

VA CARE IN THE COMMUNITY ACT

MARCH 5, 2018.—Committed to the Committee of the Whole House on the State of
the Union and ordered to be printed

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

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 4242]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 4242) to amend title 38, United States Code, to establish a permanent VA Care in the Community Program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. 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 certain 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 Affairs 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 AF-
FAIRS 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 determines 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 facilities 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 determination 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 Medicare 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 Federal 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 Secretary 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 subparagraph (A).

“(e) PROMPT PAYMENT STANDARD.—(1) The Secretary 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 subsection, regardless of whether such claims are—

“(A) made by a network provider to the Secretary;

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

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

“(2) A covered claimant that seeks payment for hospital care, medical services, or extended care services furnished 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 provider, 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 network operated by a contractor, 180 days after the date on which the contractor pays the network provider 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 before 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 electronic 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 Department, or successor system, for the purpose of furnishing 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 pharmaceutical agents on the formulary of the Department to pharmacies of the Department in a manner that is substantially 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 payment 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 sections at the beginning of chapter 17 of such title is amended by inserting after the item relating to section 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 Representatives 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 provider 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 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.

“(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 Secretary for purposes of such section.

“(12) The term ‘VA Care in the Community Program’ 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 furnishes 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 services, 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.
- “(C) Procedures for assessing eligible providers based on the risk of fraud, waste, and abuse of such providers similar to the level of screening under section 1866(j)(2)(B) of the Social Security Act (42 U.S.C. 1395(j)(2)(B)) and the standards set forth under section 9.104 of title 48, Code of Federal Regulations, or any successor regulation.
- “(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. 1320a–7b(f))) 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 Management, or any successor system.
- “(E) Procedures by which a provider whose certification is denied or revoked under the procedures established under this subsection will be identified as an excluded source on the list maintained in the System for Award Management, or successor system, if the Secretary determines that such exclusion is appropriate.
- “(2) To the extent practicable, the Secretary shall establish the procedures under paragraph (1) in a manner that takes into account any certification process administered by another department or agency of the Federal Government 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 excluded 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 striking “a contract (or agreement under section 1720(c)(1) of this title)” and inserting “an agreement”.

(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 entered 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 prescribed 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 providers 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 person 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 agreement 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 interchanges.

(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 implemented in compliance with all applicable laws, regulations and Federal Government standards regarding information security, privacy, and accessibility.

(2) Such system shall provide for the elicitation, analysis, and prioritization of functional and nonfunctional information security and privacy requirements for such system, including security and privacy services and architectural requirements relating to security and privacy based on a thorough risk assessment of all reasonably anticipated cyber and noncyber threats to the security and privacy of electronic protected health information made available through such interface.

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

(4) Such system shall provide assurance that the prioritized information security and privacy requirements 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-Depart-

ment 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”.

(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)”; and

(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 subsection (a) shall take effect on the date of the enactment of this Act and shall apply with respect to ambulance services 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 provider 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 facility 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 models; and

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

“(d) DEFINITIONS.—In this section:

“(1) The term ‘Department provider’ means an employee of the Department whose primary responsibilities include furnishing hospital care or medical services, including a physician, a dentist, an optometrist, a podiatrist, a chiropractor, an advanced practice registered nurse, and a physician’s assistant acting 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 administering programs that provide care in the community to veterans under the laws administered by the Secretary specifically grant the authority set forth in paragraph (1) to such third parties and to the directors described in that paragraph, as the case may be.

(e) DENIAL OR REVOCATION OF ELIGIBILITY OF NON-DEPARTMENT PROVIDERS.—The Secretary shall deny or revoke the eligibility of a non-Department health care provider to provide health care to veterans under the laws administered 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 regarding health care furnished by the Department of Veterans 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 facility 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 appropriations 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 appropriation is expected to meet the needs of the Department and certification that the request was made using an updated 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 Department 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 following:

(1) A statement of assurance that financial projections included in such budget or the supporting materials submitted along with such budget for the Department of Veterans Affairs are sufficient to provide 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 officers of the facilities and components of the Department to be confident in such financial projections.

SEC. 210. AUTHORITY FOR DEPARTMENT OF VETERANS AFFAIRS 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 expenditures 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 den-

tist 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, 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 material about the availability of scholarships under this paragraph.”

