To amend title 38, United States Code, to establish a permanent VA Care in the Community Program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

November 3, 2017

Mr. Roe of Tennessee (for himself, Mr. Coffman, Mr. Wenstrup, Mrs. Radewagen, Mr. Bost, Mr. Poliquin, Mr. Arrington, Mr. Rutherford, Mr. Higgins of Louisiana, Mr. Bergman, Mr. Banks of Indiana, Miss González-Colón of Puerto Rico, Mr. Bilirakis, Mr. Dunn, Mr. Walz, Ms. Kuster of New Hampshire, Miss Rice of New York, Mr. Correa, Mr. Sarlan, Ms. Esty of Connecticut, Mr. Peters, Mr. O'Rourke, Mr. Takano, and Ms. Brownley of California) introduced the following bill; which was referred to the Committee on Veterans' Affairs

March 5, 2018

Additional sponsors: Mr. Emmer, Mr. Stewart, Mr. Messer, Mr. Hudson, Mr. Johnson of Ohio, and Mr. Webster of Florida

March 5, 2018

Reported with an amendment, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

[Strike out all after the enacting clause and insert the part printed in italic]

[For text of introduced bill, see copy of bill as introduced on November 3, 2017]
A BILL

To amend title 38, United States Code, to establish a permanent VA Care in the Community Program, and for other purposes.
Be it enacted by the Senate and House of Representa-
tives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “VA
Care in the Community Act”.

(b) TABLE OF CONTENTS.—The table of contents for
this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—IMPROVED ACCESS FOR VETERANS TO NON-DEPARTMENT
OF VETERANS AFFAIRS MEDICAL CARE

Sec. 101. Assignment of veterans to primary care providers.
Sec. 102. Establishment of VA Care in the Community Program.
Sec. 103. Veterans Care Agreements.
Sec. 104. Modification of authority to enter into agreements with State homes to
provide nursing home care.
Sec. 105. Department of Veterans Affairs electronic interface for processing of
medical claims.
Sec. 106. Funding for VA Care in the Community Program.
Sec. 107. Termination of certain provisions authorizing medical care to veterans
through non-Department of Veterans Affairs providers.
Sec. 108. Implementation and transition.
Sec. 109. Transplant procedures with live donors and related services.

TITLE II—OTHER ADMINISTRATIVE MATTERS

Sec. 201. Reimbursement for emergency ambulance services.
Sec. 202. Improvement of care coordination for veterans through exchange of cer-
tain medical records.
Sec. 203. Elimination of copayment offset.
Sec. 204. Use of Department of Veterans Affairs Medical Care Collections Fund
for certain improvements in collections.
Sec. 205. Department of Veterans Affairs health care productivity improvement.
Sec. 206. Licensure of health care professionals of the Department of Veterans Af-
fairs providing treatment via telemedicine.
Sec. 207. Establishment of processes to ensure safe opioid prescribing practices by
non-Department of Veterans Affairs health care providers.
Sec. 208. Assessment of health care furnished by the Department to veterans who
live in the territories.
Sec. 209. Oversight and accountability of financial processes of Department of
Veterans Affairs.
Sec. 210. Authority for Department of Veterans Affairs Center for Innovation for
Care and Payment.
TITLE III—IMPROVEMENTS TO RECRUITMENT OF PHYSICIANS

Sec. 301. Designated scholarships for physicians and dentists under Department of Veterans Affairs Health Professional Scholarship Program.
Sec. 302. Establishment of Department of Veterans Affairs Specialty Education Loan Repayment Program.
Sec. 303. Veterans healing veterans medical access and scholarship program.

TITLE I—IMPROVED ACCESS FOR VETERANS TO NON-DEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE

SEC. 101. ASSIGNMENT OF VETERANS TO PRIMARY CARE PROVIDERS.

Section 1706 of title 38, United States Code, is amended by adding at the end the following new subsection:

“(d)(1) Except as provided in section 1703A of this title, in furnishing primary care under this chapter, the Secretary shall assign each eligible veteran to—

“(A) a patient-aligned care team of the Department; or

“(B) a dedicated primary care provider of the Department as a part of any other model of providing consistent primary care determined appropriate by the Secretary.

“(2) Each patient-aligned care team of the Department shall consist of a team of health care professionals of the Department who—
“(A) provide to each eligible veteran comprehensive primary care in partnership with the veteran; and

“(B) manage and coordinate comprehensive hospital care and medical services consistent with the goals of care agreed upon by the veteran and team.

“(3) The Secretary shall ensure that an eligible veteran is not simultaneously assigned to more than one patient-aligned care team or dedicated primary care provider under this subsection at a single location, including by establishing procedures in the event a primary care provider retires or is otherwise no longer able to treat the veteran. In the case of an eligible veteran who resides in more than one location, the Secretary may assign such veteran to a patient-aligned care team or dedicated primary care provider at each such location.

“(4) The term ‘eligible veteran’ means a veteran who—

“(A) is enrolled in the patient enrollment system of the Department established and operated under section 1705(a) of this title; and

“(B) has—

“(i) been furnished hospital care or medical services at or through a Department facility on at least one occasion during the two-year period
preceding the date of the determination of eligibility; or

“(ii) requested a first-time appointment for hospital care or medical services at a Department facility.”.

SEC. 102. ESTABLISHMENT OF VA CARE IN THE COMMUNITY PROGRAM.

(a) Establishment of Program.—

(1) In general.—Chapter 17 of title 38, United States Code, is amended by inserting after section 1703 the following new section:

§ 1703A. VA Care in the Community Program

“(a) Program.—(1) Subject to the availability of appropriations for such purpose, hospital care, medical services, and extended care services under this chapter shall be furnished to an eligible veteran through contracts or agreements authorized under subsection (d), or contracts or agreements, including national contracts or agreements, authorized under section 8153 of this title or any other provision of law administered by the Secretary, with network providers for the furnishing of such care and services to veterans.

“(2) Subject to subsection (b), an eligible veteran may select a provider of such care or services from among network providers.
“(3) The Secretary shall coordinate the furnishing of care and services under this section to eligible veterans.

“(4)(A) In carrying out this section, the Secretary shall establish regional networks of network providers. The Secretary shall determine, and may modify, such regions based on the capacity and market assessments of Veterans Integrated Service Networks conducted under subsection (k) or upon recognized need.

“(B) The Secretary may enter into one or more contracts for the purposes of managing the operations of the regional networks and for the delivery of care pursuant to this section.

“(C) The Secretary shall—

“(i) verify upon enrollment, and annually thereafter, that network providers have not been excluded from participation in other federally funded health care programs; and

“(ii) submit to the Committees on Veterans’ Affairs of the House of Representatives and the Senate an annual report on the results of such verifications.

“(b) PRIMARY AND SPECIALTY CARE.—(1)(A) If the Secretary is unable to assign an eligible veteran to a patient-aligned care team or dedicated primary care provider under section 1706(d) of this title because the Secretary de-
termines such a care team or provider at a Department facility is not available—

“(i) the Secretary shall consult with the veteran regarding available primary care providers from among network providers that are located in the regional network in which the veteran resides or a regional network that is adjacent to the regional network in which the veteran resides; and

“(ii) the veteran may select one of the available primary care providers to serve as the dedicated primary care provider of the veteran.

“(B) In determining whether a patient-aligned care team or dedicated provider under section 1706(d) of this title is available for assignment to a veteran, the Secretary shall take into consideration each of the following:

“(i) Whether the veteran faces an unusual or excessive burden in accessing such patient-aligned care team or dedicated provider at a medical facility of the Department including with respect to—

“(I) geographical challenges;

“(II) environmental factors, including roads that are not accessible to the general public, traffic, or hazardous weather;

“(III) a medical condition of the veteran; or
“(IV) such other factors as determined by the Secretary.

“(ii) Whether the veteran reasonably believes that the assignment of a particular care team or provider to the veteran would detrimentally affect the patient-provider relationship and result in sub-optimal care to the veteran.

“(iii) Whether the panel size of the care team or provider is at such a number that it would result in difficulty for the veteran in accessing timely care or in sub-optimal care to the veteran.

“(iv) Whether the veteran resides in a State where the Department does not operated a full-service medical facility.

“(C) If the Secretary determines that a patient-aligned care team or dedicated primary care provider at a Department facility has become available for assignment to an eligible veteran who had been assigned to a network provider under subparagraph (A), the Secretary shall provide the veteran with the option of reassignment to the team or provider at the Department facility.

“(D) In the case of an eligible veteran who is assigned to a network provider under subparagraph (A), the Secretary shall reevaluate such assignment not earlier than one
year after a veteran makes a selection under subparagraph (A)(ii), and on an annual basis thereafter, to—

“(i) determine whether the Secretary is able to assign to the veteran a patient-aligned care team or dedicated primary care provider under section 1706(d) of this title; and

“(ii) in consultation with and upon approval of the veteran, make such assignment if able.

“(2)(A)(i) Except as provided in clause (ii), the Secretary may only furnish specialty hospital care, medical services, or extended care services to an eligible veteran under this section pursuant to a referral for such specialty care or services made by the primary care provider of the veteran.

“(ii) The Secretary may designate specialties which shall be exempt from the requirement under clause (i).

“(B) The Secretary shall determine whether to furnish specialty hospital care, medical services, or extended care services to an eligible veteran pursuant to subparagraph (A)—

“(i) at a medical facility of the Department that is within a reasonable distance of the residence of the veteran, as determined by the Secretary;

“(ii) by a network provider that, to the greatest extent practicable, is located in the regional network
in which the veteran resides or a regional network that is adjacent to the regional network in which the veteran resides; or

“(iii) pursuant to an agreement described in subparagraph (C).

“(C) An agreement described in this subparagraph is an agreement entered into by the Secretary with a network provider under which—

“(i) specialty hospital care, medical services, or extended care services are furnished to an eligible veteran pursuant to subparagraph (A)—

“(I) at a medical facility of the Department by a network provider possessing the appropriate credentials, as determined by the Secretary; or

“(II) at a facility of a network provider by a health care provider of the Department; and

“(ii) such specialty care or services are so furnished either—

“(I) in accordance with this section with respect to fees and payments for care and services furnished under subsection (a); or

“(II) at no cost to the United States.

“(D) In making the determination under subparagraph (B), the Secretary shall give priority to medical fa-
ilities and health care providers of the Department but shall take into account—

“(i) whether the veteran faces an unusual or excessive burden in accessing such specialty hospital care, medical services, or extended care services at a medical facility of the Department, including with respect to—

“(I) geographical challenges;

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

“(III) a medical condition of the veteran; or

“(IV) such other factors as determined by the Secretary;

“(ii) whether the primary care provider of the veteran recommends that such specialty hospital care, medical services, or extended care services should be furnished by a network provider;

“(iii) whether the veteran resides in a State where the Department does not operate a full-service medical facility; and

“(iv) in the case of a veteran who requires an organ or bone marrow transplant, whether the veteran has, in the opinion of the primary care provider of the veteran, a medically compelling reason to travel.
outside the region of the Organ Procurement and Transplantation Network, established under section 372 of the National Organ Transplantation Act (Public Law 98–507; 42 U.S.C. 274), in which the veteran resides, to receive such transplant.

“(E) The Secretary shall ensure that each medical facility of the Department processes referrals for specialty hospital care, medical services, or extended care services in a standardized manner, including with respect to the organization of the program office responsible for such referrals.

