy, diagnostic radiology, cardiology, cardio-vascular surgery, and orthopedics.²⁹ Under such a contract, the VA would reimburse the non-VA provider at a negotiated rate. The VA has existing contracts with FQHCs for the provision of readjustment counseling services in rural communities where access to a VA facility is limited. (See **Appendix B**.)

Contractor-Operated Community-Based Outpatient Clinics

The VA may use its contracting authority to establish community-based outpatient clinics (CBOCs) operated by non-VA entities such as FQHCs.³⁰ In general, such contractor-operated

²⁴ Fee basis care is described in greater depth in U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *VA Fee Basis Care: Examining Solutions to a Flawed System*, 112th Cong., 2nd sess., September 14, 2012.

²⁵ 38 U.S.C. §§1703, 1725, and 1728.

²⁶ The VA's Fee Basis Care program is partially centralized (at the Veterans Integrated Service Network (VISN) level and partially decentralized (at the VAMC level); in practice, most VAMCs independently administer the Fee Basis Care Program. See 38 U.S.C. §§1703, 1725, and 1728.

²⁷ 38 U.S.C. §§1703, 1725, and 1728.

²⁸ 38 U.S.C. §§8151-8153 delineates the VA's contracting authority. The VA may enter into contracts for the purchase of health care services with any health care provider (including an FQHC); see U.S. Department of Veterans Affairs, Office of Inspector General, *Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions*, Report No. 05-01318-85, Washington, DC, February 16, 2005, p. 1.

²⁹ U.S. Department of Veterans Affairs, *Annual Report on Sharing of Health Care Resources Pursuant to the Provisions of 38 U.S.C. Section 8153, FY2012*, p. 3.

³⁰ The Veterans' Health Care Eligibility Reform Act (P.L. 104-262) authorized the VA to obtain health care resources (continued...)

CBOCs are open at least five days a week, for a minimum of 40 hours. The contractor (which may be an FQHC) is required to

- provide staff, facilities, equipment, supplies, and all administrative functions;
- meet both VA standards and The Joint Commission accreditation standards;³¹ and
- use the VA's electronic health record to document all patient care.

The VA generally pays contractor-operated CBOCs a monthly fee for each enrolled patient (e.g., each patient in the geographic area of the contractor-operated CBOC); payments for each new enrollee begin during the month of the patient's first visit.³²

Potential Considerations for VA-FQHC Collaboration

This section discusses some considerations that may arise during attempts to increase VA-FQHC collaboration. Considerations include (1) the costs of care to an FQHC, the VA, and veterans; (2) the capacity of an FQHC to serve veterans in addition to its existing patients; and (3) the compatibility of the VA and an FQHC in terms of the availability of services, quality initiatives, accreditation, and use of electronic health records.

In general these considerations are relevant to contracted care from FQHCs or specifically the use of FQHCs as contractor-operated CBOCs, and not to reimbursement of FQHCs under the Fee Basis Care Program. However, with regards to cost, the considerations also include the first scenario discussed above: when a veteran seeks care at an FQHC without VA reimbursement. Throughout this report, FQHCs are used as an example of entities with which the VA might collaborate; therefore, similar considerations may apply to the VA collaborating with facilities other than FQHCs.

Costs to FQHCs, the VA, and VA-Enrolled Veterans

Decisions regarding VA-FQHC collaboration might take into consideration the costs to FQHCs, the VA, and veterans. The potential costs incurred by each of these are discussed briefly below.

(...continued)

by entering into contracts or other agreements with any health care facility, entity, or individual. For the VA's authority to enter into contracts to establish CBOCs, see 38 U.S.C. §8153, 38 U.S.C. §7409, and 38 U.S.C. §8111. For more information about CBOCs, see Department of Veterans Affairs, Office of Inspector General, *Evaluation of VHA Community Based Outpatient Clinic Fiscal Year 2012*, Report No. 13-00090-346, Washington, DC, September 30, 2013, <http://www.va.gov/oig/pubs/VAOIG-13-00090-346.pdf>.

³¹ The Joint Commission accredits and certifies health care organizations to ensure that certain standards are met. See http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx, accessed January 9, 2014.

³² Contractor-operated CBOCs are generally paid based on a Price Negotiation Memoranda, which describes the negotiated rate and the rationale for the procurement decision. A PNP is required by Department of Veterans Affairs, *Health Care Resources Contracting – Buying Title 38 U.S.C. 8153*, VA Directive 1663, August 10, 2006. Although generally a capitated rate is used, some contracts may pay the contractor-operated CBOC on a per visit basis. Specific payment rates are generally based on the Centers for Medicare & Medicaid Services (CMS) Medicare fee schedule.

Costs to FQHCs

FQHCs may incur costs of caring for veterans (1) under contracts to provide specific services, (2) as contractor-operated CBOCs, or (3) in the absence of any formal collaboration with the VA. The following presents three scenarios under which the FQHC could collaborate with the VA, but might still use its own resources to provide care to veterans. It is not possible to determine which scenario is more likely or more or less favorable to an FQHC.

If the amount paid by the VA to an FQHC under a contract for specific services were not sufficient to cover the costs of services provided to veterans, the collaboration would represent a net loss to the FQHC, impairing its ability to serve its existing patients by depleting its resources. The VA generally reimburses non-VA facilities at the Medicare rate;³³ however, the regulation does not address whether the VA is required to pay the FQHC Medicare payment rate, which is usually higher than the general Medicare payment rate for services provided in other outpatient settings.³⁴ Despite the higher FQHC Medicare payment rate, the Government Accountability Office (GAO) and the National Association of Community Health Centers (NACHC)—the advocacy organization for FQHCs—found that FQHC Medicare rate is generally not sufficient to cover the FQHC’s cost of providing services to Medicare beneficiaries.³⁵ Whether VA reimbursements to FQHCs would be at the general Medicare outpatient rate or the Medicare FQHC rate is not known; and whether either rate would be sufficient to cover the costs of FQHC services provided to veterans is also not known.

Similarly, if the amount paid by the VA to an FQHC functioning as a contractor-operated CBOC were not sufficient to cover the costs of services provided to veterans, the collaboration would also represent a net loss to the FQHC, impairing its ability to serve its existing patients by depleting its resources. The VA pays contractor-operated CBOCs a per-patient per-month fee. If the patients require a high level of care, the fee may not cover the cost of services. Alternatively, if the patients require only a modest level of care, the fee may be more than sufficient to cover the cost of services.

In the absence of a VA contract, an FQHC might still provide services to veterans as it is required to provide services to all individuals living in a particular geographic area regardless of their ability to pay.³⁶ In this scenario, the FQHC would charge the individual veteran (in accordance with the FQHC’s fee schedule) and seek reimbursement from a third-party payer (e.g., a private health insurer or Medicare) if the veteran had one. Some veterans may meet FQHC requirements for reduced or waived costs; in this case, the FQHC might use other funds (such as the amount it receives through its federal grant) to provide care to veterans.

³³ U.S. Department of Veterans Affairs, “Payment for Inpatient and Outpatient Health Care Professional Services at Non-Departmental Facilities and Other Medical Charges Associated With Non-VA Outpatient Care,” 75 *Federal Register* 78901-78915, December 17, 2010.

³⁴ The Medicare FQHC payment rates are considered to be “higher” than the payment rates that physician practices receive, because they are cost-based and reflect a broader range of services than do payments to physician practices. See, for example, Department of Health Policy, School of Public Health and Health Services, The George Washington University, *Quality Incentives for Federally Qualified Health Centers, Rural Health Clinics and Free Clinics: A Report to Congress*, Washington, DC, January 23, 2012.

³⁵ U.S. Government Accountability Office, *Medicare Payments to Federally Qualified Health Centers*, GAO-10-576R, July 30, 2010; and discussion in CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

³⁶ 42 U.S.C. §254b.