(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 following new paragraph (4):

“(4) In the case of a participant who is enrolled in a program or education or training leading to employment as a physician, the participant fails to successfully 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 inserting “December 31, 2033”.

SEC. 302. ESTABLISHMENT OF DEPARTMENT OF VETERANS AFFAIRS SPECIALTY EDUCATION LOAN REPAYMENT 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 requirements 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 Administration provided by the Secretary, at which such facility the participant will work in a medical specialty described 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 Specialty 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 specialty;

“(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: $A=B \times ((T-S) \div T)$.

“(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 applies; and
- (6) enter into an agreement described in subsection (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 Residency Match Program;
- (D) two away rotations performed during the fourth year at a Department of Veterans Affairs 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 speciality 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 veteran 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 entering 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 include the evaluation of the Secretary of the success of the pilot program, including the number of veterans who received 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.

PURPOSE AND SUMMARY

H.R. 4242, as amended, the “VA Care in the Community Act,” would improve the provision of care and services to veterans through Department of Veterans Affairs (VA) medical facilities and through VA providers in the community. Representative David P. Roe of Tennessee, the Chairman of the Committee on Veterans’ Affairs, introduced H.R. 4242 on November 3, 2017.

BACKGROUND AND NEED FOR LEGISLATION

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

VA operates the largest integrated health care system in the country and provides care to approximately nine million veteran patients.¹ The majority of the health care that veterans receive through VA is provided by VA-employed medical professionals and support staff at VA medical facilities, which are managed by the Veterans Health Administration (VHA).² However, since 1945, VA has also collaborated with medical professionals and support staff in the community who are not VA employees to provide veterans with timely, accessible, high-quality care.³ This is generally referred to as “community care” though has previously been referred to as “non-VA care,” “fee basis care,” or “purchased care.” Over time, Congress has authorized VA to use community care when a needed clinical service cannot be provided by a VA facility and the veteran cannot be transferred to another VA facility, when VA cannot recruit a needed clinician, when a veteran cannot access a VA facility due to geographic inaccessibility, when there is an emergent situation in which a delay in care in order to travel to a VA facility could be considered life-threatening, and in order to meet patient wait time standards.

The most recent VA community care authority is the Choice program (Choice). Choice was established by the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 128 STAT. 1754). Choice expanded the availability of community care to veteran patients by setting specific triggers that would require VA to give veterans the option of receiving care in the community rather than in a VA medical facility. In general, veterans are eligible to receive care through Choice if they are unable to secure an appointment at a VA medical facility within 30 days or if they reside more than 40 miles from the nearest VA medical facility. Through Choice, veteran patients are referred to regional networks

¹ *About VHA*. Veterans Health Administration. <https://www.va.gov/health/aboutVHA.asp>. Accessed November 14, 2017.

² United States Cong. House Committee on Veterans’ Affairs. “*The State of VA’s Fiscal Year 2015 Budget*” June 25, 2015. 114th Cong. 1st sess. Washington: GPO, 2015 (statement of the Honorable Sloan Gibson, Deputy Secretary of Veterans Affairs).

³ January 11, 2017, MyVA Advisory Committee Meeting, Georgetown University, Washington, D.C.

of community providers who are managed by Third Party Administrators. However, under other community care programs, VA refers veteran patients to community providers through agreements with the Indian Health Service, the Department of Defense, or academic affiliates; through the Patient Centered Community Care program; or through national or local contracts or sharing agreements.⁴

Each of VA's current community care programs and authorities contain different eligibility criteria, reimbursement rates, payment structures, referral and authorization requirements, and contracting approaches.⁵ According to VA, "this has resulted in a complex and confusing landscape for veterans, community providers, and [the] VA employees that serve and support them."⁶ As a result, "veterans face excessive bureaucracy, access based on administrative eligibility, and minimal care coordination [which] inhibits the delivery of high-quality personalized care."⁷ This led VA and the Committee to conclude that, "it is imperative for VA to modernize how care is provided through a high performing integrated network which includes care provided both in VA and in the community."⁸