“(F) In carrying out this section, the Secretary shall establish a process to review any disagreement between an eligible veteran and the Department, or between an eligible veteran and a health care provider of the Department, regarding the eligibility of the veteran to receive care or services from a network provider under this section or the assignment of a primary care provider of the Department to the veteran. In reviewing a disagreement under such process with respect to the availability of and assignment to a patient aligned care team or dedicated primary care provider, the Secretary may give deference to the veteran with respect to any determination under subsection (b)(1)(B)(ii).

“(G)(i) The Secretary shall develop procedures to ensure that assigning a veteran to a patient-aligned care team or dedicated primary care provider under subparagraph...
(A), (C), or (D) does not adversely affect the continuity or quality of care for the veteran during the transition.

“(ii) Procedures under clause (i) shall provide for—

“(I) the appointment of a contact in the Department for the veteran who shall provide information to the veteran and resolve issues regarding the transition;

“(II) the transfer of relevant medical records;

“(III) coordination of care between providers;

“(IV) the continued treatment of chronic or current episodes of care (by means including medication, subspecialty care, and ancillary services); and

“(V) any other action the Secretary determines is necessary.

“(c) EPISODES OF CARE.—(1) The Secretary shall ensure that, at the election of an eligible veteran who receives hospital care, medical services, or extended care services from a network provider in an episode of care under this section, the veteran receives such care or services from that network provider, another network provider selected by the veteran, or a health care provider of the Department, through the completion of the episode of care, including all specialty and ancillary services determined necessary by the provider as part of the treatment recommended in the course of such care or services. In making such determina-
tion with respect to necessary specialty and ancillary services provided by a network provider, the network provider shall consult with the Secretary, acting through the program office of the appropriate medical facility.

“(2) In cases of episodes of care that the Secretary determines case management to be appropriate, the Secretary shall provide case management to an eligible veteran who receives hospital care, medical services, or extended care services from a network provider for such episodes of care. The Secretary may provide such case management through the Veterans Health Administration or through an entity that manages the operations of the regional networks pursuant to subsection (a)(4)(B).

“(d) Care and Services Through Contracts and Agreements.—(1) The Secretary shall enter into contracts or agreements, including national contracts or agreements for, but not limited to, dialysis, for furnishing care and services to eligible veterans under this section with network providers.

“(2)(A) In entering into a contract or agreement under paragraph (1) with a network provider, the Secretary shall—

“(i) negotiate rates for the furnishing of care and services under this section; and
“(ii) reimburse the provider for such care and services at the rates negotiated pursuant to clause (i) as provided in such contract or agreement.

“(B)(i) Except as provided in paragraph (3), 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) In determining the rates under the Medicare Program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for purposes of clause (i), in the case of care or services furnished by a provider of services with respect to which such rates are determined under a fee schedule to which the area wage index under section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) applies, such area wage index so applied to such provider of services may not be less than 1.00.

“(C) In carrying out paragraph (2), the Secretary may incorporate the use of value-based reimbursement models to promote the provision of high-quality care.

“(3)(A) With respect to the furnishing of care or services under this section to an eligible veteran who resides
in a highly rural area (as defined under the rural-urban commuting area codes developed by the Secretary of Agriculture and the Secretary of Health and Human Services), the Secretary of Veterans Affairs may negotiate a rate that is more than the rate paid by the United States as described in paragraph (2)(B).

“(B) 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.

“(C) With respect to furnishing care or services under this section in a State with an All-Payer Model Agreement under the Social Security Act that became effective on or after January 1, 2014, the Medicare payment rates under paragraph (2)(B) shall be calculated based on the payment rates under such agreement, or any such successor agreement.

“(D) With respect to furnishing care or services under this section in a location in which the Secretary determines that adjusting the rate paid by the United States as described in paragraph (2)(B) is appropriate, the Secretary may negotiate such an adjusted rate.

“(E) With respect to furnishing care or services under this section in a location or in a situation in which an
exception to the rates paid by the United States 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
applies, the Secretary may follow such exception.

“(F) With respect to furnishing care or services under
this section for care or services not covered under the Medi-
care Program under title XVIII of the Social Security Act
(42 U.S.C. 1395 et seq.), the Secretary shall establish a
schedule of fees for such care or services.

“(G) With respect to furnishing care or services under
this section pursuant to an agreement with a tribal or Fed-
eral entity, the Secretary may negotiate a rate that is more
than the rate paid by the United States as described in
paragraph (2)(B).

“(4) For the furnishing of care or services pursuant
to a contract or agreement under paragraph (1), a network
provider may not collect any amount that is greater than
the rate negotiated pursuant to paragraph (2)(A).

“(5)(A) If, in the course of an episode of care under
this section, any part of care or services is furnished by
a medical provider who is not a network provider, the Sec-
retary may compensate such provider for furnishing such
care or services.

“(B) The Secretary shall make reasonable efforts to
enter into a contract or agreement under this section with
any provider who is compensated pursuant to subpara-
graph (A).

“(e) PROMPT PAYMENT STANDARD.—(1) The Sec-
retary shall ensure that claims for payments for hospital
care, medical services, or extended care services furnished
under this section are processed in accordance with this sub-
section, regardless of whether such claims are—

“(A) made by a network provider to the Sec-
retary;

“(B) made by a network provider to a regional
network operated by a contractor pursuant to sub-
section (a)(4)(B); or

“(C) made by such a regional network to the
Secretary.

“(2) A covered claimant that seeks payment for hos-
ital care, medical services, or extended care services fur-
nished under this section shall submit to the covered payer
a claim for payment not later than—

“(A) with respect to a claim by a network pro-
vider, 180 days after the date on which the network
provider furnishes such care or services; or

“(B) with respect to a claim by a regional net-
work operated by a contractor, 180 days after the
date on which the contractor pays the network pro-
vider for furnishing such care or services.
“(3) Notwithstanding chapter 39 of title 31 or any other provision of law, the covered payer shall pay a covered claimant for hospital care, medical services, or extended care services furnished under this section—

“(A) in the case of a clean claim submitted to the covered payer on paper, not later than 45 calendar days after receiving the claim; or

“(B) in the case of a clean claim submitted to the covered payer electronically, not later than 30 calendar days after receiving the claim.

“(4)(A) If the covered payer denies a claim submitted by a covered claimant under paragraph (1), the covered payer shall notify the covered claimant of the reason for denying the claim and the additional information, if any, that may be required to process the claim—

“(i) in the case of a clean claim submitted to the covered payer on paper, not later than 45 calendar days after receiving the claim; or

“(ii) in the case of a clean claim submitted to the covered payer electronically, not later than 30 calendar days after receiving the claim.

“(B) Upon receipt by the covered payer of additional information specified under subparagraph (A) relating to a claim, the covered payer shall pay, deny, or otherwise
adjudicate the claim, as appropriate, not later than 30 calendar days after receiving such information.

“(5)(A) If the covered payer has not paid a covered claimant or denied a clean claim for payment by the covered claimant under this subsection during the appropriate period specified in this subsection, such clean claim shall be considered overdue.

“(B) If a clean claim for payment by a covered claimant is considered overdue under subparagraph (A), in addition to the amount the covered payer owes the covered claimant under the claim, the covered payer shall owe the covered claimant an interest penalty amount that shall—

“(i) be prorated daily;

“(ii) accrue from the date the payment was overdue;

“(iii) be payable at the time the claim is paid; and

“(iv) be computed at the rate of interest established by the Secretary of the Treasury, and published in the Federal Register, for interest payments under subsections (a)(1) and (b) of section 7109 of title 41 that is in effect at the time the covered payer accrues the obligation to pay the interest penalty amount.
“(6)(A) If the covered payer overpays a covered claimant for hospital care, medical services, or extended care services furnished under this section—

“(i) the covered payer shall deduct the amount of any overpayment from payments due to the covered claimant after the date of such overpayment; or

“(ii) if the covered payer determines that there are no such payments due after the date of the overpayment, the covered claimant shall refund the amount of such overpayment not later than 30 days after such determination.

“(B)(i) Before deducting any amount from a payment to a covered claimant under subparagraph (A), the covered payer shall ensure that the covered claimant is provided an opportunity—

“(I) to dispute the existence or amount of any overpayment owed to the covered payer; and

“(II) to request a compromise with respect to any such overpayment.

“(ii) The covered payer may not make any deduction from a payment to a covered claimant under subparagraph (A) unless the covered payer has made reasonable efforts to notify the covered claimant of the rights of the covered claimant under subclauses (I) and (II) of clause (i).
“(iii) Upon receiving a dispute under subclause (I) of clause (i) or a request under subclause (II) of such clause, the covered payer shall make a determination with respect to such dispute or request before making any deduction under subparagraph (A) unless the time required to make such a determination would jeopardize the ability of the covered payer to recover the full amount owed to the covered payer.

“(7) Notwithstanding any other provision of law, the Secretary may, except in the case of a fraudulent claim, false claim, or misrepresented claim, compromise any claim of an amount owed to the United States under this section.

“(8) This subsection shall apply only to payments made on a claims basis and not to capitation or other forms of periodic payments to network providers.

“(9) A network provider that provides hospital care, medical services, or extended care services to an eligible veteran under this section may not seek any payment for such care or services from the eligible veteran.

“(10) With respect to making a payment for hospital care or medical services furnished to an eligible veteran by a network provider under this section—

“(A) the Secretary may not require receipt by the veteran or the Department of a medical record under subsection (g) detailing such care or services be-
fore a covered payer makes a payment for such care or services; and

“(B) the Secretary may require that the network provider attests to such care or services so provided before a covered payer makes a payment for such care or services.

“(f) Cost-Sharing.—(1) 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 under this chapter.

“(2) 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 under this chapter.

“(3) 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 this title, the Secretary shall recover or collect reasonable charges for such care or services
from a health-plan contract described in section 1705A in accordance with such section 1729.

“(g) MEDICAL RECORDS.—(1) The Secretary shall ensure that any network provider that furnishes care or services under this section to an eligible veteran—

“(A) upon the request of the veteran, provides to the veteran the medical records related to such care or services; and

“(B) upon the completion of the provision of such care or services to such veteran, provides to the Department the medical records for the veteran furnished care or services under this section in a timeframe and format specified by the Secretary for purposes of this section, except the Secretary may not require that any payment by the Secretary to the eligible provider be contingent on such provision of medical records.

“(2) To the extent practicable, the Secretary shall submit to a network provider that furnishes care or services under this section to an eligible veteran the medical records of such eligible veteran that are maintained by the Department and are relevant to such care or services.

“(3) To the extent practicable, the Secretary shall—

“(A) ensure that the medical records shared under paragraphs (1) and (2) are shared in an elec-
tronic format accessible by network providers and the
Department through an Internet website; and

“(B) provide to network providers access to the
electronic patient health record system of the Depart-
ment, or successor system, for the purpose of fur-

ishing care or services under this section.

“(h) USE OF CARD.—The Secretary shall ensure that
the veteran health identification card, or such successor
identification card, includes sufficient information to act
as an identification card for an eligible entity or other non-
Department facility. The Secretary may not use any
amounts made available to the Secretary to issue separate
identification cards solely for the purpose of carrying out
this section.