Costs to the VA

The VA incurs costs of services provided to veterans (1) by FQHCs under a contract for specific services, (2) when FQHCs function as contractor-operated CBOCs, or (3) in the absence of any formal collaboration with FQHCs (i.e., when the VA provides the services directly). Whether the VA reimburses an FQHC (under a contract for specific services) under a fee-for-service arrangement (at the Medicare rate or at another negotiated rate) or pays an FQHC (functioning as a contractor-operated CBOC) a per-patient per-month fee, the cost of contracted care may be greater than the cost of providing the care directly. In the absence of formal collaboration with an FQHC, veterans who live a long distance from VA facilities may forgo routine care, potentially allowing manageable conditions to worsen until more intensive (and generally more expensive) care is required. Predicting which scenario is likely to be most cost-effective for the VA is virtually impossible.

These options may be viewed from the perspective of the agency or from the perspective of individual VISNs and VAMCs. At the agency level, if the VA's congressionally appropriated funds do not increase to accommodate additional contracting, the VA may face a trade-off between funding spent on contracts and funding available to provide services at VA facilities.³⁷ At the VISN level, because the allocation to the VISN does not increase to accommodate additional contracting, individual VISNs may face trade-offs between funding spent on contracted services and funding available to provide services through VA-operated facilities.³⁸ At the VAMC level, if the VISN does not increase the allocation to the VAMC to accommodate additional contracting, the facility may face trade-offs between funding spent on contracted services and funding available to provide services directly. Some Veterans Service Organizations (organizations that advocate on behalf of veterans) have argued that increased contracting would reduce the funds available to provide quality care within the VA health care delivery system.³⁹

Costs to VA-Enrolled Veterans

The potential costs to veterans may depend on their cost-sharing obligations within the VA system,⁴⁰ their cost-sharing obligations at the FQHC (based on income),⁴¹ and the services they

³⁷ It is also possible that the patients who opt to receive services at FQHCs may have different health conditions than the patients who receive services at VA facilities. The VA allocation formula takes into account the complexity of each patient's treatment. Should this complexity differ between those receiving services within the VA and under contract and should this complexity not be reflected in VA records, it might affect the VA's allocation formula.

³⁸ Each year the VA allocates a majority of congressionally appropriated funds for health care services to the VISNs using a formula-based system called the Veterans Equitable Resource Allocation (VERA). Each VISN's VERA allocation is based primarily on the number of patients treated; the complexity of each patient's treatment; adjustments for regional variations in labor and contract costs; and budgetary need for education support, research support, equipment, and non-recurring maintenance. The VERA allocation takes into account each VISN's unique characteristics and is adjusted to account for those veterans who receive care in more than one VISN. A veteran receiving outpatient services must receive a medical history and physical examination at least once in a three-year period to remain as an active patient included in allocation calculations. For more information, see **Appendix B**.

³⁹ AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars, *Independent Budget, Fiscal Year 2014*, February 2013, http://www.independentbudget.org/2014/00_IB.pdf.

⁴⁰ Veterans' out-of-pocket costs may vary with factors such as income and service-connected disability.

⁴¹ FQHCs are required to charge individuals without coverage based on a fee schedule that the FQHC develops and to collect reimbursements from individuals enrolled in private insurance plans or public coverage (e.g., Medicare or Medicaid). 42 U.S.C. §254b. Fees may be reduced or waived depending on patients' income, see <http://bphc.hrsa.gov/about/requirements/index.html>.

require. Under a collaborative arrangement between the VA and an FQHC, the same cost-sharing requirements⁴² would apply to veterans who receive a service included in the standard VA medical benefit package regardless of whether they receive their care at the VA or at an FQHC.⁴³ Veterans who receive FQHC services that are not included in the VA standard medical benefit might be required to pay out of pocket for these services.⁴⁴ In the absence of formal VA-FQHC collaboration, veterans might have to pay for services at an FQHC that they could have received at a VA facility for little or no cost.

FQHC Capacity

Depending on the terms of a VA-FQHC contract, an FQHC may be strained to provide care to the veterans and its existing population. FQHCs are required to be located in underserved areas and serve underserved populations, which, by definition, have access to few providers.⁴⁵ FQHCs are also required to provide care to all individuals regardless of their ability to pay. These requirements often mean that many FQHCs are operating at capacity. If this is the case, then providing services to additional patients (whether veterans or other patients) might push it beyond its capacity, rendering it unable to provide services to everyone seeking care. In such a situation, it is possible that veterans could displace existing FQHC patients, forcing the existing patients to seek alternative sources of care.⁴⁶ The likelihood of this displacement occurring may depend on the terms of the contract between the VA and the FQHC. For example, if the contract were to require that veterans receive preference over other FQHC patients, the displacement would be more likely to occur.

An FQHC's capacity may be partially determined by the availability of a sufficient workforce, and provider shortages may impede an FQHC's ability to expand its treatment capacity in response to a formal collaboration with the VA. FQHCs are required to be located in medically underserved areas that, by definition, have provider shortages.⁴⁷ FQHCs also focus on providing types of care with documented provider shortages, such as primary care and behavioral health.⁴⁸

⁴² Generally, veterans do not pay for any service-connected condition or disability.

⁴³ 38 C.F.R. §1738.

⁴⁴ For example, FQHCs offer preventive dental services, but not all veterans are eligible for outpatient dental care through the VA. For detailed information on VA dental care, see <http://www.va.gov/DENTAL/infoforpts.asp> and <http://www.va.gov/healthbenefits/assets/documents/publications/IB10-442.pdf#Dental>, accessed January 9, 2014. Section 510 of the Caregiver and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) required the VA to conduct a pilot program, by contract, for the purposes of offering a dental insurance plan to certain beneficiaries.

⁴⁵ Specifically, FQHCs must be located in Medically Underserved Areas (MUA): Areas of varying size—whole counties, groups of contiguous counties, civil divisions, or a group of urban census tracts—where residents have a shortage of health care services, or must serve Medically Underserved Populations (MUPs): Groups that face economic, cultural, or linguistic barriers to accessing health care. See Health Resources and Services Administration, Bureau of Primary Care, Shortage Designations, at <http://bhpr.hrsa.gov/shortage/index.html>, accessed January 9, 2014.

⁴⁶ Given that many FQHC patients are uninsured, some may seek care in emergency rooms because emergency rooms are required to provide care regardless of insurance status. Emergency room care is more expensive than care provided at an FQHC and may be less appropriate. For information on health outcomes and cost savings associated with FQHCs, see U.S. Government Accountability Office, *Hospital Emergency Departments: Health Center Strategies that May Help Reduce Their Use*, GAO-11-414R, April 11, 2011.

⁴⁷ CRS Report R42029, *Physician Supply and the Affordable Care Act*, by Elayne J. Heisler,

⁴⁸ For information about primary care providers see, CRS Report R42029, *Physician Supply and the Affordable Care Act*, by Elayne J. Heisler, and for more information of behavioral health providers, see, CRS Report R43255, *The Mental Health Workforce: A Primer*, by Elayne J. Heisler and Erin Bagalman. See also, Roger A. Rosenblatt et al., "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion," *Journal of the* (continued...)

The NACHC estimated that, in 2008, health centers had 1,800 too few primary care providers (physicians, nurse practitioners, and certified nurse midwives).⁴⁹ The NACHC further estimated that, by 2015, health centers would have between 15,000 and 19,000 too few primary care providers. Even with additional resources from a VA contract, an FQHC may have difficulty attracting new providers because FQHC compensation is less than compensation available in private practice.⁵⁰ For all of these reasons, provider shortages may impede FQHC's ability to collaborate with the VA.