That imperative has been exacerbated by a significant increase in veteran demand for community care in recent years. Since the establishment of Choice in fiscal year 2014, community care appointments have increased by 61 percent overall and by 41 percent as a percentage of total VA appointments.⁹ In fiscal year 2016, 31 percent of all completed appointments across the VA health care system were held in the community.¹⁰ However, Choice represents a relatively small portion of the overall community care landscape, accounting for just 23 percent of all community care appointments in fiscal year 2016.¹¹

Despite the increased demand for and utilization of community care, VA has struggled to effectively administer community care programs and veterans do not always receive timely care when utilizing community care. For many years, the VA Inspector General has documented substantial problems with VA's management of community care programs, including issues authorizing and scheduling appointments, managing consults, ensuring network adequacy, and promptly paying community providers.¹² The IG concluded that, "our audits, reviews, and inspections have highlighted that VA has had a history of challenges in administering its purchased care programs. Veteran's access to care, proper expenditure

⁴United States Cong. House Committee on Veterans' Affairs. "*The State of VA's Fiscal Year 2015 Budget*" June 25, 2015. 114th Cong. 1st sess. Washington: GPO, 2015 (statement of the Honorable Sloan Gibson, Deputy Secretary of Veterans Affairs).

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

⁶May 24, 2017. U.S. Department of Veterans Affairs Fact Sheet. "A Consolidated and Modernized VA Community Care Program."

⁷Ibid.

⁸Ibid.

⁹January 11, 2017, MyVA Advisory Committee Meeting, Georgetown University, Washington, D.C.

¹⁰United States Cong. House Committee on Veterans' Affairs. "*The State of VA's Fiscal Year 2015 Budget*" June 25, 2015. 114th Cong. 1st sess. Washington: GPO, 2015 (statement of the Honorable Sloan Gibson, Deputy Secretary of Veterans Affairs).

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

¹²United States Cong. House Committee on Veterans' Affairs. "*Shaping the Future: Consolidating and Improving VA Community Care*" March 7, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement of the Honorable Michael Missal, Inspector General, U.S. Department of Veterans Affairs).

of funds, timely payment of providers, and continuity of care are at risk to the extent that VA lacked adequate processes to manage funds and oversee program execution.”¹³ The Government Accountability Office (GAO) has found similar problems with community care programs. Most recently, in March 2017, GAO found that veterans who were referred to Choice for routine care because such care was not available through a VA medical facility in a timely manner could potentially wait up to 81 calendar days to obtain Choice care.¹⁴ GAO also found that VA had failed to establish standardized processes and procedures for Choice, to issue program guidance, and to track or monitor how long it took VA medical centers to refer a veteran to Choice (a process which GAO found was duplicative and could take as long as 21 days).¹⁵

The Committee concurs with the IG and GAO regarding the long history of challenges with regard to VA community care programs. The Committee also concurs with VA’s assessment about the need to consolidate VA’s multiple community care programs and authorities in order to create a more seamless network of care in VA medical facilities and in the community to better serve veterans and achieve improved health outcomes, patient satisfaction, care coordination, and efficiency.¹⁶ Accordingly, Title I of the bill would establish a permanent VA Care in the Community Program (the Program) to provide hospital care, medical services, and extended care to veteran patients through contracts or agreements with network providers. In this program, VA would be required to establish regional networks of community providers and to coordinate the care veterans receive through network providers as well as provide case management, where appropriate. A veteran would be eligible to receive primary care through the Program if VA is unable to assign that veteran to a primary care provider in a VA medical facility and would be eligible to receive specialty care through the Program if that veteran is referred by his/her primary care provider. In determining whether or not to provide specialty care to a veteran in a VA medical facility rather than through the Program, VA would be required to consider whether the VA medical facility is within a reasonable distance of the veteran’s residence and to take into account any unusual or excessive travel burdens and geographical or environmental challenges the veteran may face, the veteran’s medical condition, and the recommendation of the veteran’s primary care provider. Once a veteran is referred to a community provider through the Program, VA would be required to ensure that the veteran receives care through the completion of an episode of care including specialty and ancillary services and to ensure appropriate medical documentation of such care is returned to VA. VA would be required to establish a process to review disagreements regarding the eligibility of a veteran to receive care or services from a community provider using the Program. Under the Program, community providers would be reimbursed in accordance with Medi-

¹³ Ibid.