“(i) PRESCRIPTION MEDICATIONS.—(1) With respect
to requirements relating to the licensing or credentialing
of a network provider, the Secretary shall ensure that the
network provider is able to submit prescriptions for phar-
maceutical agents on the formulary of the Department to
pharmacies of the Department in a manner that is substan-
tially similar to the manner in which the network provider
submits prescriptions to retail pharmacies.

“(2) Nothing in this section shall be construed to affect
the process of the Department for filling and paying for
prescription medications.
“(j) QUALITY OF CARE.—In carrying out this section, the Secretary shall use the quality of care standards set forth or used by the Centers for Medicare & Medicaid Services or other quality of care standards, as determined by the Secretary.

“(k) CAPACITY AND COMMERCIAL MARKET ASSESSMENTS.—(1) On a periodic basis, but not less often than once every three years, the Secretary shall conduct an assessment of the capacity of each Veterans Integrated Service Network and medical facility of the Department to furnish care or services under this chapter. Each such assessment shall—

“(A) identify gaps in furnishing such care or services at such Veterans Integrated Service Network or medical facility;

“(B) identify how such gaps can be filled by—

“(i) entering into contracts or agreements with network providers under this section or with entities under other provisions of law;

“(ii) making changes in the way such care and services are furnished at such Veterans Integrated Service Network or medical facility, including but not limited to—

“(I) extending hours of operation;

“(II) adding personnel; or
“(III) expanding space through construction, leasing, or sharing of health care facilities; and
“(iii) the building or realignment of Department resources or personnel;
“(C) forecast, based on future projections and historical trends, both the short- and long-term demand in furnishing care or services at such Veterans Integrated Service Network or medical facility and assess how such demand affects the needs to use such network providers;
“(D) include a commercial health care market assessment of designated catchment areas in the United States conducted by a nongovernmental entity; and
“(E) consider the unique ability of the Federal Government to retain a presence in an area otherwise devoid of commercial health care providers or from which such providers are at a risk of leaving.
“(2) The Secretary shall submit each assessment under paragraph (1) to the Committees on Veterans’ Affairs of the House of Representatives and the Senate and shall make each such assessment publicly available.
“(l) ALLOCATION OF FUNDS.—The Secretary shall develop a plan for the allocation of funds in the Medical Community Care account.

“(m) REPORTS ON RATES.—Not later than December 31, 2019, and annually thereafter during each of the subsequent three years, the Secretary shall submit to the Committees on Veterans’ Affairs of the House of Representatives and the Senate a report detailing, for the fiscal year preceding the fiscal year during which the report is submitted, the rates paid by the Secretary for hospital care, medical services, or extended care services under this section that, pursuant to subsection (d)(3), are more than the rates described in subsection (d)(2)(B) for the same care or services.

“(n) DEFINITIONS.—In this section:

“(1) The term ‘clean claim’ means a claim submitted—

“(A) to the covered payer by a covered claimant for purposes of payment by the covered payer of expenses for hospital care or medical services furnished under this section;

“(B) that contains substantially all of the required elements necessary for accurate adjudication, without requiring additional information from the network provider; and
“(C) in such a nationally recognized format as may be prescribed by the Secretary for purposes of paying claims for hospital care or medical services furnished under this section.

“(2) The term ‘covered claimant’ means—

“(A) a network provider that submits a claim to the Secretary for purposes of payment by the Secretary of expenses for hospital care or medical services furnished under this section; or

“(B) a regional network operated by a contractor pursuant to subsection (a)(4)(B) that submits a claim to the Secretary for purposes of reimbursement for a payment made by the contractor to a network provider for hospital care or medical services furnished under this section.

“(3) The term ‘covered payer’ means—

“(A) a regional network operated by a contractor pursuant to subsection (a)(4)(B) with respect to a claim made by a network provider to the contractor for purposes of payment by the contractor of expenses for hospital care or medical services furnished under this section; or

“(B) the Secretary with respect to—

“(i) a claim made by a network provider to the Secretary for purposes of pay-
ment by the Secretary of expenses for hospital care or medical services furnished under this section; and

“(ii) a claim made by a regional network operated by a contractor pursuant to subsection (a)(4)(B) for purposes of reimbursement for a payment described by subparagraph (A).

“(4) The term ‘eligible veteran’ means a veteran who—

“(A) is enrolled in the patient enrollment system of the Department established and operated under section 1705(a) of this title; and

“(B) has—

“(i) been furnished hospital care or medical services at or through a Department facility on at least one occasion during the two-year period preceding the date of the determination of eligibility; or

“(ii) requested a first-time appointment for hospital care or medical services at a Department facility.

“(5) The term ‘fraudulent claim’ means a claim by a network provider for reimbursement under this section that includes an intentional and deliberate
misrepresentation of a material fact or facts that is
intended to induce the Secretary to pay an amount
that was not legally owed to the provider.”.

(2) CLERICAL AMENDMENT.—The table of sec-
tions at the beginning of chapter 17 of such title is
amended by inserting after the item relating to sec-
tion 1703 the following new item:

“1703A. VA Care in the Community Program.”.

(b) CONFORMING AMENDMENTS.—The Veterans Access,
Choice, and Accountability Act of 2014 (Public Law 113–
146) is amended—

(1) in section 101(p)(1) (38 U.S.C. 1701 note),
by inserting before the period at the end the following:
“or the date on which the Secretary certifies to the
Committees on Veterans’ Affairs of the House of Rep-
resentatives and the Senate that the Secretary is fully
implementing section 1703A of title 38, United States
Code, whichever occurs first”; and

(2) in section 208(1), by striking “section 101”
and inserting “section 1703A of title 38, United
States Code”.

(c) DEFINITIONS.—Section 1701 of title 38, United
States Code, is amended by adding at the end the following
new paragraphs:

“(11) The term ‘network provider’ means any of
the following health care providers that have entered
into a contract or agreement under which the pro-
vider agrees to furnish care and services to eligible
veterans under section 1703A of this title:

“(A) Any health care provider or supplier
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.

“(B) Any provider of items and services re-
ceiving payment under a State plan under title
XIX of such Act (42 U.S.C. 1396 et seq.) or a
waiver of such a plan.

“(C) 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))).

“(D) The Department of Defense.

“(E) The Indian Health Service.

“(F) Any health care provider that is an
academic affiliate of the Department.

“(G) Any health care provider not otherwise
covered under any of subparagraphs (A) through
(F) that meets criteria established by the Sec-
retary for purposes of such section.

“(12) The term ‘VA Care in the Community Pro-
gram’ means the program under which the Secretary
furnishes hospital care or medical services to veterans through network providers pursuant to section 1703A of this title.”.

(d) Transition of Provision of Care.—This Act, and the amendments made by this Act, may not be construed to affect the obligations of the Secretary of Veterans Affairs under contracts and agreements for the provision of hospital care, medical services, and extended care services entered into before the date of the enactment of this Act at the terms and rates contained in such contracts and agreements.

SEC. 103. VETERANS CARE AGREEMENTS.

(a) In General.—Subchapter I of chapter 17 of title 38, United States Code, is further amended by inserting after section 1703A, as added by section 102, the following new section:

"§ 1703B. Veterans Care Agreements with non-network providers

"(a) VETERANS CARE AGREEMENTS.—(1) In addition to furnishing hospital care, medical services, or extended care services under this chapter at facilities of the Department or under contracts or agreements entered into pursuant to section 1703A of this title or any other provision of law other than this section, the Secretary may furnish such care and services to eligible veterans through the use
of agreements, to be known as ‘Veterans Care Agreements’, entered into under this section by the Secretary with eligible non-network providers.

“(2) The Secretary may enter into a Veterans Care Agreement under this section with an eligible non-network provider if the Secretary determines that—

“(A) the provision of the hospital care, medical services, or extended care services at a Department facility is impracticable or inadvisable because of the medical condition of the veteran, the travel involved, or the nature of the care or services required, or a combination of such factors; and

“(B) such care or services are not available to be furnished by a non-Department health care provider under a contract or agreement entered into pursuant to a provision of law other than this section.

“(3)(A) In accordance with subparagraphs (C) and (D), the Secretary shall review each Veterans Care Agreement with a non-network provider to determine whether it is practical or advisable to, instead of carrying out such agreement—

“(i) provide at a Department facility the hospital care, medical services, or extended care services covered by such agreement; or
“(ii) enter into an agreement with the provider under section 1703A of this title to provide such care or services.

“(B) If the Secretary determines pursuant to a review of a Veterans Care Agreement under subparagraph (A) that it is practical or advisable to provide hospital care, medical services, or extended care services at a Department facility, or enter into an agreement under section 1703A of this title to provide such care or services, as the case may be, the Secretary—

“(i) may not renew the Veterans Care Agreement; and

“(ii) shall take such actions as are necessary to implement such determination.

“(C) This paragraph shall apply with respect to Veterans Care Agreements entered into with a non-network provider whose gross annual revenue, as determined under subsection (b)(1), exceeds—

“(i) $3,000,000, in the case of a provider that furnish homemaker or home health aide services; or

“(ii) $1,000,000, in the case of any other provider.

“(D) The Secretary shall conduct each review of a Veterans Care Agreement under subparagraph (A) as follows:
“(i) Once during the 18-month period beginning on the date that is six months after date on which the agreement is entered into.

“(ii) Not less than once during each four-year period beginning on the date on which the review under subparagraph (A) is conducted.

“(b) ELIGIBLE NON-NETWORK PROVIDERS.—A provider of hospital care, medical services, or extended care services is eligible to enter into a Veterans Care Agreement under this section if the Secretary determines that the provider meets the following criteria:

“(1) The gross annual revenue of the provider under contracts or agreements entered into with the Secretary in the year preceding the year in which the provider enters into the Veterans Care Agreement does not exceed—

“(A) $5,000,000 (as adjusted in a manner similar to amounts adjusted pursuant to section 5312 of this title), in the case of a provider that furnishes homemaker or home health aide services; or

“(B) $2,000,000 (as so adjusted), in the case of any other provider.

“(2) The provider is not a network provider and does not otherwise provide hospital care, medical serv-
ices, or extended care services to patients pursuant to a contract entered into with the Department.

“(3) The provider is—

“(A) a provider of services that has enrolled and entered into a provider agreement under section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a));

“(B) a physician or supplier that has enrolled and entered into a participation agreement under section 1842(h) of such Act (42 U.S.C. 1395u(h));

“(C) a provider of items and services receiving payment under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or a waiver of such a plan;

“(D) an Aging and Disability Resource Center, an area agency on aging, or a State agency (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)); or

“(E) a center for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)).

“(4) The provider is certified pursuant to the process established under subsection (c)(1).
“(5) Any additional criteria determined appropriate by the Secretary.

“(c) Provider Certification.—(1) The Secretary shall establish a process for the certification of eligible providers to enter into Veterans Care Agreements under this section that shall, at a minimum, set forth the following:

“(A) Procedures for the submission of applications for certification and deadlines for actions taken by the Secretary with respect to such applications.

“(B) Standards and procedures for the approval and denial of certifications and the revocation of certifications.


“(D) Requirement for denial or revocation of certification if the Secretary determines that the otherwise eligible provider is—

“(i) excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C.}
under section 1128 or 1128A of the
Social Security Act (42 U.S.C. 1320a–7 and
1320a–7a); or

“(ii) identified as an excluded source on the
list maintained in the System for Award Man-
agement, or any successor system.