VA-FQHC Compatibility

Collaboration between the VA and FQHCs might require compatibility between the two systems in areas including (but not limited to) services available, quality initiatives, accreditation, and electronic health records. Each of these is discussed briefly below.

Services Available

Services available at an FQHC may not align with the VA standard medical benefit, which all VA-enrolled veterans are eligible to receive.⁵¹ The services available, including whether specialty care is available, vary by facility, both within the VA health care delivery system and across FQHCs. Regulation requires FQHCs to provide primary, preventive, and emergency health services; however, specialty care is optional and available specialty services vary by facility.⁵² Given this variation, it is possible that FQHCs that contract with the VA may not provide some of the services that veterans need. Conversely, FQHCs may provide certain services—such as dental services—that the VA does not routinely cover.

Quality Initiatives

VA contracts may impose requirements to join in new VA quality initiatives, which an FQHC may not wish to do. VA agency policy defines the quality standards contractors (including FQHCs) must meet. In compliance with a statutory mandate to undertake a comprehensive program to monitor and evaluate the quality of VA healthcare,⁵³ the VA engages in initiatives to improve the quality of care delivered to veterans. For example, VA is currently undertaking an initiative to implement a patient-centered medical home model at all VA primary care sites, with the intention of improving healthcare delivery by increasing access, coordination, communication, and

(...continued)

American Medical Association, vol. 295, no. 9 (March 2006), pp. 1042-1049; and U.S. Government Accountability Office, *Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services*, GAO-08-472T, February 12, 2008.

⁴⁹ National Association of Community Health Centers, *The Struggle to Build a Strong Workforce at Health Centers*, Fact Sheet #0609, Washington, DC, 2009.

⁵⁰ Roger A. Rosenblatt et al., "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion," *Journal of the American Medical Association*, vol. 295, no. 9 (March 2006), pp. 1042-1049.

⁵¹ The standard medical benefits package is described in detail in 38 C.F.R. §17.38. In addition to the standard medical benefits package, some veterans may receive additional benefits (e.g., dental care) based on their priority group or service-connected condition.

⁵² 42 C.F.R. §51c.102(h).

⁵³ 38 U.S.C. §7311.

continuity of care. Keeping up with these initiatives may be costly or otherwise burdensome to an FQHC or other entity with which the VA may wish to collaborate.

Accreditation

The lack of alignment in accreditation requirements between the VA and FQHCs may impede certain collaboration efforts. The VA requires all contractor-operated CBOCs to meet the accreditation standards of The Joint Commission.⁵⁴ In contrast, FQHCs are not required to be accredited by a national accreditation agency; instead, Health Resources and Services Administration (HRSA), the agency that oversees FQHCs, encourages FQHCs to be accredited by either the Accreditation Association for Ambulatory Health Care or The Joint Commission.⁵⁵

Electronic Health Records

VA contracting requirements with respect to electronic health records may hinder VA-FQHC collaboration;⁵⁶ specifically, the VA requires contractor-operated CBOCs to be able to connect to the VA's electronic health records system. Although statute requires that FQHCs report certain data to HHS, have quality assurance systems in place, and maintain billing systems, there is no requirement for a specific type of system.⁵⁷ Thus, the systems in place at FQHCs may not be compatible with VA systems.

An FQHC's ability to connect to the VA's electronic health records system might also be a consideration if the VA were to contract with an FQHC for specific services; the care provided by an FQHC may not be documented in the VA's electronic health record, which may limit coordination and continuity of care.⁵⁸ For example, VA regulations do not allow VA pharmacies to fill prescriptions issued by non-VA prescribers except in limited circumstances.⁵⁹ Prescriptions ordered by VA prescribers are filled through pharmacies located at VA facilities or through VA mail order pharmacies and are captured in the VA's integrated electronic health record. If veterans fill prescriptions outside the VA system, their VA providers may not be aware of these prescriptions, which could potentially affect treatment decisions. The same principle (i.e., all providers needing to know about all care received) applies to treatments other than prescriptions as well.

⁵⁴ U.S. Department of Veterans Affairs, Veterans Health Administration, *Planning and Activating Community-Based Outpatient Clinics*, VHA Handbook 1006.1, May 19, 2004, p. 8.

⁵⁵ CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

⁵⁶ Recent work by GAO found that system compatibility was an issue in VA-DOD collaboration. See U.S. Government Accountability Office, *Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities*, GAO-12-992, September 28, 2012, <http://www.gao.gov/products/GAO-12-992>.

⁵⁷ 42 U.S.C. §254b.

⁵⁸ FQHCs may also receive increased Medicaid payments for using electronic health records. FQHCs are required to have their own record system, so an FQHC that contracts with the VA may have to ensure that its electronic health record system can be used under the contract and for the Medicaid incentive program; otherwise the FQHC would have to forgo the Medicaid incentive payments. For more information on Medicaid incentive payments for electronic health records see CRS Report R40161, *The Health Information Technology for Economic and Clinical Health (HITECH) Act*, by C. Stephen Redhead.

⁵⁹ For exceptions, see 38 CFR §17.96.

Policy Levers Available to Congress

Policy levers Congress might use to encourage adoption of specific strategies for increasing VA-FQHC collaboration include (1) oversight, (2) an incentive fund, (3) directed spending, (4) statutory mandates, and (5) watchful waiting. Congress may also consider a combination of these levers should it wish to enhance VA-FQHC collaboration. All of the policy levers discussed here may be applicable to any number of other potential collaborations between VA and non-VA facilities. The textbox provides examples of past congressional actions that have encouraged or facilitated VA-FQHC collaboration.⁶⁰ Each of the policy levers is then discussed briefly.

Examples of Past Congressional Actions to Encourage VA-FQHC Collaboration

- **106th Congress:** The Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies, Appropriations Act, 2000 (P.L. 106-74; H.Rept. 106-379) report “urge[d] the VA to partner with existing, [FQHCs] to provide outpatient primary and preventive health care services to area veterans in their home communities” and stated that doing so “would greatly enhance access to quality health care for veterans living in remote areas.”⁶¹
- **109th Congress:** Section 212 of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (P.L. 109-461) established the VA’s Office of Rural Health (ORH) to coordinate efforts to improve health care for rural veterans.
- **111th Congress:** The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (P.L. 110-329) and the Consolidated Appropriations Act, 2010 (P.L. 111-117) appropriated \$533 million to improve health care for rural veterans. According to the VA Inspector General, in FY2009, ORH received \$250 million to implement new rural health outreach and delivery initiatives. In FY2010, ORH received an additional \$250 million for rural health care, \$30 million to open 51 rural Community Based Outpatient Clinics, and \$3 million for rural hiring initiatives.⁶²
- **111th Congress:** The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) authorizes, among other things, demonstration projects on alternatives for expanding care for veterans in rural areas. The law also authorizes ORH to carry out demonstration projects that would establish partnerships between the VA and the Centers for Medicare and Medicaid Services to coordinate care for veterans in rural areas at critical access hospitals (i.e., small rural hospitals eligible to receive higher Medicare payments). This law also authorizes ORH to establish partnerships between the VA and HHS to coordinate care for veterans in rural areas at community health centers (i.e., FQHCs), and authorizes \$5 million for FY2010 and subsequent fiscal years to conduct these demonstration projects.
- **112th Congress:** The Consolidated Appropriations Act, 2012 (P.L. 112-74) includes \$250 million to improve access and quality of care for veterans residing in rural areas.

Source: CRS analysis of legislation and U.S. Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration Audit of the Office of Rural Health*, Report No:10-02461-154, April 29, 2011.