¹⁴ United States Cong. House Committee on Veterans’ Affairs. “*Shaping the Future: Consolidating and Improving VA Community Care*” March 7, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement of Randall B. Williamson, Director, Health Care, Government Accountability Office).

¹⁵ Ibid.

¹⁶ May 24, 2017. U.S. Department of Veterans Affairs Fact Sheet. “A Consolidated and Modernized VA Community Care Program.”

care rates with certain exceptions allowed for, for example, highly rural areas, Alaska, states with all-payer models, and federal or tribal entities. In addition, VA would be authorized to enter into value-based reimbursement models. To ensure the care veterans receive through the Program is high quality, VA would be required to develop quality standards to track the quality of network providers.

Title I of the bill would require the Program to be funded out of the Community Care account established by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (Public Law 114–41; 129 STAT. 443) and stipulate that remaining funds, if any, in the Veterans Choice Fund established by the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 128 STAT. 1754) to be transferred to the Community Care account one year after enactment. Importantly, it would also terminate VA’s existing care in the community programs and authorities upon commencement of the Program, which would occur no later than one year after enactment via interim final regulations after VA has certified to Congress that each community care provider and VA employee is trained to furnish care under the Program and has established standard, written guidance with respect to the policies and procedures of the Program.

The Committee strongly believes that VA’s ability to accurately process timely payments to community provider providers in compliance with the prompt payment rule is critical to the Program’s success and to ensuring access to community care for the increasing number of veterans who rely on it. However, in 2014, GAO issued a report which found that community providers experienced “lengthy delays” in the processing of their claims that, in some cases, took years to resolve.¹⁷ According to GAO, this resulted in an environment where community providers are hesitant to provide care to veterans due to fears they will not be paid for services provided on VA’s behalf.¹⁸ These findings were echoed in testimony GAO provided in 2016, which stated that “the substantial increase in utilization of VA care in the community programs poses challenges for VHA, which has had ongoing difficulty processing claims from community providers in a timely manner.”¹⁹ As such, Title I of the bill would also establish a prompt payment standard in which claims are required to be submitted 180 days after care is provided (or a network provider is paid by a contractor) and clean paper claims are either paid or denied within 45 days of receipt and clean electronic claims are either paid or denied within 30 days of receipt. If a claim is denied and additional information has been submitted, adjudication would be required within 30 days of receipt. Pursuant to this authority, VA would be required to pay interest payments for overdue claims, allow for the recovery of overpayments through deductions of future payments or refunds from the claimant, and prohibited from requiring receipt of medical records as a requisite for payment. Title I of the bill would also re-

¹⁷ GAO–14–175, *Actions Needed to Improve Administration and Oversight of Veterans’ Millennium Act Emergency Care Benefit*. <http://www.gao.gov/assets/670/661404.pdf>.

¹⁸ *Ibid.*

¹⁹ United States Cong. House Committee on Veterans’ Affairs, Subcommittee on Health. *Choice Consolidation: Improving VA Community Care Billing and Reimbursement* February 11, 2016. 114th Cong. 2nd sess. Washington: GPO, 2016 (statement of Randall B. Williamson, Director, Health Care, U.S. Government Accountability Office).

quire VA to establish a Center for Innovation to test and develop innovative pilot models for payment and service delivery for community care. The Committee believes this could potentially reduce expenditures while preserving or enhancing the quality of care furnished by VA.