“(E) Procedures by which a provider whose cer-
tification is denied or revoked under the procedures
established under this subsection will be identified as
an excluded source on the list maintained in the Sys-
tem for Award Management, or successor system, if
the Secretary determines that such exclusion is appro-
proprie.

“(2) To the extent practicable, the Secretary shall es-
tablish the procedures under paragraph (1) in a manner
that takes into account any certification process adminis-
tered by another department or agency of the Federal Gov-
ernment that an eligible provider has completed by reason
of being a provider described in any of subparagraphs (A)
through (E) of subsection (b)(4).

“(3) The Secretary shall—

“(A) verify upon enrollment, and annually
thereafter, that eligible providers have not been ex-
cluded from participation in other federally funded
health care programs; and
“(B) submit to the Committees on Veterans’ Affairs of the House of Representatives and the Senate an annual report on the results of such verifications.

“(d) TERMS OF AGREEMENTS.—Subsections (d), (e), (f), and (g) of section 1703A of this title shall apply with respect to a Veterans Care Agreement in the same manner such subsections apply to contracts and agreements entered into under such section.

“(e) EXCLUSION OF CERTAIN FEDERAL CONTRACTING PROVISIONS.—(1) Notwithstanding any other provision of law, the Secretary may enter into a Veterans Care Agreement using procedures other than competitive procedures.

“(2)(A) Except as provided in subparagraph (B) and unless otherwise provided in this section, an eligible non-network provider that enters into a Veterans Care Agreement under this section is not subject to, in the carrying out of the agreement, any provision of law that providers of services and suppliers under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.) are not subject to.

“(B) In addition to the provisions of laws covered by subparagraph (A), an eligible non-network provider shall be subject to the following provisions of law:
“(i) Any applicable law regarding integrity, ethics, or fraud, or that subject a person to civil or criminal penalties.

“(ii) Section 1352 of title 31, except for the filing requirements under subsection (b) of such section.

“(iii) Section 4705 or 4712 of title 41, and any other applicable law regarding the protection of whistleblowers.

“(iv) Section 4706(d) of title 41.

“(v) Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.) to the same extent as such title applies with respect to the eligible non-network provider in providing care or services through an agreement or arrangement other than under a Veterans Care Agreement.

“(f) TERMINATION OF A VETERANS CARE AGREEMENT.—(1) An eligible non-network provider may terminate a Veterans Care Agreement with the Secretary under this section at such time and upon such notice to the Secretary as the Secretary may specify for purposes of this section.

“(2) The Secretary may terminate a Veterans Care Agreement with an eligible non-network provider under this section at such time and upon such notice to the provider
as the Secretary may specify for the purposes of this section, if the Secretary determines necessary.

“(g) DISPUTES.—(1) The Secretary shall establish administrative procedures for providers with which the Secretary has entered into a Veterans Care Agreement to present any dispute arising under or related to the agreement.

“(2) Before using any dispute resolution mechanism under chapter 71 of title 41 with respect to a dispute arising under a Veterans Care Agreement under this section, a provider must first exhaust the administrative procedures established by the Secretary under paragraph (1).

“(h) AUTHORITY TO PAY FOR OTHER AUTHORIZED SERVICES.—(1) If, in the course of an episode of care for which hospital care, medical services, or extended care services are furnished to an eligible veteran pursuant to a Veterans Care Agreement, any part of such care or services is furnished by a medical provider who is not an eligible non-network provider or a network provider, the Secretary may compensate such provider for furnishing such care or services.

“(2) The Secretary shall make reasonable efforts to enter into a Veterans Care Agreement with any provider who is compensated pursuant to paragraph (1).
“(i) **ANNUAL REPORTS.**—(1) Not later than December 31 of the year following the fiscal year in which the Secretary first enters into a Veterans Care Agreement under this section, and each year thereafter, the Secretary shall submit to the appropriate congressional committees an annual report that includes a list of all Veterans Care Agreements entered into as of the date of the report.

“(2) The requirement to submit a report under paragraph (1) shall terminate on the date that is five years after the date of the enactment of this section.

“(j) **QUALITY OF CARE.**—In carrying out this section, the Secretary shall use the quality of care standards set forth or used by the Centers for Medicare & Medicaid Services or other quality of care standards, as determined by the Secretary.

“(k) **DELEGATION.**—The Secretary may delegate the authority to enter into or terminate a Veterans Care Agreement to an official of the Department at a level not below the Director of a Veterans Integrated Service Network or the Director of a Network Contracting Office.

“(l) **DEFINITIONS.**—In this section:

“(1) The term ‘appropriate congressional committees’ means—

“(A) the Committees on Veterans’ Affairs of the House of Representatives and the Senate; and
“(B) the Committees on Appropriations of
the House of Representatives and the Senate.
“(2) The term ‘eligible veteran’ has the meaning
given such term in section 1703A(m) of this title.”.

(b) CLERICAL AMENDMENT.—The table of sections at
the beginning of such chapter is amended by inserting after
the item relating to section 1703A, as added by section 102,
the following new item:
“1703B. Veterans Care Agreements with non-network providers.”.

SEC. 104. MODIFICATION OF AUTHORITY TO ENTER INTO
AGREEMENTS WITH STATE HOMES TO PROVIDE NURSING HOME CARE.

(a) USE OF AGREEMENTS.—

(1) IN GENERAL.—Paragraph (1) of section
1745(a) of title 38, United States Code, is amended,
in the matter preceding subparagraph (A), by strik-
ing “a contract (or agreement under section
1720(c)(1) of this title)” and inserting “an agree-
ment”.

(2) PAYMENT.—Paragraph (2) of such section is
amended by striking “contract (or agreement)” each
place it appears and inserting “agreement”.

(b) TREATMENT OF CERTAIN LAWS.—Such section is
amended by adding at the end the following new paragraph:
“(4)(A) An agreement under this section may be en-
tered into without regard to any law that would require
the Secretary to use competitive procedures in selecting the
party with which to enter into the agreement.

“(B)(i) Except as provided in clause (ii) and unless
otherwise provided in this section or in regulations pre-
scribed pursuant to this section, a State home that enters
into an agreement under this section is not subject to, in
the carrying out of the agreement, any law to which pro-
viders of services and suppliers are not subject under the
original Medicare fee-for-service program under parts A
and B of title XVIII of the Social Security Act (42 U.S.C.
1395 et seq.) or the Medicaid program under title XIX of
such Act (42 U.S.C. 1396 et seq.).

“(ii) The exclusion under clause (i) does not apply to
laws regarding integrity, ethics, fraud, or that subject a per-
son to civil or criminal penalties.

“(C) Title VII of the Civil Rights Act of 1964 (42
U.S.C. 2000e et seq.) shall apply with respect to a State
home that enters into an agreement under this section to
the same extent as such title applies with respect to the
State home in providing care or services through an agree-
ment or arrangement other than under this section.”.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by
this section shall apply to agreements entered into
under section 1745 of such title on and after the date
on which the regulations prescribed by the Secretary of Veterans Affairs to implement such amendments take effect.

(2) Publication.—The Secretary shall publish the date described in paragraph (1) in the Federal Register not later than 30 days before such date.

SEC. 105. DEPARTMENT OF VETERANS AFFAIRS ELECTRONIC INTERFACE FOR PROCESSING OF MEDICAL CLAIMS.

(a) Electronic Interface.—Not later than the implementation date specified in section 108(a), the Chief Information Officer of the Department of Veterans Affairs shall ensure that the information technology system used by the Department to receive, process, and pay claims under the VA Care in the Community Program established in section 1703A of title 38, United States Code, as added by section 102, and under Veterans Care Agreements established in section 1703B of such title, as added by section 103, includes the following:

(1) A function through which a covered non-Department health care provider may submit all required data and supporting information required for claims reimbursement through electronic data interchange.
(2) An ability to automatically adjudicate claims.

(3) A centralized claims database that is accessible nationwide.

(4) Integration with the relevant eligibility and authorization information technology systems of the Department.

(5) Ability for a covered non-Department health care provider to ascertain the status of a pending claim submitted by the provider, receive information regarding missing documentation or discrepancies that may impede claim processing timelines or result in rejection, and receive notification when such claim is accepted for reimbursement or rejected.

(6) A claim review system similar to that used by the Centers for Medicare & Medicaid Services, as of the date of the enactment of this Act, including the use of contractors to perform audits through data analytics, to determine the appropriateness and accuracy of claims of providers and to ensure program integrity and oversight.

(b) SECURITY AND PRIVACY.—The Chief Information Officer shall also ensure that the information technology system covered under subsection (a) meets the following criteria:
(1) Such system shall be developed and imple-
mented in compliance with all applicable laws, regu-
lations and Federal Government standards regarding
information security, privacy, and accessibility.

(2) Such system shall provide for the elicitation,
analysis, and prioritization of functional and non-
functional information security and privacy require-
ments for such system, including security and privacy
services and architectural requirements relating to se-
curity and privacy based on a thorough risk assess-
ment of all reasonably anticipated cyber and
noncyber threats to the security and privacy of elec-
tronic protected health information made available
through such interface.

(3) Such system shall provide for the elicitation,
analysis, and prioritization of secure development re-
quirements relating to such system.

(4) Such system shall provide assurance that the
prioritized information security and privacy require-
ments of such system—

(A) are correctly implemented in the design
and implementation of such system through the
systems development lifecycle; and
(B) satisfy the information objectives of such system relating to security and privacy throughout the systems development lifecycle.

(c) CONTRACT AUTHORITY.—The Chief Information Officer may enter into a contract for purposes of carrying out this section.

(d) DEFINITIONS.—In this section:

(1) The term “electronic protected health information” has the meaning given that term in section 160.103 of title 45, Code of Federal Regulations, as in effect on the date of the enactment of this Act.

(2) The term “covered non-Department health care provider” means—

(A) a network provider (as defined by section 1701(11) of title 38, United States Code, as added by section 102);

(B) a non-network provider with which the Secretary has entered into a Veterans Care Agreement under section 1703B of such title, as added by section 103; or

(C) any other non-Department eligible provider or non-Department health care provider that furnishes hospital care or medical services pursuant to chapter 17 of such title.
(3) The term “secure development requirements” means, with respect to the information technology system established under subsection (a), activities that are required to be completed during the system development lifecycle of such interface, such as secure coding principles and test methodologies.

(4) The term “VA Care in the Community Program” has the meaning given that term in section 1701(12) of title 38, United States Code, as added by section 102.

SEC. 106. FUNDING FOR VA CARE IN THE COMMUNITY PROGRAM.

(a) In General.—All amounts required to carry out the VA Care in the Community Program and Veterans Care Agreements under section 1703B of title 38, United States Code, shall be derived from the Veterans Health Administration, Medical Community Care account.

(b) Transfer of Amounts.—

(1) In General.—Any unobligated amounts in the Veterans Choice Fund under section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note) shall be transferred to the Veterans Health Administration, Medical Community Care account on the later of the following dates:
(A) The date that is one year after the date of the enactment of this Act.

(B) The date on which the Secretary of Veterans Affairs submits to the Committees on Veterans’ Affairs of the Senate and the House of Representatives the certification required by section 107(c).

(2) CONFORMING REPEAL.—

(A) IN GENERAL.—Effective immediately following the transfer of amounts under paragraph (1), section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note) is repealed.