Oversight

Congress has oversight of executive branch agencies, which it may leverage to encourage VA-FQHC collaboration. For example, on the topic of access to mental health care services for

⁶⁰ The Executive Branch may also encourage or facilitate collaboration. For example, a 2012 Executive Order required that the VA and the Department of Defense to, among other things, use pilot projects to collaborate with community providers (including FQHCs) to provide timely mental health services to veterans, members of the armed forces, and their families. See Executive Order 13625, “Improving Access to Mental Health Services for Veterans, Service Members, and Military Families,” 77 *Federal Register* 54783-54786, August 31, 2012.

⁶¹ “Conference Report on H.R. 2684 Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2000,” *Congressional Record*, October 13, 1999, p. H10005.

⁶² U.S. Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration Audit of the Office of Rural Health*, Report No:10-02461-154, Washington, DC, April 29, 2011, p. 1.

veterans, Congress has conducted oversight hearings and requested reports from both GAO and the VA's Office of Inspector General.⁶³ Congress may consider holding a hearing (or a series of hearings) on topics related to VA collaboration with FQHCs. Congress may also consider requesting a report evaluating the feasibility of increased collaboration between the VA and FQHCs, to be undertaken by the VA, GAO, or another entity. Such oversight might motivate the VA to address some of the considerations discussed in this report, even in the absence of other congressional activity.

Incentive Fund

Congress may consider appropriating funds to establish incentive funds to encourage or facilitate specified activities. For example, on the topic of collaboration between the VA and the Department of Defense (DOD), Congress used its authority to establish an incentive fund to increase VA-DOD collaboration.⁶⁴ Congress may consider establishing an incentive fund to encourage the VA to contract with FQHCs. Such funds might be used, for example, to provide technical assistance to enable FQHCs to meet VA contracting requirements (e.g., to defray the cost of accreditation) or to enable the VA to manage the additional contracts.

Directed Spending

Congress may also consider using the appropriations process to direct funding for specific purposes. For example, on the topic of VA mental health care, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (P.L. 110-329) required the VA to spend at least \$3.8 billion for mental health care.⁶⁵ Congress may consider employing a similar approach to direct that a certain amount of the VA's appropriation be spent on contracts with FQHCs. Such directed spending for the purpose of VA-FQHC collaboration might address VA funding considerations.

Statutory Mandates

Congress can mandate that executive agencies undertake certain activities. For example, Congress required the VA to coordinate with the Indian Health Service to provide care to American Indian and Alaska Native veterans who seek care at the Indian Health Service.⁶⁶

⁶³ See, for example, U.S. Congress, Senate Committee on Veterans' Affairs, *VA Mental Health Care: Addressing Wait Times and Access to Care*, 112th Cong., 1st sess., November 30, 2011; U.S. Government Accountability Office, *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, GAO-12-12, October 14, 2011, <http://www.gao.gov/products/GAO-12-12>; and U.S. Department of Veterans Affairs, Office of Inspector General, *Review of Veterans' Access to Mental Health Care*, Report Number 12-00900-168, April 23, 2012, <http://www.va.gov/oig/publications/report-summary.asp?id=2654>.

⁶⁴ See the Bob Stump National Defense Authorization Act of 2003 (P.L. 107-314); 38 U.S.C. §8111(d). The purpose of this fund is to provide seed money for innovative sharing initiatives with the goal of improving access to, and the cost-effectiveness of, the health care provided to veterans and active duty servicemembers. The DOD and the VA contribute \$15 million each fiscal year (through FY2015) to the Fund from funds appropriated to the two departments. For a discussion of this collaboration, see U.S. Government Accountability Office, *Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities*, GAO-12-992, September 28, 2012, <http://www.gao.gov/products/GAO-12-992>.

⁶⁵ See the CRS Report RL34598, *Veterans Medical Care: FY2009 Appropriations*, by Sidath Viranga Panangala.

⁶⁶ See 25 U.S.C. §1645 described in Sec. 154 of CRS Report R41630, *The Indian Health Care Improvement Act* (continued...)

Congress may consider mandating that the VA engage in more collaboration with FQHCs. Congress may also consider requiring the VA to implement some or all of the recommendations in the NACHC report on VA-FQHC collaboration.⁶⁷

Watchful Waiting

Watchful waiting is an option that is always available to Congress. If, for example, Congress determines that current levels of VA-FQHC collaboration are adequate, or that ongoing initiatives are sufficient to increase VA-FQHC collaboration to an adequate level, Congress may allow the current situation to unfold without further congressional involvement.

Concluding Comments

This report uses FQHCs as an extended example of existing facilities with which the VA might collaborate to provide services for veterans who do not live near a VA facility. This example forms the basis for discussing considerations that might come into play when the VA and non-VA providers (e.g., FQHCs) are deciding whether to collaborate, as well as for discussing policy levers available to Congress. Collaboration with non-VA providers is one option available to Congress should it want to expand access to rural veterans. Other available options include, but are not limited to, building new VA facilities (either CBOCs or VAMCs), expanding telehealth services,⁶⁸ expanding the VA's Fee Basis Care program,⁶⁹ or expanding VA travel benefits.⁷⁰

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Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline, by Elayne J. Heisler. See also U.S. Department of Veteran's Affairs, "VA and Indian Health Service Announce National Reimbursement Agreement," press release, December 6, 2012.

⁶⁷ National Association of Community Health Centers and Atlas Research, *Collaboration with Rural Community Health Centers VISN 5, Task 4: Final Report*, June 2011, pp. 66-67

⁶⁸ This strategy is currently being used in collaborations between the VA and HHS; see Department of Health and Human Services, "Veterans in Rural Areas to Get Expanded Access to Health Care," press release, September 12, 2012, <http://www.hhs.gov/news/press/2012pres/09/20120912b.html>.

⁶⁹ In late 2012, the VA initiated an effort to create a system-wide health care contracting strategy known as the Patient-Centered Community Care (PC3) initiative. As part of this effort, in September 2013, the VA awarded contracts to two companies (Health Net Inc. and TriWest Healthcare Alliance Corp.) to provide eligible veterans with access to care through a comprehensive network of non-VA providers that provide VA-quality care in instances when the VA cannot provide care within its own facilities. For more information, see Kathleen Miller, "Health Net, TriWest Win \$9 Billion in U.S. Veterans Awards," *BloombergGovernment.Com*, September 4, 2013.

⁷⁰ CRS Report R41626, *Veterans Affairs Beneficiary Travel Program: Questions and Answers*, by Carol D. Davis.

Appendix A. Existing VA-FQHC Collaborations

A 2011 VA-commissioned report by the National Association of Community Health Centers (NACHC) recommended specific strategies to encourage VA-FQHC collaboration, several of which address considerations discussed in this CRS report (e.g., sufficiency of reimbursements).⁷¹ Strategies such as those recommended in the NACHC report may be adopted without congressional action; however, Congress may choose to encourage, discourage, mandate, or prohibit specific strategies using a range of policy levers.

Some recommendations from the NACHC report are summarized in the **text box**.

Examples of Recommendations from VA-FQHC Collaborations Report

By request of the VA, the National Association of Community Health Centers and Atlas Research prepared a report entitled *Collaboration with Rural Community Health Centers VISN 5*. Although the report is specific to VISN 5 (the District of Columbia, Maryland, northern Virginia, and eastern West Virginia), the recommendations may be broadly applicable across the VA health care system. Below are some examples of relevant recommendations:

- Pilot test different payment mechanisms to reimburse FQHCs for services provided to veterans.
- Explore the feasibility of making VA electronic health records interoperable with FQHC record systems and develop quality indicators and other metrics to share data on veterans who access both VA facilities and FQHCs.
- Investigate models for coordination between the VA and FQHCs.
- Develop telehealth linkages between FQHCs and the VA for behavioral health care for veterans.
- Implement various strategies to increase FQHC provider education and awareness of the VA patient population.
- Consider contracting with FQHCs to act as CBOCs in areas where the VA population is too small to sustain a VA-operated facility.