The Committee recognizes that, in certain cases, veterans may require community care outside of the Program. In general, VA's community care authorities utilize traditional Federal Acquisition Regulation (FAR)-based contracts to do business with private providers. However, the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 128 STAT. 1754) granted VA the authority to purchase community care through non-FAR based provider agreements. This was in recognition of the difficult and sometimes burdensome processes and requirements that the FAR imposes on community providers who are small or unaccustomed to federal contracting. VA has requested legislative authority to enter into non FAR-based provider agreements since 2015.²⁰ In particular, some community providers have cited their classification as federal contractors subject to the audit and reporting requirements of the Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) as especially onerous. VA has claimed that provider agreement authority would “. . . ensure that veterans receive the necessary care they earned through the fullest complement of non-VA providers” and, the absence of such authority, “has resulted in complications with extended care providers and other [non-Choice providers as] some small, long-term care facilities have already withdrawn their support of veterans due to the overwhelming administrative requirements of the FAR.”²¹ The American Health Care Association concurs and has testified about the “onerous reporting requirements and regulations” that have “dissuaded nursing care centers from admitting VA patients” which “limits the care available to veterans needing long term care in their local communities.”²² This has created an acute need in some areas, particularly for those veterans who live in rural areas where VA facilities are far away and community providers are scarce. Title I of the bill would authorize VA to enter into provider agreements to deliver care to veteran patients when furnishing such care at VA facilities is impractical or inadvisable for a particular veteran and such care is not available from a community provider under a traditional FAR-based contract or sharing agreement. This provider agreement authority would be limited to not more than \$5 million for community providers furnishing homemaker or home health aide services and to not more than \$2 million for other community providers. VA would be required to establish a process to certify eligible providers and ensure they meet certain terms, conditions, and quality standards. Importantly, Title I of the bill would stipulate that provider agreements under this authority are not subject to competitive procedures and are exempted from any provision of law that Medicare providers are exempted from but are sub-

²⁰January 2, 2017. U.S. Department of Veterans Affairs, The Honorable Secretary Robert McDonald. “Caring for Those Who Have Borne the Battle: Cabinet Exit Memo.” <https://www.va.gov/opa/publications/docs/VA-Exit-Memo.pdf>.

²¹Ibid.

²²United States Cong. House Committee on Veterans' Affairs. Legislative Hearing. October 24, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement for the record from the American Health Care Association).

ject to the Civil Rights Act of 1964. Title I of the bill would also modify VA’s authority to enter into agreements with State Veterans Homes by stipulating that such agreements are not subject to competitive procedures or laws that Medicare providers are exempt from but are subject to all laws regarding integrity, ethics, fraud, and that would protect against employment discrimination.

The Committee is committed to ensuring that the care provided through the Program supplements but does not supplant the care provided in VA medical facilities and that VA continues to provide timely, high quality care to veterans both in the community and in VA. To that end, Title I of the bill would also require VA to conduct periodic (defined as not less often than once every three years) capacity and commercial market assessments in each Veterans Integrated Service Network and VA medical facility to identify gaps in care and recommend how such gaps could be filled via changing how care is furnished and/or building or realigning VA resources or personnel.

Section 109. Transplant procedures with live donors and related services

VA has offered solid organ transplant services for eligible veteran patients since 1962 and bone marrow transplant services for eligible veteran patients since 1982.²³ Through VA’s National Transplant Program, VA provides transplants primarily through 13 VA transplant centers located in: Palo Alto, California; Portland, Oregon; Seattle, Washington; Houston, Texas; San Antonio, Texas; Salt Lake City, Utah; Iowa City, Iowa; Madison, Wisconsin; Birmingham, Alabama; Nashville, Tennessee; West Roxbury, Massachusetts; Bronx, New York; Pittsburgh, Pennsylvania; and Richmond, Virginia.²⁴

The Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 128 STAT. 1754) created the Choice program to increase access to care in the community for veteran patients unable to receive care at VA medical facilities due to long waiting times for VA appointments or lengthy travel distances to VA medical facilities. Since the implementation of the Choice program, the Committee has heard an increasing number of complaints about the VA transplant program from veterans who are concerned about the lengthy travel required for many veterans to reach a VA transplant center and barriers to receiving transplant care in the community. For example, in 2016, Charles Nelson—a 100 percent service-connected veteran from Leander, Texas—attempted to receive a kidney transplant through the VA health care system.²⁵ Mr. Nelson’s non-veteran son, Austin, was willing and able to serve as Mr. Nelson’s live donor.²⁶ Rather than travel to VA transplant centers in Nashville, Tennessee, or Portland, Oregon, to receive his kidney transplant, Mr. Nelson asked VA to authorize him to receive his transplant at the University Hospital in San Antonio via the

²³ VA National Transplant Program. <https://www.va.gov/health/services/transplant/> Accessed October 30, 2017.

²⁴ *Ibid.*

²⁵ United States Cong. House Committee on Veterans’ Affairs. Legislative Hearing. October 24, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement for the record Representative John Carter).