(B) CONFORMING AMENDMENT.—Section 4003 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (Public Law 114–41; 38 U.S.C. 1701 note) is amended by striking “for non-Department provider programs (as defined in section 2(d))” and all that follows through “1802)” and inserting the following: “for the VA Care in the Community Program (as defined in section 1701(12) of title 38, United States Code) and Veterans Care Agreements under section 1703B of title 38, United States Code”.

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(c) VA Care in the Community Program Defined.—In this section, the term “VA Care in the Community Program” has the meaning given that term in section 1701(12) of title 38, United States Code, as added by section 102.

SEC. 107. TERMINATION OF CERTAIN PROVISIONS AUTHORIZING MEDICAL CARE TO VETERANS THROUGH NON-DEPARTMENT OF VETERANS AFFAIRS PROVIDERS.

(a) Termination of Authority To Contract for Care in Non-Department Facilities.—

(1) In general.—Section 603 of title 38, United States Code, is amended by adding at the end the following new subsection:

“(e) The authority of the Secretary to carry out this section terminates on the date on which the Secretary certifies to the Committees on Veterans’ Affairs of the House of Representatives and the Senate that the Secretary is fully implementing section 1703A of this title.”.

(2) Conforming Amendments.—

(A) Dental Care.—Section 1712(a) of such title is amended—

(i) in paragraph (3), by striking “under clause (1), (2), or (5) of section 1703(a) of this title” and inserting “under
the VA Care in the Community Program’’;

and

(ii) in paragraph (4)(A), in the first sentence—

(I) by striking ‘‘and section 1703 of this title’’ and inserting ‘‘and the VA Care in the Community Program (with respect to such a year beginning on or after the date on which the Secretary commences implementation of the VA Care in the Community Program)’’; and

(II) by striking ‘‘in section 1703 of this title’’ and inserting ‘‘under the VA Care in the Community Program’’.

(B) READJUSTMENT COUNSELING.—Section 1712A(e)(1) of such title is amended by striking ‘‘(under sections 1703(a)(2) and 1710(a)(1)(B) of this title)’’ and inserting ‘‘(under the VA Care in the Community Program)’’.

(C) DEATH IN DEPARTMENT FACILITY.—Section 2303(a)(2)(B)(i) of such title is amended by striking ‘‘in accordance with section 1703 of this title’’ and inserting ‘‘under the VA Care in the Community Program’’.
(D) Medicare Provider Agreements.—

Section 1866(a)(1)(L) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(L)) is amended—

(i) by striking “under section 1703 of title 38” and inserting “under the VA Care in the Community Program (as defined in section 1701(12) of title 38, United States Code)”;

(ii) by striking “such section” and inserting “such program”.

(b) Repeal of Authority To Contract for Scarce Medical Specialists.—

(1) In General.—Section 7409 of title 38, United States Code, is repealed.

(2) Clerical Amendment.—The table of sections at the beginning of chapter 74 of such title is amended by striking the item relating to section 7409.

(c) Effective Date.—The amendments made by subsections (a) and (b) shall take effect on the date on which the Secretary certifies to the Committees on Veterans’ Affairs of the House of Representatives and the Senate that the Secretary is fully implementing section 1703A of title 38, United States Code, as added by section 102.
SEC. 108. IMPLEMENTATION AND TRANSITION.

(a) IMPLEMENTATION.—The Secretary of Veterans Affairs shall commence the implementation of section 1703A of title 38, United States Code, as added by section 102, and section 1703B of such title, as added by section 103, and shall make the transfer under section 106(b), by not later than one year after the date of the enactment of this Act. The Secretary shall prescribe interim final regulations to implement such sections and publish such regulations in the Federal Register.

(b) TRAINING.—Before commencing the implementation of sections 1703A and 1703B of title 38, United States Code, as added by sections 102 and 103, respectively, the Secretary of Veterans Affairs shall—

(1) certify to the Committees on Veterans’ Affairs of the House of Representatives and the Senate that—

(A) each network provider (as defined by section 1701(11) of title 38, United States Code) and eligible non-network provider that furnishes care or services under such section 1703A or section 1703B is trained to furnish such care or services under such sections; and

(B) each employee of the Department that refers, authorizes, or coordinates such care or services is trained to carry out such sections; and
(2) establish standard, written guidance for network providers, non-Department health care providers, and any non-Department administrative entities acting on behalf of such providers, with respect to the policies and procedures for furnishing care or services under such sections.

SEC. 109. TRANSPLANT PROCEDURES WITH LIVE DONORS AND RELATED SERVICES.

(a) IN GENERAL.—Subchapter I of chapter 17 of title 38, United States Code, is further amended by inserting after section 1703B, as added by section 103, the following new section:

§1703C. Transplant procedures with live donors and related services

“(a) IN GENERAL.—Subject to subsections (b) and (c), in a case in which a veteran is eligible for a transplant procedure from the Department, the Secretary may provide for an operation on a live donor to carry out such procedure for such veteran, notwithstanding that the live donor may not be eligible for health care from the Department.

“(b) OTHER SERVICES.—Subject to the availability of appropriations for such purpose, the Secretary shall furnish to a live donor any care or services before and after conducting the transplant procedure under subsection (a) that may be required in connection with such procedure.
“(c) Use of Non-Department Facilities.—(1) In carrying out this subsection, the Secretary may provide for the operation described in subsection (a) on a live donor and furnish to the live donor the care and services described in subsection (b) at a non-Department facility pursuant to an agreement entered into by the Secretary under this section. The live donor shall be deemed to be an individual eligible for hospital care and medical services at a non-Department facility pursuant to such an agreement solely for the purposes of receiving such operation, care, and services at the non-Department facility.

“(2) The Secretary may only provide for an operation at a non-Department of Veterans Affairs transplant center pursuant to paragraph (1) if the center is in compliance with regulations prescribed by the Centers for Medicare & Medicaid Services applicable to transplant centers.”.

(b) Clerical Amendment.—The table of section at the beginning of such chapter is further amended by inserting after the item relating to section 1703B, as added by section 103, the following new item:

“1703C. Transplant procedures with live donors and related services.”.
TITLE II—OTHER
ADMINISTRATIVE MATTERS

SEC. 201. REIMBURSEMENT FOR EMERGENCY AMBULANCE SERVICES.

(a) In General.—Section 1725(c) of title 38, United States Code, is amended by adding at the end the following new paragraph:

“(5) In delineating the circumstances under which reimbursement may be made under this section for ambulance services for an individual, the Secretary shall treat such services as emergency services for which reimbursement may be made under this section if the Secretary determines that—

“(A) the request for ambulance services was made as a result of the sudden onset of a medical condition of such a nature that a prudent layperson who possesses an average knowledge of health and medicine—

“(i) would have reasonably expected that a delay in seeking immediate medical attention would have been hazardous to the life or health of the individual; or

“(ii) could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy,
the serious impairment of bodily functions, or
the serious dysfunction of any bodily organ or
part; and
“(B) the individual is transported to the most
appropriate medical facility capable of treating such
medical condition.”.

(b) EFFECTIVE DATE.—The amendment made by sub-
section (a) shall take effect on the date of the enactment
of this Act and shall apply with respect to ambulance serv-
ices provided on or after January 1, 2019.

SEC. 202. IMPROVEMENT OF CARE COORDINATION FOR
VETERANS THROUGH EXCHANGE OF CERTAIN
MEDICAL RECORDS.

Section 7332(b) of title 38, United States Code, is
amended—

(1) in paragraph (2), by adding at the end the
following new subparagraphs:

“(I) To a public or private health care pro-
vider in order to provide treatment or health
care to a shared patient.

“(J) To a third party in order to recover or
collect reasonable charges for care furnished to a
veteran for a non-service-connected disability
pursuant to section 1729 of this title or section
1 of Public Law 87–693 (42 U.S.C. 2651).”; and
(2) by adding at the end the following new paragraph:

“(4) Nothing in this section shall be construed to authorize any provision of records in violation of relevant health record privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).”

SEC. 203. ELIMINATION OF COPAYMENT OFFSET.

(a) IN GENERAL.—Section 1729(a) of title 38, United States Code, is amended by adding at the end the following new paragraph:

“(4) Notwithstanding any other provision of law, any amount that the United States may collect or recover under this section shall not affect any copayment amount a veteran is otherwise obligated to pay under this chapter.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and apply with respect to a copayment obligation that arises on or after the date of the enactment of this Act.
SEC. 204. USE OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE COLLECTIONS FUND FOR CERTAIN IMPROVEMENTS IN COLLECTIONS.

Section 1729A(c)(1)(B) of title 38, United States Code, is amended by inserting “(including with respect to automatic data processing or information technology improvements)” after “collection”.

SEC. 205. DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE PRODUCTIVITY IMPROVEMENT.

(a) In General.—Subchapter I of chapter 17 of title 38, United States Code, is further amended by inserting after section 1705A the following new section:

“§ 1705B. Management of health care: productivity

“(a) Relative Value Unit Tracking.—The Secretary shall track relative value units for all Department providers.

“(b) Clinical Procedure Coding Training.—The Secretary shall require all Department providers to attend training on clinical procedure coding.

“(c) Performance Standards.—(1) The Secretary shall establish for each Department facility—

“(A) in accordance with paragraph (2), standardized performance standards based on nationally recognized relative value unit production standards applicable to each specific profession in order to
evaluate clinical productivity at the provider and fa-
cility level;

“(B) remediation plans to address low clinical
productivity and clinical inefficiency; and

“(C) an ongoing process to systematically review
the content, implementation, and outcome of the plans
developed under subparagraph (B).

“(2) In establishing the performance standards under
paragraph (1)(A), the Secretary may—

“(A) incorporate values-based productivity mod-
els; and

“(B) take into account non-clinical duties, in-
cluding with respect to training and research.

“(d) DEFINITIONS.—In this section:

“(1) The term ‘Department provider’ means an
employee of the Department whose primary respon-
sibilities include furnishing hospital care or medical
services, including a physician, a dentist, an optom-
etrist, a podiatrist, a chiropractor, an advanced prac-
tice registered nurse, and a physician’s assistant act-
ing as an independent provider.

“(2) The term ‘relative value unit’ means a unit
for measuring workload by determining the time,
mental effort and judgment, technical skill, physical
effort, and stress involved in delivering a procedure.”.
(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is further amended by inserting after the item relating to section 1705A the following new item:

“1705B. Management of health care: productivity.”.

(c) REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the implementation of section 1705B of title 38, United States Code, as added by subsection (a). Such report shall include, for each professional category of Department providers, the relative value unit of such category of providers at the national, Veterans Integrated Service Network, and facility levels.

SEC. 206. LICENSURE OF HEALTH CARE PROFESSIONALS OF THE DEPARTMENT OF VETERANS AFFAIRS PROVIDING TREATMENT VIA TELEMEDICINE.

(a) IN GENERAL.—Chapter 17 of title 38, United States Code, is further amended by inserting after section 1730A the following new section:

“§ 1730B. Licensure of health care professionals providing treatment via telemedicine

“(a) IN GENERAL.—Notwithstanding any provision of law regarding the licensure of health care professionals, a covered health care professional may practice the health care profession of the health care professional at any location in any State, regardless of where the covered health
care professional or the patient is located, if the covered health care professional is using telemedicine to provide treatment to an individual under this chapter.