Source: Adapted from National Association of Community Health Centers and Atlas Research, *Collaboration with Rural Community Health Centers VISN 5*, Task 4: Final Report, June 2011, pp. 66-67.

In addition to the 2011 commissioned report, the VA has also pursued contracts with FQHCs. See **Table A-1**.

⁷¹ National Association of Community Health Centers and Atlas Research, *Collaboration with Rural Community Health Centers VISN 5*, Task 4: Final Report, June 2011, pp. 66-67.

Table A-1. Contracts Between the VA and Federally Qualified Health Centers (FQHCs)

Contracts for Counseling Services, by Veterans Integrated Service Network (VISN)

Veterans Integrated Service Network (VISN)^a	Number of Current Contracts
VISN 1: New England Healthcare System	6
VISN 2: VA Health Care Upstate New York	5
VISN 3: VA NY/NJ Veterans Healthcare Network	1
VISN 4: VA Healthcare - VISN 4	2
VISN 6: VA Mid-Atlantic Health Care Network	1
VISN 7: VA Southeast Network	7
VISN 8: VA Sunshine Healthcare Network	1
VISN 17: VA Heart of Texas Health Care Network	5
VISN 18: VA Southwest Health Care Network	3
VISN 19: Rocky Mountain Network	8
VISN 20: Northwest Network	7
VISN 21: Sierra Pacific Network	4
VISN 22: Desert Pacific Healthcare Network	2
Total	52

Source: U.S. Department of Veterans Affairs, Veterans Health Administration. Information provided in response to a Congressional Research Service request. Data current as of March 2012.

- a. VISNs, geographically defined networks within the VA health care system, are described in **Appendix B**. VISNs not included in the table do not currently (as of February 2012) have contracts with FQHCs.

Appendix B. Background on Health Care Delivered or Financed by the Department of Veterans Affairs

The following appendix presents a brief overview of the VA health care system. This overview is not meant to be a comprehensive description; instead, it focuses on aspects of the VA health care system that are most relevant to collaboration with FQHCs.

Overview of VA Health Care

The VA operates the nation's largest integrated health care delivery system, with more than 270,000 full-time equivalent employees⁷² providing care to more than 6.3 million patients.⁷³ The organization of the VA health system, the services available, and their costs, among other factors influence the VA's decisions to enter into contracts with outside providers and the need for such contracts. The following sections briefly summarize the VA health care system, including (1) enrollment, medical benefits, and cost-sharing; (2) budgetary and decision-making authority; (3) delivery of care; and (4) financing of care from non-VA providers.

VA Enrollment, Medical Benefits, and Cost-Sharing

The VA health care system is generally a provider—rather than a financer—of health care services; however, like public programs and private companies that finance health care (e.g., Medicare or private health insurance), the VA has enrollment criteria, a medical benefits package, and cost-sharing arrangements. VA enrollment, medical benefits, and cost-sharing have implications for the potential scope, feasibility, and cost of collaboration between the VA and non-VA providers such as FQHCs. For more information on each of these topics, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala and Erin Bagalman.

Formal collaborative arrangements between the VA and non-VA providers would apply only to veterans enrolled in VA health care. In general, eligibility for enrollment in VA health care operates through a system of eight priority groups, based on veteran status,⁷⁴ presence of service-connected disabilities⁷⁵ or exposures,⁷⁶ income,⁷⁷ and/or other factors, such as status as a former

⁷² U.S. Department of Veterans Affairs, *FY 2012 Performance and Accountability Report*, Washington, DC, December 16, 2013, Part 1 of 2.

⁷³ CRS Report R43179, *Veterans' Medical Care: FY2014 Appropriations*, by Sidath Viranga Panangala.

⁷⁴ Veteran status is established by active-duty status in the U.S. Armed Forces and an honorable discharge or release from active military service. Generally, persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed two years of active duty or the full period of their initial service obligation to be eligible for VA health care benefits. Servicemembers discharged at any time because of service-connected disabilities are not held to this requirement. Veterans returning from combat operations are eligible to enroll for five years from the date of discharge without having to satisfy a means test or demonstrate a service-connected disability.

⁷⁵ A service-connected disability is a disability that was incurred or aggravated in the line of duty in the U.S. Armed Forces (38 U.S.C. §101 (16)). The VA determines whether veterans have service-connected disabilities and, for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability (38 C.F.R. §§4.1-4.31).

⁷⁶ For example, veterans who may have been exposed to Agent Orange during the Vietnam War or veterans who may have diseases potentially related to service in the Gulf War may be eligible to receive care.

prisoner of war or receipt of a Purple Heart. Once enrolled in the VA health care system, a veteran remains enrolled and does not have to reapply, even if the veteran's priority group changes (due, for example, to a change in income).

Alignment between medical benefits available from the VA and services available from non-VA providers may affect the feasibility of collaboration. All enrolled veterans are offered a standard medical benefits package.⁷⁸ In addition to the standard medical benefits package, some veterans may receive additional benefits (e.g., dental care) based on their priority group or service-connected condition.

A veteran's out-of-pocket cost of care from a non-VA provider may vary depending on whether the care is provided under formal collaboration with the VA. Veterans do not pay premiums or enrollment fees to receive care from the VA; however, some veterans may incur out-of-pocket costs for VA care related to conditions that are not service-connected.⁷⁹ Whether enrolled in VA health care or not, veterans may have other sources of care (including, but not limited to, FQHCs), as well as various sources of health care financing (including, but not limited to, Medicare or private health insurance).⁸⁰ When a veteran receives health care services that are neither provided by the VA nor financed by the VA, the veteran or a third party payer would be responsible for the cost of the services.

VA Decision-Making Authority and Budgetary Responsibility

VA decision-making authority and budgetary responsibility are somewhat decentralized such that decisions about collaboration may be influenced by considerations at multiple levels within the agency. While policies and guidelines developed at VA headquarters are applied throughout the VA health care system, basic decision-making authority is delegated to 21 geographically defined Veterans Integrated Service Networks (VISNs).⁸¹ (See **Figure B-1** for a map of the VISNs.) Within each VISN, some authority—which may include decision making on collaboration—is further delegated to facility directors.