²⁶ *Ibid.*

Choice program.^{27 28} Though his request was approved by local VA officials in Texas, VA Central Office in Washington, D.C. denied Mr. Nelson’s request to receive his transplant through the Choice program, arguing that because Austin was not a veteran VA would be unable to use Choice funds to cover the costs of his care.²⁹ Though Choice is just one of several care in the community programs that VA could have used to cover the costs of Mr. Nelson’s transplant at the University Hospital in San Antonio, Mr. Nelson eventually received his transplant at that facility using his Medicare benefits, private donations, and personal savings to cover the cost of his care.³⁰

On June 29, 2016, the Journal of the American Medical Association published an article which found that greater distance from a VA Transplant Center was associated with a lower likelihood of receiving a transplant and a greater likelihood of death among certain veteran transplant patients.³¹ Given the article’s findings the Committee believes that veterans residing far from VA transplant centers should be given the option of receiving their transplant from transplant centers in the community closer to the veteran’s place of residence. The Committee also believes that, wherever possible, VA should remove barriers to transplant care in the community for veteran patients. Consistent with those goals, section 109 of the bill would authorize veterans to obtain a transplant outside of the region of the Organ Procurement and Transplantation Network if veteran’s primary care provider opines that there is a medically compelling reason and also authorize VA to support the cost of a donor transplant operation, including perioperative care and care performed in a non-VA facility, for a live donor who is not a veteran but who is donating an organ for a veteran.

TITLE II—OTHER ADMINISTRATIVE MATTERS

Section 201. Reimbursement for emergency ambulance services

While VA has experienced long-standing difficulties complying with prompt pay rules in general, VA has had particular challenges issuing timely reimbursement for ambulance providers. In June 2015, American Medical Response, the nation’s largest single ambulance provider, testified before the Subcommittee on Health that they have had “consistent difficulty” receiving reimbursement from VA and, despite working with VA for a year, had a payment backlog totaling approximately \$12 million.³² Section 201 of the bill would require VA to reimburse an ambulance provider or other emergency transport service for providing transportation to a veteran for purposes of receiving emergency medical care at a community facility if the request for transportation was made as a result

²⁷ Ibid.

²⁸ Fox 7, “Leander Veteran Fighting for VA to Pay for Kidney Transplant,” May 24, 2016, <http://www.fox7austin.com/news/local-news/disabled-leander-veteran-fighting-to-get-va-to-pay-for-kidney-transplant>.

²⁹ United States Cong. House Committee on Veterans’ Affairs. Legislative Hearing. October 24, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement for the record Representative John Carter).

³⁰ Ibid.

³¹ Journal of the American Medical Association, “Association of Distance from a Transplant Center with Access to Waitlist Placement, Receipt of Liver Transplantation, and Survival Among U.S. Veterans, June 29, 2016, <https://www.ncbi.nlm.nih.gov/pubmed/24668105>.

³² United States Cong. House Committee on Veterans’ Affairs. “Assessing VA’s Ability to Promptly Pay Non-VA Providers.” June 3, 2015. 114th Cong. 1st sess. Washington: GPO, 2017 (statement for the record from American Medical Response).

of the sudden onset of a medical condition of such a nature that it meets the prudent layperson standard and the veteran is transported to the most appropriate medical facility.

Section 202. Improvement of care coordination for veterans through exchange of certain medical records

Since fiscal year 2014, VA community care appointments have increased by 61 percent overall and by 41 percent as a percentage of total VA appointments.³³ In FY 2016 alone, 25.5 million appointments—or 30 percent of all VA appointments—occurred in the community rather than in VA medical facilities.³⁴ Given the dramatic increase in VA community care demand in recent years and the need to ensure that the care veterans receive both in VA medical facilities and in the community is effectively coordinated to ensure quality, the Committee believes that it is critically important for VA and community providers to be able to share pertinent medical record information about the veteran patients they are jointly treating while also ensuring appropriate protections are in place to secure patient privacy.

Accordingly, section 202 of the bill would amend section 7332 of title 38 U.S.C. to permit VA to share confidential medical information with a public or private health care provider in order to provide care or treatment to a shared patient and to a third party in order to recover (or collect) reasonable charges for care furnished to a veteran for a non-service connected disability with the stipulation that such sharing must be in accordance with relevant health record privacy laws (including HIPPA). The Committee believes this would improve the provision of care to veteran patients from both VA providers and community providers while also ensuring that personal patient information is safeguarded from inappropriate disclosure.