“(b) Property of Federal Government.—Subsection (a) shall apply to a covered health care professional providing treatment to a patient regardless of whether the covered health care professional or patient is located in a facility owned by the Federal Government during such treatment.

“(c) Construction.—Nothing in this section may be construed to remove, limit, or otherwise affect any obligation of a covered health care professional under the Controlled Substances Act (21 U.S.C. 801 et seq.).

“(d) Covered Health Care Professional Defined.—In this section, the term ‘covered health care professional’ means a health care professional who—

“(1) is an employee of the Department appointed under the authority under section 7306, 7401, 7405, 7406, or 7408 of this title, or title 5;

“(2) is authorized by the Secretary to provide health care under this chapter;

“(3) is required to adhere to all quality standards relating to the provision of telemedicine in accordance with applicable policies of the Department; and
“(4) has an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional.”.

(b) Clerical Amendment.—The table of sections at the beginning of chapter 17 of such title is further amended by inserting after the item relating to section 1730A the following new item:

“1730B. Licensure of health care professionals providing treatment via telemedicine.”.

(c) Report on Telemedicine.—

(1) In General.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs 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 effectiveness of the use of telemedicine by the Department of Veterans Affairs.

(2) Elements.—The report required by paragraph (1) shall include an assessment of the following:

(A) The satisfaction of veterans with telemedicine furnished by the Department.

(B) The satisfaction of health care providers in providing telemedicine furnished by the Department.
(C) The effect of telemedicine furnished by the Department on the following:

(i) The ability of veterans to access health care, whether from the Department or from non-Department health care providers.

(ii) The frequency of use by veterans of telemedicine.

(iii) The productivity of health care providers.

(iv) Wait times for an appointment for the receipt of health care from the Department.

(v) The reduction, if any, in the use by veterans of in-person services at Department facilities and non-Department facilities.

(D) The types of appointments for the receipt of telemedicine furnished by the Department that were provided during the one-year period preceding the submittal of the report.

(E) The number of appointments for the receipt of telemedicine furnished by the Department that were requested during such period,
disaggregated by Veterans Integrated Service Network.

(F) Savings by the Department, if any, including travel costs, of furnishing health care through the use of telemedicine during such period.

SEC. 207. ESTABLISHMENT OF PROCESSES TO ENSURE SAFE OPIOID PRESCRIBING PRACTICES BY NON-DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE PROVIDERS.

(a) Receipt and Review of Guidelines.—The Secretary of Veterans Affairs shall ensure that all covered health care providers are provided a copy of and certify that they have reviewed the evidence-based guidelines for prescribing opioids set forth by the Opioid Safety Initiative of the Department of Veterans Affairs under sections 911(a)(2) and 912(c) of the Jason Simcakoski Memorial and Promise Act (Public Law 114–198; 38 U.S.C. 1701 note) before first providing care under the laws administered by the Secretary and at any time when those guidelines are modified thereafter.

(b) Inclusion of Medical History and Current Medications.—The Secretary shall implement a process to ensure that, if care of a veteran by a covered health care provider is authorized under the laws administered by the
Secretary, the document authorizing such care includes the relevant medical history of the veteran and a list of all medications prescribed to the veteran.

(c) **SUBMITTAL OF PRESCRIPTIONS.—**

(1) **IN GENERAL.—**Except as provided in paragraph (3), the Secretary shall require, to the maximum extent practicable, each covered health care provider to submit prescriptions for opioids—

(A) to the Department for prior authorization for the prescribing of a limited amount of opioids under contracts the Department has with retail pharmacies; or

(B) directly to a pharmacy of the Department for the dispensing of such prescription.

(2) **DEPARTMENT RESPONSIBILITY.—**In carrying out paragraph (1), upon receipt by the Department of a prescription for opioids for a veteran under the laws administered by the Secretary, the Secretary shall—

(A) record such prescription in the electronic health record of the veteran; and

(B) monitor such prescription as outlined in the Opioid Safety Initiative of the Department.

(3) **EXCEPTION.—**
(A) In general.—A covered health care provider is not required under paragraph (1)(B) to submit an opioid prescription directly to a pharmacy of the Department if—

(i) the health care provider determines that there is an immediate medical need for the prescription, including an urgent or emergent prescription or a prescription dispensed as part of an opioid treatment program that provides office-based medications; and

(ii)(I) following an inquiry into the matter, a pharmacy of the Department notifies the health care provider that it cannot fill the prescription in a timely manner; or

(II) the health care provider determines that the requirement under paragraph (1)(B) would impose an undue hardship on the veteran, including with respect to travel distances, as determined by the Secretary.

(B) Notification to department.—If a covered health care provider uses an exception under subparagraph (A) with respect to an opioid prescription for a veteran, the health care
provider shall, on the same day the prescription is written, submit to the Secretary for inclusion in the electronic health record of the veteran a notice, in such form as the Secretary may establish, providing information about the prescription and describing the reason for the exception.

(C) Report.—

(i) In general.—Not less frequently than quarterly, 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 evaluating the compliance of covered health care providers with the requirements under this paragraph and setting forth data on the use by health care providers of exceptions under subparagraph (A) and notices under subparagraph (B).

(ii) Elements.—Each report required by clause (i) shall include the following with respect to the quarter covered by the report:

(I) The number of exceptions used under subparagraph (A) and notices received under subparagraph (B).
(II) The rate of compliance by the Department with the requirement under subparagraph (B) to include such notices in the health records of veterans.

(III) The identification of any covered health care providers that, based on criteria prescribed the Secretary, are determined by the Secretary to be statistical outliers regarding the use of exceptions under subparagraph (A).

(d) **USE OF OPIOID SAFETY INITIATIVE GUIDELINES.**—

(1) IN GENERAL.—If a director of a medical center of the Department or a Veterans Integrated Service Network determines that the opioid prescribing practices of a covered health care provider conflicts with or is otherwise inconsistent with the standards of appropriate and safe care, as that term is used in section 913(d) of the Jason Simcakoski Memorial and Promise Act (Public Law 114–198; 38 U.S.C. 1701 note), the director shall take such action as the director considers appropriate to ensure the safety of all veterans receiving care from that health care provider,
including removing or directing the removal of any
such health care provider from provider networks or
otherwise refusing to authorize care of veterans by
such health care provider in any program authorized
under the laws administered by the Secretary.

(2) Inclusion in Contracts.—The Secretary
shall ensure that any contracts entered into by the
Secretary with third parties involved in admin-
istering programs that provide care in the community
to veterans under the laws administered by the Sec-
retary specifically grant the authority set forth in
paragraph (1) to such third parties and to the direc-
tors described in that paragraph, as the case may be.

(e) Denial or Revocation of Eligibility of Non-
Department Providers.—The Secretary shall deny or re-
voke the eligibility of a non-Department health care pro-
vider to provide health care to veterans under the laws ad-
ministered by the Secretary if the Secretary determines that
the opioid prescribing practices of the provider—

(1) violate the requirements of a medical license
of the health care provider; or

(2) detract from the ability of the health care
provider to deliver safe and appropriate health care.

(f) Covered Health Care Provider Defined.—
In this section, the term “covered health care provider”
means a non-Department of Veterans Affairs health care
provider who provides health care to veterans under the
laws administered by the Secretary of Veterans Affairs.

SEC. 208. ASSESSMENT OF HEALTH CARE FURNISHED BY

THE DEPARTMENT TO VETERANS WHO LIVE

IN THE TERRITORIES.

(a) In General.—Not later than 180 days after the
date of the enactment of this Act, the Secretary of Veterans
Affairs shall submit to the Committees on Veterans’ Affairs
of the Senate and the House of Representatives a report re-
garding health care furnished by the Department of Vet-
erans Affairs to veterans who live in the territories.

(b) Elements.—The report under subsection (a) shall
include assessments of the following:

(1) The ability of the Department to furnish to
veterans who live in the territories the following:

(A) Hospital care.

(B) Medical services.

(C) Mental health services.

(D) Geriatric services.

(2) The feasibility of establishing a medical facil-
ity of the Department in any territory that does not
contain such a facility.
(c) DEFINITION.—In this section, the term “territories” means the Northern Mariana Islands, Puerto Rico, American Samoa, Guam, and the Virgin Islands.

SEC. 209. OVERSIGHT AND ACCOUNTABILITY OF FINANCIAL PROCESSES OF DEPARTMENT OF VETERANS AFFAIRS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) the normal budget process for the Department of Veterans Affairs should be grounded in sound actuarial analysis based on accurate demand forecasting;

(2) the regular budget process for the Department should be the norm;

(3) supplemental requests for appropriations should be used sparingly and for unforeseen demand or natural occurrences; and

(4) upon receipt of the financial audit of the Office of Inspector General of the Department, the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives shall give due consideration to the report, including by holding hearings as appropriate.

(b) PLANS FOR USE OF SUPPLEMENTAL APPROPRIATIONS REQUIRED.—Whenever the Secretary submits to address a budgetary issue affecting the Department of Vet-
erans Affairs to Congress a request for supplemental appropri-
ations or any other appropriation when the request is
submitted outside the standard budget process, the Secretary
shall, not later than 45 days before the date on which such
budgetary issue would start affecting a program or service,
submit to Congress a justification for the request, including
a plan that details how the Secretary intends to use the
requested appropriation and how long the requested appro-
priation is expected to meet the needs of the Department
and certification that the request was made using an up-
dated and sound actuarial analysis.

(c) ANNUAL ATTESTATION REGARDING FINANCIAL
PROJECTIONS.—Concurrent with the President’s annual
budget request submitted to Congress under section 1105 of
title 31, United States Code, for fiscal year 2019 and each
fiscal year thereafter, the Chief Financial Officer of the De-
partment of Veterans Affairs shall submit to the Committee
on Veterans’ Affairs of the Senate and the Committee on
Veterans’ Affairs of the House of Representatives the fol-
lowing:

(1) A statement of assurance that financial pro-
jections included in such budget or the supporting
materials submitted along with such budget for the
Department of Veterans Affairs are sufficient to pro-
vide benefits and services under laws administered by
the Secretary of Veterans Affairs.

(2) A certification of the Chief Financial Officer’s responsibility for internal financial controls of
the Department.

(3) An attestation that the Chief Financial Officer has collaborated sufficiently with the financial of-
ficers of the facilities and components of the Depart-
ment to be confident in such financial projections.

SEC. 210. AUTHORITY FOR DEPARTMENT OF VETERANS AF-
FAIRS CENTER FOR INNOVATION FOR CARE
AND PAYMENT.

(a) In General.—Subchapter I of chapter 17, as
amended by section 103, is further amended by inserting
after section 1703C, as added by section 109, the following
new section:

§ 1703D. Center for Innovation for Care and Payment
“(a) In General.—(1) There is established within the
Department a Center for Innovation for Care and Payment
(in this section referred to as the ‘Center’).

“(2) The Secretary, acting through the Center, may
carry out such pilot programs the Secretary determines to
be appropriate to develop innovative approaches to testing
payment and service delivery models in order to reduce ex-
penditures while preserving or enhancing the quality of care furnished by the Department.

“(3) The Secretary, acting through the Center, shall test payment and service delivery models to determine whether such models—

“(A) improve access to, and quality, timeliness, and patient satisfaction of care and services; and

“(B) create cost savings for the Department.