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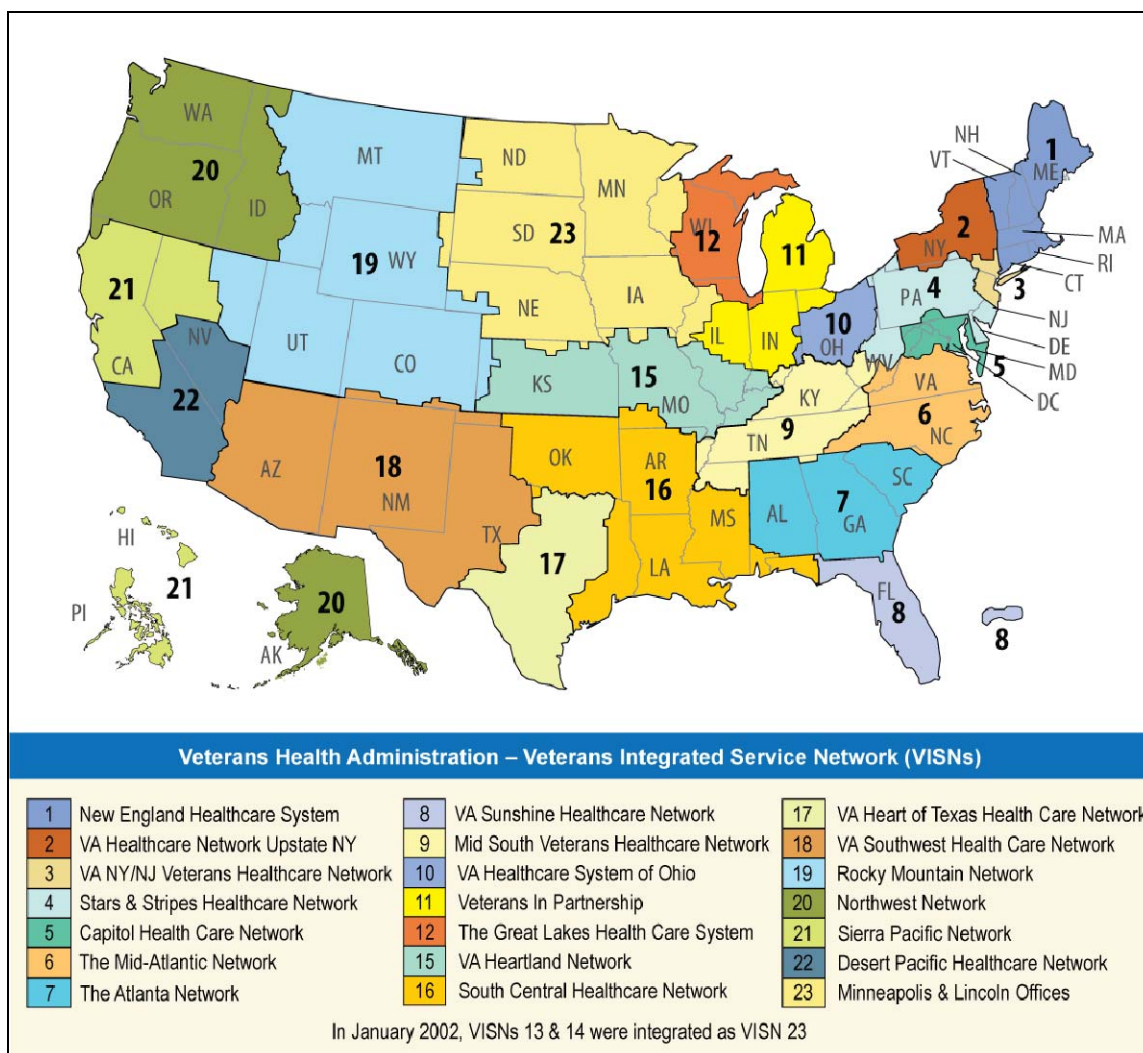
⁷⁷ Veterans meeting certain income criteria may be eligible to enroll in the VA without a service-connected condition.

⁷⁸ The standard medical benefits package is described in detail in 38 C.F.R. §17.38.

⁷⁹ 38 U.S.C. §1729. Veterans rated 50% or more service-connected disabled are exempt from all copayments.

⁸⁰ The VA is required to collect reasonable charges for medical care or services (including prescription drugs) from a third-party insurer if the care provided would be covered under a private insurance plan; however, the VA generally does not collect reimbursements from Medicare or Medicaid. 38 U.S.C. §1729(a)(2)(D); 38 C.F.R. §17.101(a)(1)(i) (2011). Some veterans may also be eligible to receive services either directly from the military health system or paid for by TRICARE, which purchases care for active duty servicemembers and other eligible beneficiaries (such as military retirees). For more information see CRS Report RL33537, *Military Medical Care: Questions and Answers*, by Don J. Jansen.

⁸¹ Kenneth Kizer, John Demakis, and John Feussner, "Reinventing VA Health Care: Systematizing Quality Improvement and Quality Innovation." *Medical Care*, vol. 38, no. 6 (June 2000), Suppl 1:17-16.

Figure B-1. Veterans Integrated Service Networks (VISNs)

Source: U.S. Department of Veterans Affairs, adapted by the Congressional Research Service.

Each year the VA allocates a majority of congressionally appropriated funds for health care services to the VISNs using a formula-based system called the Veterans Equitable Resource Allocation (VERA).⁸² Each VISN's VERA allocation is based primarily on the number of patients treated; the complexity of each patient's treatment; adjustments for regional variations in labor and contract costs; and budgetary need for education support, research support, equipment, and non-recurring maintenance. The VERA allocation takes into account each VISN's unique characteristics and is adjusted to account for those veterans who receive care in more than one VISN. The VA provides each VISN director a standardized model that proposes allocations to facilities within the VISN; the VISN director has the flexibility to adjust the proposed allocations.⁸³ Facility directors bear responsibility for managing their facilities' budgets.

⁸² For more information on appropriations for VA health care, see CRS Report R43179, *Veterans' Medical Care: FY2014 Appropriations*, by Sidath Viranga Panangala.

⁸³ U.S. Government Accountability Office, *VA Health Care: Need for More Transparency in New Resource Allocation* (continued...)

VA Delivery of Care

The services available at VA facilities, their locations, and the extent to which they are integrated are important for understanding the system available to rural veterans and any gaps that might be filled through collaboration. The VA health care delivery system includes medical and non-medical facilities, which differ in both the services available and the use of an integrated electronic health record. Each of these components of the VA health care delivery system is described briefly below.

VA medical facilities include more than 150 VA medical centers (VAMCs), 800 community-based outpatient clinics (CBOCs), and a range of other types of facilities (e.g., nursing homes). In general, VAMCs are located in urban areas and provide a wide range of primary and specialty care services, including both outpatient and inpatient (medical and surgical) care. CBOCs function as satellites of VAMCs, expanding the geographic reach of the VA health care system while generally offering a more limited range of services than VAMCs.⁸⁴ CBOCs are intended to make services available closer to where veterans reside, relative to VAMCs; nearly half of CBOCs are located in rural areas.⁸⁵ Generally all CBOCs provide primary care and mental health services; some may also provide specialty care and subspecialty care.⁸⁶ All VAMCs and CBOCs share an integrated electronic health record, which allows VA providers to view documentation of a patient's treatment regardless of which facility provided the treatment.

Alongside the VA's network of medical facilities, some 300 readjustment counseling centers (Vet Centers) provide psychosocial services—but not medical care. As of FY2013, the VA also has 70 Mobile Vet Centers, which were created in 2009 as part of a pilot program to improve access to services for veterans in rural areas.⁸⁷ Vet Centers, which have different eligibility criteria than the rest of the VA health care system, provide veterans and their families with services such as screening and counseling for PTSD or substance use disorders, bereavement counseling, military sexual trauma counseling, marital and family counseling, and employment and educational counseling. Vet Centers do not share the electronic health record used by VAMCs and CBOCs.

VA Financing of Care from Non-VA Providers

The VA is statutorily required to provide VA-enrolled veterans with access to timely and quality medical care;⁸⁸ meeting this requirement may involve the use of non-VA providers paid by the

(...continued)

Process and for Written Policies on Monitoring Resources, GAO-11-426, April 29, 2011, p. 13.

⁸⁴ The VA also operates 6 independent outpatient clinics (which are not satellites of VAMCs and are not part of the VISN structure) and 10 mobile outpatient clinics. U.S. Department of Veterans Affairs, FY2014 Budget Submission, Medical Programs and Information Technology Programs, Volume 2 of 4, Apr. 2013.

⁸⁵ U.S. Department of Veterans Affairs, *Reaching Out to Three Million "Rural" Veterans*, August 16, 2012, <http://www.va.gov/health/NewsFeatures/20120816a.asp>.

⁸⁶ See, Department of Veterans Affairs, Office of Inspector General, *Evaluation of VHA Community Based Outpatient Clinic Fiscal Year 2012*, Report No. 13-00090-346, Washington, DC, September 30, 2013, <http://www.va.gov/oig/pubs/VAOIG-13-00090-346.pdf>.