Section 203. Elimination of copayment offset

As a condition for receiving VA health care services, veterans with income greater than VA income thresholds must agree to pay a copayment for care VA provides that is not related to a service-connected condition.³⁵ Section 1729 of title 38 United States Code authorizes VA to bill a veteran's private (third party) health insurance reasonable charges for treatment of a veteran's non service-connected conditions and to reduce any copayment amounts such veteran would otherwise owe to VA dollar for dollar based on the collection from the private insurer.³⁶ Funds collected by VA from private insurers are deposited in the VA Medical Care Collections Fund (MCCF) and used to augment VA's medical care accounts and cover expenses incurred by VA as a result of first and third-party collections. VA estimates that approximately twenty-three percent of veterans enrolled in the VA health care system pay copayments to VA for treatment in connection with a non-service connected condition have billable private insurance plans.³⁷ According to VA, the

³³ January 11, 2017, MyVA Advisory Committee Meeting, Georgetown University, Washington, D.C.

³⁴ Ibid.

³⁵ VA Fiscal Year 2018 Budget Submission, Volume 2, VHA-347.

³⁶ Ibid.

³⁷ Ibid.

practice of reducing a veteran's copayment amounts using money from such veteran's private insurer ". . . reduces the total collections received by VA that is available for use in providing direct medical care and does not align with standard health care industry practice."³⁸ The Committee concurs with VA's assessment.

As such, section 203 of the bill would eliminate the current requirement for VA to offset a veteran's copayment with amounts recovered from the veteran's third party insurance. VA estimates that this will result in improved collections totaling approximately \$62 million.³⁹ While the Committee does not believe that eliminating the requirement for VA to offset a veterans copayment amount with collections from private insurance companies is, on its own, sufficient to incentive a veteran to abandon his/her other health insurance, the Committee intends to closely monitor how the number of veteran patients with other health insurance and MCCF collection rates are impacted by enactment of this section of the bill.

Section 204. Use of Department of Veterans Affairs Medical Care Collections Fund for certain improvements in collections

The Balanced Budget Act of 1997 (Public Law 105-33; 111 STAT. 251) established the VA MCCF and required that amounts collected or recovered after June 30, 1997, be deposited into the MCCF and used to furnish medical care and services to eligible veterans and to cover expenses incurred to collect amounts owed by first or third parties for the medical care and services furnished by VA.⁴⁰ VA's fiscal year 2018 budget submission notes that the Department has re-estimated collections in 2017 and 2018 downward due to broader healthcare payer changes that have resulted in third-party payers proposing reductions to their reimbursement levels.⁴¹ The Committee is increasingly concerned that VA is not sufficiently collecting revenue from first and third party payers. As a result, section 204 of the bill would include automatic data processing and information technology improvements as an MCCF expense allowed in the billing, auditing, and collecting of such revenues.

Section 205. Department of Veterans Affairs health care productivity improvement

The Committee believes it is important that VA achieves and maintains a high level of productivity among VA clinicians in order to maximize veteran access to care and ensure a prudent use of taxpayer dollars. However, recent analyses have called into question how well VA tracks provider productivity and how productive they are compared to their non-VA counterparts. For example, the 2015 Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs found that VA specialty providers are less productive than their private sector counterparts on two industry measures—encounters and relative value units (RVUs).⁴² RVUs are a commonly used

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ VA Fiscal Year 2018 Budget Submission, Volume 2, VHA-173.

⁴¹ VA Fiscal Year 2018 Budget Submission, Volume 2, VHA-174.

⁴² CMS Alliance to Modernize Healthcare Federally Funded Research and Development Center, September 1, 2015, "Independent Assessment of the Health Care Delivery Systems and

measure of a provider's productivity that take into account the time, technical skill, mental effort, and stress that are needed for a clinician to provide a given clinical service.⁴³ More recently, the Government Accountability Office released a report in 2017, which found that VA lacks complete and accurate information on clinical productivity and efficiency because VA's existing productivity metrics and efficiency models do not account for all providers and clinical services, may not accurately reflect the intensity of clinical workloads or staffing levels, and may be adversely impacted by inaccurate data.⁴⁴ GAO also found that VA Central Office does not systematically oversee productivity and efficiency and, thus, cannot ensure that low productivity and clinical inefficiencies are addressed at individual VA medical facilities or identify and correct patterns that could increase productivity and efficiency across the VA health care system. Accordingly, section 205 of the bill would require VA to track RVUs for all VA providers, to ensure that all VA providers attending training on clinical procedure coding, and to establish RVU-based performance standards as well as remediation plans to address low clinical productivity and inefficiency.