“(4)(A) The Secretary shall test a model in a location where the Secretary determines that the model will address deficits in care (including poor clinical outcomes or potentially avoidable expenditures) for a defined population.

“(B) The Secretary shall focus on models the Secretary expects to reduce program costs while preserving or enhancing the quality of care received by individuals receiving benefits under this chapter.

“(C) The models selected may include those described in section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B)).

“(5) In selecting a model for testing, the Secretary may consider, in addition to other factors identified in this subsection, the following factors:

“(A) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and
preferences of individuals receiving benefits under this chapter.

“(B) Whether the model places the individual receiving benefits under this chapter at the center of the care team (including family members and other caregivers) of such individual.

“(C) Whether the model uses technology or new systems to coordinate care over time and across settings.

“(D) Whether the model demonstrates effective linkage with other public sector payers, private sector payers, or statewide payment models.

“(6)(A) Models tested under this section may not be designed in such a way that would allow the United States to recover or collect reasonable charges from a Federal health care program for care or services furnished by the Secretary to a veteran under pilot programs carried out under this section.

“(B) In this paragraph, the term ‘Federal health care program’ means—

“(i) an insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of such Act (42 U.S.C. 1395j); or
“(ii) a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.); or

“(iii) a TRICARE program operated under sections 1075, 1075a, 1076, 1076a, 1076c, 1076d, 1076e, or 1076f of title 10.

“(b) DURATION.—Each pilot program carried out by the Secretary under this section shall terminate no later than five years after the date of the commencement of the pilot program.

“(c) LOCATION.—The Secretary shall ensure that each pilot program carried out under this section occurs in an area or areas appropriate for the intended purposes of the pilot program.

“(d) BUDGET.—Funding for each pilot program carried out by the Secretary under this section shall come from appropriations—

“(1) provided in advance in appropriations acts for the Veterans Health Administration; and

“(2) provided for information technology systems.

“(e) NOTICE.—The Secretary shall—

“(1) publish information about each pilot program under this section in the Federal Register; and
“(2) take reasonable actions to provide direct notice to veterans eligible to participate in such pilot programs.

“(f) WAIVER OF AUTHORITIES.—(1) Subject to reporting under paragraph (2) and approval under paragraph (3), in implementing a pilot program under this section, the Secretary may waive such requirements in subchapters I, II, and III of this chapter as the Secretary determines necessary solely for the purposes of carrying out this section with respect to testing models described in subsection (a).

“(2) Before waiving any authority under paragraph (1), the Secretary shall submit a report to the Speaker of the House of Representatives, the minority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the Senate, and each standing committee with jurisdiction under the rules of the Senate and of the House of Representatives to report a bill to amend the provision or provisions of law that would be waived by the Department describing in detail the following:

“(A) The specific authorities to be waived under the pilot program.

“(B) The standard or standards to be used in the pilot program in lieu of the waived authorities.

“(C) The reasons for such waiver or waivers.
“(D) A description of the metric or metrics the Secretary will use to determine the effect of the waiver or waivers upon the access to and quality, timeliness, or patient satisfaction of care and services furnished through the pilot program.

“(E) The anticipated cost savings, if any, of the pilot program.

“(F) The schedule for interim reports on the pilot program describing the results of the pilot program so far and the feasibility and advisability of continuing the pilot program.

“(G) The schedule for the termination of the pilot program and the submission of a final report on the pilot program describing the result of the pilot program and the feasibility and advisability of making the pilot program permanent.

“(H) The estimated budget of the pilot program.

“(3)(A) Upon receipt of a report submitted under paragraph (2), each House of Congress shall provide copies of the report to the chairman and ranking member of each standing committee with jurisdiction under the rules of the House of Representatives or the Senate to report a bill to amend the provision or provisions of law that would be waived by the Department under this subsection.
“(B)(i) The waiver requested by the Secretary under paragraph (2) shall be considered approved under this paragraph if there is enacted into law a bill or joint resolution approving such request in its entirety. Such bill or joint resolution shall be passed by recorded vote to reflect the vote of each member of Congress thereon.

“(ii) The provisions of this paragraph are enacted by Congress—

“(I) as an exercise of the rulemaking power of the Senate and the House of Representatives and as such shall be considered as part of the rules of each House of Congress, and shall supersede other rules only to the extent that they are inconsistent therewith; and

“(II) with full recognition of the constitutional right of either House of Congress to change the rules (so far as they relate to the procedures of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

“(C) During the 60-calendar-day period beginning on the date on which the Secretary submits the report described in paragraph (2) to Congress, it shall be in order as a matter of highest privilege in each House of Congress to consider a bill or joint resolution, if offered by the majority leader
of such House (or a designee), approving such request in its entirety.

“(g) LIMITATIONS.—(1) The waiver provisions in subsection (f) shall not apply unless the Secretary, in accordance with the requirements in subsection (f), submits the first proposal for a pilot program not later than 18 months after the date of the enactment of the VA Care in the Community Act.

“(2) Notwithstanding section 502 of this title, decisions by the Secretary under this section shall, consistent with section 511 of this title, be final and conclusive and may not be reviewed by any other official or by any court, whether by an action in the nature of mandamus or otherwise.

“(3)(A) If the Secretary determines that the pilot program is not improving the quality of care or producing cost savings, the Secretary shall—

“(i) propose a modification to the pilot program in the interim report that shall also be considered a report under subsection (f)(2)(A) and shall be subject to the terms and conditions of subsection (f)(2); or

“(ii) terminate such pilot program not later than 30 days after submitting the interim report to Congress.

“(B) If the Secretary terminates the pilot program under subparagraph (A)(ii), for purposes of clauses (vi) and
(vii) of subsection (f)(2)(A), such interim report will also serve as the final report for that pilot program.

“(h) Evaluation and Reporting Requirements.—

(1) The Secretary shall conduct an evaluation of each model tested, which shall include, at a minimum, an analysis of—

“(A) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

“(B) the changes in spending by reason of that model.

“(2) The Secretary shall make the results of each evaluation under this subsection available to the public in a timely fashion and may establish requirements for other entities participating in the testing of models under this section to collect and report information that the Secretary determines is necessary to monitor and evaluate such models.

“(i) Coordination and Consultation.—(1) The Secretary shall consult with the Under Secretary for Health and the Special Medical Advisory Group established pursuant to section 7312 of this title in the development and implementation of any pilot program operated under this section.
“(2) In carrying out the duties under this section, the Secretary shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The Secretary shall use appropriate mechanisms to seek input from interested parties.

“(j) Expansion of Successful Pilot Programs.—Taking into account the evaluation under subsection (f), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (a) to the extent determined appropriate by the Secretary, if—

“(1) the Secretary determines that such expansion is expected to—

“(A) reduce spending without reducing the quality of care; or

“(B) improve the quality of patient care without increasing spending; and

“(2) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits for individuals receiving benefits under this chapter.”.

(b) Conforming Amendment.—The table of sections at the beginning of such chapter, as amended by section
109, is further amended by inserting after the item relating to section 1703C the following new item:

“1703D. Center for Innovation for Care and Payment.”.

**TITLE III—IMPROVEMENTS TO RECRUITMENT OF PHYSICIANS**

**SEC. 301. DESIGNATED SCHOLARSHIPS FOR PHYSICIANS AND DENTISTS UNDER DEPARTMENT OF VETERANS AFFAIRS HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM.**

(a) Scholarships for Physicians and Dentists.—Section 7612(b) of title 38, United States Code, is amended by adding at the end the following new paragraph:

“(6)(A) Of the scholarships awarded under this subchapter, the Secretary shall ensure that not less than 50 scholarships are awarded each year to individuals who are accepted for enrollment or enrolled (as described in section 7602 of this title) in a program of education or training leading to employment as a physician or dentist until such date as the Secretary determines that the staffing shortage of physicians and dentists in the Department is less than 500.

“(B) After such date, the Secretary shall ensure that of the scholarships awarded under this subchapter, a number of scholarships is awarded each year to individuals referred to in subparagraph (A) in an amount equal to not less than ten percent of the staffing shortage of physicians and dentists in the Department.
and dentists in the Department, as determined by the Secretary.

“(C) Notwithstanding subsection (c)(1), the agreement between the Secretary and a participant in the Scholarship Program who receives a scholarship pursuant to this paragraph shall provide the following:

“(i) The Secretary’s agreement to provide the participant with a scholarship under this subchapter for a specified number (from two to four) of school years during which the participant is pursuing a course of education or training leading to employment as a physician or dentist.

“(ii) The participant’s agreement to serve as a full-time employee in the Veterans Health Administration for a period of time (hereinafter in this subchapter referred to as the ‘period of obligated service’) of 18 months for each school year or part thereof for which the participant was provided a scholarship under the Scholarship Program.

“(D) In providing scholarships pursuant to this paragraph, the Secretary may provide a preference for applicants who are veterans.

“(E) On an annual basis, the Secretary shall provide to appropriate educational institutions informational ma-
terial about the availability of scholarships under this para-
graph.”.

(b) BREACH OF AGREEMENT.—Section 7617(b) of such
title is amended—

(1) by redesignating paragraphs (4) and (5) as
paragraphs (5) and (6), respectively; and

(2) by inserting after paragraph (3) the fol-
lowing new paragraph (4):

“(4) In the case of a participant who is enrolled
in a program or education or training leading to em-
ployment as a physician, the participant fails to suc-
cessfully complete post-graduate training leading to
eligibility for board certification in a specialty.”.

(c) EXTENSION OF PROGRAM.—Section 7619 of such
title is amended by striking “December 31, 2019” and in-
serting “December 31, 2033”.

SEC. 302. ESTABLISHMENT OF DEPARTMENT OF VETERANS
AFFAIRS SPECIALTY EDUCATION LOAN RE-
PAYMENT PROGRAM.

(a) IN GENERAL.—Chapter 76 of title 38, United
States Code, is amended by inserting after subchapter VII
the following new subchapter:
“SUBCHAPTER VIII—SPECIALTY EDUCATION
LOAN REPAYMENT PROGRAM

“§ 7691. Establishment

“As part of the Educational Assistance Program, the Secretary may carry out a student loan repayment program under section 5379 of title 5. The program shall be known as the Department of Veterans Affairs Specialty Education Loan Repayment Program (in this chapter referred to as the ‘Specialty Education Loan Repayment Program’).

“§ 7692. Purpose

“The purpose of the Specialty Education Loan Repayment Program is to assist, through the establishment of an incentive program for certain individuals employed in the Veterans Health Administration, in meeting the staffing needs of the Veterans Health Administration for physicians in medical specialties for which the Secretary determines recruitment or retention of qualified personnel is difficult.

“§ 7693. Eligibility; preference; covered costs

“(a) ELIGIBILITY.—An individual is eligible to participate in the Specialty Education Loan Repayment Program if the individual—

“(1) is hired under section 7401 of this title to work in an occupation described in section 7692 of this title;
“(2) owes any amount of principal or interest under a loan, the proceeds of which were used by or on behalf of that individual to pay costs relating to a course of education or training which led to a degree that qualified the individual for the position referred to in paragraph (1); and

“(3) is—

“(A) recently graduated from an accredited medical or osteopathic school and matched to an accredited residency program in a medical specialty described in section 7692 of this title; or

“(B) a physician in training in a medical specialty described in section 7692 of this title with more than two years remaining in such training.