⁸⁷ FY2014 Budget Submission, Medical Programs and Information Technology Programs, Volume 2 of 4, Apr. 2013, U.S. Department of Veterans Affairs, *Vet Center: Services*, 2010, http://www.vetcenter.va.gov/Vet_Center_Services.asp; and U.S. Department of Veterans Affairs, "VA Deploying 20 New Mobile Vet Centers," press release, January 4, 2012, <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=2241>.

⁸⁸ 38 U.S.C. §7301.

VA. Two mechanisms for VA financing of care from non-VA providers—contracted care and fee basis care—are described briefly below.⁸⁹ Contracted care is more likely than fee basis care to be used in formal VA-FQHC collaborations.

Contracted Care

The VA has statutory authority to contract for services from non-VA providers when essential medical services are not readily available within the VA's integrated health care system.⁹⁰ The VA may enter into contracts for the purchase of health care services with any health care provider (including an FQHC).⁹¹ The VA generally purchases health care services that may not be readily available at VAMCs; examples include radiation therapy, diagnostic radiology, cardiology, cardiovascular surgery, and orthopedics.⁹²

A specific use of the VA's contracting authority is to enter into contracts with non-VA providers (including FQHCs) to establish contractor-operated CBOCs.⁹³ In general, contractor-operated CBOCs are open at least five days a week, for a minimum of 40 hours. The contractor is required to

- provide staff, facilities, equipment, supplies, and all administrative functions;
- meet both VA standards and The Joint Commission accreditation standards,⁹⁴ and
- use the VA's electronic health record to document all patient care.

The VA generally pays contractor-operated CBOCs a monthly fee for each enrolled patient; payments for each new enrollee begin during the month of the patient's first visit.⁹⁵

⁸⁹ Fee basis care is described in greater depth in U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *VA Fee Basis Care: Examining Solutions to a Flawed System*, 112th Cong., 2nd sess., September 14, 2012.

⁹⁰ 38 U.S.C. §§8151-8153 delineates the VA's contracting authority.

⁹¹ U.S. Department of Veterans Affairs, Office of Inspector General, *Evaluation of VHA Sole-Source Contracts With Medical Schools And Other Affiliated Institutions*, Report No. 05-01318-85, Washington, DC, February 16, 2005, p. 1.

⁹² U.S. Department of Veterans Affairs, *Annual Report on Sharing of Health Care Resources Pursuant to the Provisions of 38 U.S.C. Section 8153, FY2012*, p. 3.

⁹³ The Veterans' Health Care Eligibility Reform Act (P.L. 104-262) authorized the VA to obtain health care resources by entering into contracts or other agreements with any health care facility, entity, or individual. For the VA's authority to enter into contracts to establish CBOCs, see 38 U.S.C. §8153, 38 U.S.C. §7409, and 38 U.S.C. §8111. Unless otherwise noted, information about contractor-operated CBOCs is from Department of Veterans Affairs, Office of Inspector General, *Evaluation of VHA Community Based Outpatient Clinic Fiscal Year 2012*, Report No. 13-00090-346, Washington, DC, September 30, 2013, <http://www.va.gov/oig/pubs/VAOIG-13-00090-346.pdf>.

⁹⁴ The Joint Commission accredits and certifies health care organizations to ensure that certain standards are met. See http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx, accessed January 9, 2014.

⁹⁵ Although generally a capitated rate is used, some contracts may pay the contractor-operated CBOC on a per visit basis. Specific payment rates are generally based on the Centers for Medicare & Medicaid Services (CMS) Medicare fee schedule. A Price Negotiation Memorandum, which describes the negotiated rate and the rationale for the procurement decision, is required by Department of Veterans Affairs, *Health Care Resources Contracting – Buying: Title 38 U.S.C. 8153*, VA Directive 1663, August 10, 2006.

Fee Basis Care

The VA may reimburse non-VA providers (including FQHCs) for health care services rendered to veterans on a fee-for-service basis (commonly referred to as Fee Basis Care); this program is only used under certain circumstances and does not represent a formal collaborative relationship between the VA and a particular non-VA provider (such as an FQHC). Specifically, Fee Basis Care is authorized under the following circumstances: (1) when a clinical service cannot be provided at a VAMC; (2) when a veteran is unable to access VA health care facilities due to geographic inaccessibility; or (3) in emergencies when delays could lead to life-threatening situations.⁹⁶ The VA's Fee Basis Care program is partially centralized (at the VISN level) and partially decentralized (at the VAMC level); in practice, most VAMCs independently administer the Fee Basis Care Program.⁹⁷

Although fee basis care may include inpatient care, emergency care, medical transportation, and dental services, it is used predominantly to provide outpatient care.⁹⁸ The Fee Basis Care Program Office at the local VAMC pre-authorizes outpatient fee basis care if the care is determined to be appropriate, the veteran is eligible for the program, and an appropriate justification has been provided. Once outpatient fee basis care has been authorized, the veteran selects a provider and receives the service. The provider then sends a claim to the Fee Basis Care Program Office at the authorizing VAMC. After the claim is reviewed and processed, the non-VA provider receives payment electronically.⁹⁹

⁹⁶ 38 U.S.C. §§1703, 1725, and 1728. The VA released and subsequently withdrew a proposed rule that would have extended this program and permit the VA to reimburse care that is provided to complete treatment for an episode of care that was provided by a non-VA providers. 77 *Federal Register* 70967-70968, November 28, 2012 and 78 *Federal Register* 76064.

⁹⁷ U.S. Department of Veterans Affairs, Office of Inspector General, *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*, Report No. 08-02901-185, Washington, DC, August 23, 2009.

⁹⁸ Ibid.

⁹⁹ Ibid.

Appendix C. Background on Federally Qualified Health Centers (FQHCs)

The following appendix presents a brief overview of the FQHCs. This overview is not meant to be a comprehensive description; instead, it focuses on aspects of the FQHCs that are most relevant to collaboration with the VA.

Any entity that receives a grant under the Federal Health Center Program¹⁰⁰ is called a health center; to be designated a federally qualified health center (FQHC), a health center must be (1) enrolled as a provider in the Medicare and Medicaid programs and (2) certified as an FQHC by the Centers for Medicare & Medicaid Services (CMS), making it eligible for generally higher Medicare and Medicaid payment rates.¹⁰¹ The terms health center and FQHC are often used interchangeably, because most health centers receive the FQHC designation. The following sections describe the basic requirements to receive a Federal Health Center grant; these basic requirements affect, amongst other things, the services available and the location of facilities that, in turn, may affect collaboration with the VA.¹⁰²

FQHCs are funded by grants authorized in Section 330 of the Public Health Service Act (PHSA), which establishes the requirements for entities to receive a grant; the alignment of these granting requirements and VA contracting requirements may affect collaboration. The grants awarded to support FQHCs are administered by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS). Health centers receiving a grant must, among other things: (1) offer specific health services; (2) provide services to all individuals in a given area regardless of their ability to pay, have an established fee schedule, and collect reimbursements for individuals enrolled in public or private insurance programs; and (3) be located in specific geographic areas.

Health Service Requirements

PHSA Section 330 requires that a health center provide certain services; the alignment of these required services with the VA basic medical benefits package may affect the feasibility of a VA-FQHC collaboration. Specifically, FQHCs must provide primary, preventive, and emergency health services.¹⁰³ Primary health services are those provided by primary care physicians¹⁰⁴ or physician extenders (e.g., nurse practitioners) to diagnose, treat, or refer patients and include relevant diagnostic laboratory and radiology services. Preventive health services include well-child care, prenatal and postpartum care, immunization, family planning, health education, and preventive dental care. Emergency health services refer to the requirement that a health center have defined arrangements with outside providers for emergency cases that the center is not equipped to treat and for after-hours care.

¹⁰⁰ The Federal Health Center Program is authorized in Section 330 of the Public Health Service Act; 42 U.S.C. §254b.