“(b) PREFERENCE FOR VETERANS.—In selecting individuals for participation in the Specialty Education Loan Repayment Program under this subchapter, the Secretary may give preference to veterans.

“(c) COVERED COSTS.—For purposes of subsection (a)(2), costs relating to a course of education or training include—

“(1) tuition expenses;
“(2) all other reasonable educational expenses, including expenses for fees, books, equipment, and laboratory expenses; and

“(3) reasonable living expenses.

§ 7694. Specialty education loan repayment

“(a) In general.—Payments under the Specialty Education Loan Repayment Program shall consist of payments for the principal and interest on loans described in section 7682(a)(2) of this title for individuals selected to participate in the Program to the holders of such loans.

“(b) Frequency of payment.—The Secretary shall make payments for any given participant in the Specialty Education Loan Repayment Program on a schedule determined appropriate by the Secretary.

“(c) Maximum amount; waiver.—(1) The amount of payments made for a participant under the Specialty Education Loan Repayment Program may not exceed $160,000 over a total of four years of participation in the Program, of which not more than $40,000 of such payments may be made in each year of participation in the Program.

“(2)(A) The Secretary may waive the limitations under paragraph (1) in the case of a participant described in subparagraph (B). In the case of such a waiver, the total amount of payments payable to or for that participant is
the total amount of the principal and the interest on the  
participant’s loans referred to in subsection (a).  

“(B) A participant described in this subparagraph is  
a participant in the Program who the Secretary determines  
serves in a position for which there is a shortage of qualified  
employees by reason of either the location or the require-  
ments of the position.

“§ 7695. Choice of location  

“Each participant in the Specialty Education Loan  
Repayment Program who completes residency may select,  
from a list of medical facilities of the Veterans Health Ad-
ministration provided by the Secretary, at which such facil-
ity the participant will work in a medical specialty de-
scribed in section 7692 of this title.

“§ 7696. Term of obligated service  

“(a) IN GENERAL.—In addition to any requirements  
under section 5379(c) of title 5, a participant in the Spe-
cialty Education Loan Repayment Program must agree, in  
writing and before the Secretary may make any payment  
to or for the participant, to—  

“(1) obtain a license to practice medicine in a  
State;  

“(2) successfully complete post-graduate training  
leading to eligibility for board certification in a spe-


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“(3) serve as a full-time clinical practice employee of the Veterans Health Administration for 12 months for every $40,000 in such benefits that the employee receives, but in no case for fewer than 24 months; and

“(4) except as provided in subsection (b), to begin such service as a full-time practice employee by not later than 60 days after completing a residency.

“(b) FELLOWSHIP.—In the case of a participant who receives an accredited fellowship in a medical specialty other than a medical specialty described in section 7692 of this title, the Secretary, on written request of the participant, may delay the term of obligated service under subsection (a) for the participant until after the participant completes the fellowship, but in no case later than 60 days after completion of such fellowship.

“(c) PENALTY.—(1) An employee who does not complete a period of obligated service under this section shall owe the Federal Government an amount determined in accordance with the following formula: \[ A = B \times \left( \frac{(T - S)}{T} \right) \].

“(2) In the formula in paragraph (1):

“(A) ‘A’ is the amount the employee owes the Federal Government.
“(B) ‘B’ is the sum of all payments to or for the participant under the Specialty Education Loan Repayment Program.

“(C) ‘T’ is the number of months in the period of obligated service of the employee.

“(D) ‘S’ is the number of whole months of such period of obligated service served by the employee.

“§ 7697. Relationship to Educational Assistance Program

“Assistance under the Specialty Education Loan Repayment Program may be in addition to other assistance available to individuals under the Educational Assistance Program.”.

(b) Conforming and Technical Amendments.—

(1) Conforming Amendments.—

(A) Section 7601(a) of title 38, United States Code, is amended—

(i) in paragraph (4), by striking “and”;

(ii) in paragraph (5), by striking the period and inserting “; and”; and

(iii) by adding at the end the following new paragraph:
“(6) the specialty education loan repayment program provided for in subchapter VIII of this chapter.”.

(B) Section 7603(a)(1) of title 38, United States Code, is amended by striking “or VI” and inserting “VI, or VIII”.

(C) Section 7604 of title 38, United States Code, is amended by striking “or VI” each place it appears and inserting “VI, or VIII”.

(D) Section 7631 of title 38, United States Code, is amended—

(i) in subsection (a)(1)—

(I) by striking “and” after “scholarship amount,”; and

(II) by inserting “, and the maximum specialty education loan repayment amount” after “reduction payments amount”; and

(ii) in subsection (b) by adding at the end the following new paragraph:

“(7) The term ‘specialty education loan repayment amount’ means the maximum amount of specialty education loan repayment payments payable to or for a participant in the Department of Veterans Affairs Specialty Education Loan Repayment Program under subchapter VIII of
this chapter, as specified in section 7694(c)(1) of this title and as previously adjusted (if at all) in accordance with this section.”.

(E) Section 7632 of title 38, United States Code, is amended—

(i) in paragraph (1), by striking “and the Education Debt Reduction Program” and inserting “the Education Debt Reduction Program, and the Specialty Education Loan Repayment Program”; and

(ii) in paragraph (4), by striking “and per participant in the Education Debt Reduction Program” and inserting “per participant in the Education Debt Reduction Program, and per participant in the Specialty Education Loan Repayment Program”.

(2) TABLE OF SECTIONS.—The table of sections at the beginning of chapter 76 of such title is amended by inserting after the items relating to subchapter VII the following:

“SUBCHAPTER VIII—SPECIALTY EDUCATION LOAN REPAYMENT PROGRAM

“7691. Establishment.
“7692. Purpose.
“7693. Eligibility; preference; covered costs.
“7694. Specialty education loan repayment.
“7695. Choice of location.
“7696. Term of obligated service.
“7697. Relationship to Educational Assistance Program.”.
(c) Needs of the VHA.—In making determinations each year under section 7692 of title 38, United States Code, as enacted by subsection (a), the Secretary of Veterans Affairs shall consider the anticipated needs of the Veterans Health Administration during the period two to six years in the future.

(d) Offer Deadline.—In the case of an applicant who applies before receiving a residency match and whom the Secretary of Veterans Affairs selects for participation in the Specialty Education Loan Repayment Program established by subsection (a), the Secretary shall offer participation to the applicant not later than 28 days after—

(1) the applicant matches with a residency in a medical specialty described in section 7692 of title 38, United States Code, as enacted by subsection (a); and

(2) such match is published.

(e) Publicity.—The Secretary of Veterans Affairs shall take such steps as the Secretary determines are appropriate to publicize the Specialty Education Loan Repayment Program established under subchapter VIII of chapter 76 of title 38, United States Code, as enacted by subsection (a).
SEC. 303. VETERANS HEALING VETERANS MEDICAL ACCESS
AND SCHOLARSHIP PROGRAM.

(a) Establishment.—The Secretary of Veterans Affairs, acting through the Office of Academic Affiliations of the Department of Veterans Affairs, shall carry out a pilot program under which the Secretary shall provide funding for the medical education of a total of 18 eligible veterans. Such funding shall be provided for two veterans enrolled in each covered medical schools in accordance with this section.

(b) Eligible Veterans.—To be eligible to receive funding for medical education under this section, a veteran shall—

(1) have been discharged from the Armed Forces not more than ten years before the date of application for admission to a covered medical school;

(2) not be entitled to educational assistance under chapter 30, 31, 32, 33, 34, or 35 of title 38, United States Code, or chapter 1606 or 1607 of title 10, United States Code;

(3) apply for admission to a covered medical school for the entering class of 2019;

(4) indicate on such application for admission that the veteran would like to be considered for an award of funding under this section;
(5) meet the minimum admissions criteria for
the covered medical school to which the veteran ap-
plies; and

(6) enter into an agreement described in sub-
section (e).

(c) AWARD OF FUNDING.—

(1) IN GENERAL.—Each covered medical school
that opts to participate in the program under this
section shall reserve two seats in the entering class of
2019 for eligible veterans who receive funding under
such program. Such funding shall be awarded to the
two eligible veterans with the highest admissions
rankings for such class at such school.

(2) AMOUNT OF FUNDING.—Each eligible veteran
who receives funding under this section shall receive
an amount equal to the actual cost of—

(A) tuition at the covered medical school at
which the veteran enrolls for four years;

(B) books, fees, and technical equipment;

(C) fees associated with the National Resi-
dency Match Program;

(D) two away rotations performed during
the fourth year at a Department of Veterans Af-
fairs medical facility; and
(E) a monthly stipend for the four-year period during which the veteran is enrolled in medical school in an amount to be determined by the Secretary.

(3) DISTRIBUTION OF FUNDING.—In the event that two or more eligible veterans do not apply for admission at one of the covered medical schools for the entering class of 2019, the Secretary shall distribute the available funding to eligible veterans who applied for admission at other covered medical schools.

(d) AGREEMENT.—

(1) TERMS OF AGREEMENT.—Each eligible veteran who accepts funding for medical education under this section shall enter into an agreement with the Secretary that provides that the veteran agrees—

(A) to maintain enrollment and attendance in the medical school;

(B) while enrolled in such medical school, to maintain an acceptable level of academic standing (as determined by the medical school under regulations prescribed by the Secretary);

(C) to complete post-graduate training leading to eligibility for board certification in a specialty applicable to the Department of Veterans Affairs, as determined by the Secretary;
(D) after completion of medical school, to
obtain a license to practice medicine in a State;
and

(E) after completion of medical school and
post-graduate training, to serve as a full-time
clinical practice employee in the Veterans Health
Administration for a period of four years.

(2) Breach of Agreement.—If an eligible vet-
eran who accepts funding under this section breaches
the terms of the agreement described in paragraph
(1), the United States shall be entitled to recover
damages in an amount equal to the total amount of
such funding received by the veteran.

(e) Rule of Construction.—Nothing in this section
shall be construed to prevent any covered medical school
from accepting more than two eligible veterans for the enter-
ing class of 2019.

(f) Report to Congress.—Not later than December
31, 2020, and annually thereafter for the subsequent three
years, the Secretary shall submit to Congress a report on
the pilot program under this section. Such report shall in-
clude the evaluation of the Secretary of the success of the
pilot program, including the number of veterans who re-
ceived funding under the program who matriculated and
an evaluation of the academic progress of such veterans.
(g) COVERED MEDICAL SCHOOLS.—In this section, the term “covered medical school” means any of the following.

(1) The Teague-Cranston medical schools, consisting of—

(A) Texas A&M College of Medicine;

(B) Quillen College of Medicine at East Tennessee State University;

(C) Boonshoft School of Medicine at Wright State University;

(D) Joan C. Edwards School of Medicine at Marshall University; and

(E) University of South Carolina School of Medicine.

(2) Charles R Drew University of Medicine and Science.

(3) Howard University College of Medicine.

(4) Meharry Medical College.

(5) Morehouse School of Medicine.
A BILL

[H. R. 4242]

To amend title 38, United States Code, to establish VA Care in the Community Program, and for other purposes.

March 5, 2018

Reported with an amendment, commended to the Committee of the Whole House on the State of the Union, and ordered to be printed.