¹⁰¹ See discussion in Appendix B of CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

¹⁰² For more information see CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

¹⁰³ 42 C.F.R. §51c.102(h).

¹⁰⁴ The regulation defines primary care physicians as those in family practice, internal medicine, pediatrics, or obstetrics and gynecology.

In addition to these three types of services (primary, preventive, and emergency), a health center must meet a variety of other service requirements. A health center must provide diabetes self-management training for patients with diabetes or renal disease. Health center providers must also have admitting privileges at one or more hospitals located near the health center to ensure care continuity for hospitalized health center patients. A health center is required to provide enabling services, such as transportation for individuals residing in each center's service area who have difficulty accessing the center, translation services, and health education. A health center may also provide supplemental services such as additional dental care, mental health services, or substance abuse treatment. The supplemental services provided vary by health center, and this variation may affect collaboration with the VA or other entities.

Fee Schedule and Collection Requirements

FQHCs provide care to all individuals (including veterans) regardless of their ability to pay for services, and are required to collect reimbursements for the cost of these services; therefore all veterans have access to FQHCs, but payment for services received may be a consideration in VA-FQHC collaboration. A health center must establish a fee schedule that takes into account local rates for health services and the costs that the health center incurs providing services. The health center is then required to establish a separate discounted fee schedule, which is then further discounted or waived based on a patient's ability to pay. Ability to pay is determined by the patient's income relative to the federal poverty level. The statute requires that individuals whose income is above 200% of the federal poverty level pay full charges, while individuals whose incomes are at or below 100% of the federal poverty level pay only nominal fees.¹⁰⁵

A health center must seek reimbursement from third party payers such as private insurance plans, Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP). The VA is not technically a third party payer (although it functions as such when reimbursing for fee basis care or contracting for services); therefore, FQHCs are not required to seek reimbursements from the VA. Instead, in absence of formal collaboration with the VA, an FQHC would seek reimbursement directly from the veteran (or a third-party payer if available) who receives care at the FQHC.

Location Requirements

PHSA Section 330 requires that a health center be located in a medically underserved area or serve a medically underserved population (see **text box**).¹⁰⁶ As a result of this requirement, many health centers are located in rural areas, which may make them candidates for collaboration with the VA to improve access for rural veterans.

¹⁰⁵ 42 C.F. R. §51c.303(f) and Section 330(k)(3)(G)(i) of the Public Health Service Act (PHSA).

¹⁰⁶ Section 5602 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) required the Secretary of HHS to revise the criteria and methodology used to designate health professional shortage areas (HPSAs) and MUPs. The ACA also required that HHS appoint a committee to undertake this revision and publish a final rule with the new criteria. The committee released a report on October 1, 2011, see <http://www.hrsa.gov/advisorycommittees/shortage/nrmcfinalreport.pdf>, but failed to reach a consensus; therefore, HRSA has discretion in using the committee's recommendation when undertaking rulemaking to revise the criteria and methodology used to designate HPSAs and MUPs. HRSA has not begun rulemaking in this area as of the date of this report's publication.

Medically Underserved Areas/Populations

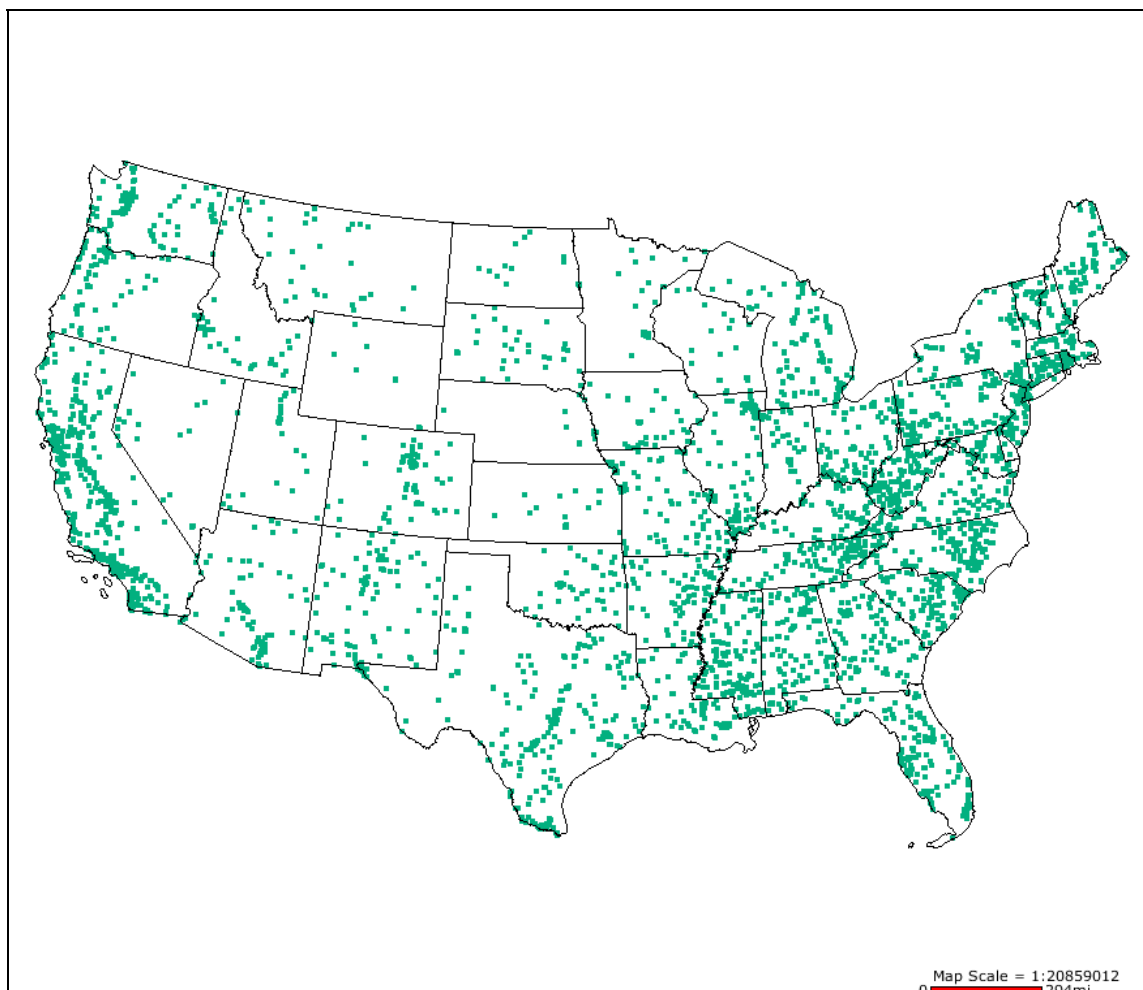
Medically Underserved Areas (MUA): Areas of varying size—whole counties, groups of contiguous counties, civil divisions, or a group of urban census tracts—where residents have a shortage of health care services.

Medically Underserved Populations (MUPs): Groups that face economic, cultural, or linguistic barriers to accessing health care.

Source: HRSA, Bureau of Primary Care, Shortage Designations, at <http://bhpr.hrsa.gov/shortage/index.html>.

Because the definition of a medically underserved area/population encompasses both urban and rural areas, FQHCs are located throughout the United States. The map (**Figure C-1**) below shows that FQHCs are dispersed throughout the country with each state having at least one FQHC. The requirements for FQHCs to be located in medically underserved areas may mean that they are located in rural areas where veterans reside.

Figure C-1. Federally Qualified Health Centers (FQHCs)



Source: Rural Assistance Center, at <http://www.raconline.org/racmaps/#fqhc>. Map is based on data obtained from the Center for Medicare & Medicaid Services, Quarter 2, 2011, which represents the most current data available as of this report's publication.

Note: This map does not depict Alaska or Hawaii, although both states have FQHCs.

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