Section 206. Licensure of health care professionals of the Department of Veterans Affairs providing treatment via telemedicine

As a national, integrated health care system, the Veterans Health Administration (VHA) has a responsibility to ensure that veteran patients receive access to care no matter where the veteran patient is located.⁴⁵ This is a particular challenge for veteran patients residing in remote, rural, or medically underserved areas far from VA medical facilities and for veteran patients with mobility or other issues that impact their ability to travel to VA medical facilities to receive care.⁴⁶

Telemedicine refers to “the use of telehealth technologies to provide clinical care in circumstances where distance separates those receiving services and those providing services.”⁴⁷ By allowing VA clinicians to provide “the right care in the right place at the right time,” telemedicine is critical to VA's ability to deliver health care to veteran patients who could not otherwise access such care.^{48 49} According to VA, “[telemedicine] increases the accessibility of VA health care, bringing VA medical services to locations convenient for beneficiaries, including clinics in remote communities and beneficiaries’ homes.”⁵⁰ In fiscal year 2016, VA health care providers provided more than 2 million episodes of care via telemedicine to more than 700,000 veteran patients, approximately 12 percent of

Management Processes of the Department of Veterans Affairs,” https://www.va.gov/opa/choiceact/documents/assessments/Integrated_Report.pdf.

⁴³ January 12, 2015, National Health Policy Forum, “The Basics: Relative Value Units,” https://www.nhpf.org/library/the-basics/Basics_RVUs_01-12-15.pdf.

⁴⁴ GAO-17-480, May 2017, “Improvements Needed in Data and Monitoring of Clinical Productivity and Efficiency,” <https://www.gao.gov/assets/690/684869.pdf>.

⁴⁵ Authority of Health Care Providers to Practice Telehealth. <https://www.federalregister.gov/documents/2017/10/02/2017-20951/authority-of-health-care-providers-to-practice-telehealth>. Accessed October 31, 2017.

⁴⁶ *Ibid.*

⁴⁷ VA Telehealth Services. <https://www.telehealth.va.gov/> Accessed October 30, 2017.

⁴⁸ *Ibid.*

⁴⁹ Authority of Health Care Providers to Practice Telehealth. <https://www.federalregister.gov/documents/2017/10/02/2017-20951/authority-of-health-care-providers-to-practice-telehealth>. Accessed October 31, 2017.

⁵⁰ *Ibid.*

VA's total patient population.⁵¹ Veteran patients who have had experience with VA telemedicine programs have demonstrated improved health outcomes, including decreases in hospital admissions.⁵²

However, the continued expansion of telemedicine across the VA health care system is constrained by restrictions on the ability of VA providers to practice telemedicine across state lines without jeopardizing their state licensure and facing potential penalties for the unauthorized practice of medicine.⁵³ VA claims that this disparity—between VA health care practice and state medical licensure laws—has severely inhibited the provision of telemedicine in VA and, therefore, reduced the availability and accessibility of care for veteran patients.⁵⁴

In response to this, VA announced on August 3, 2017, that VA would be amending regulations to allow VA health care providers who are licensed, registered, or certified in “a state” to practice in any state when they are acting within the scope of their VA employment—regardless of individual state licensure, registration, or certification restrictions except for applicable state restrictions on the authority to prescribe and administer controlled substances.⁵⁵ VA claims that this action would serve to “authorize VA health care providers to furnish care, consistent with their employment obligations, through [telemedicine], without fear of adverse action by any state.”⁵⁶ Despite this rulemaking, VA testified during a Committee hearing that legislation was needed to “[provide] statutory protection and [codify] VA’s longstanding practice of allowing VA providers to practice in any state as long as they are licensed in a state.”⁵⁷

Therefore, section 206 of the bill would exercise preemption of state licensure, registration, and certification laws, rules, and regulations or requirements to the extent such state laws conflict with the ability of VA providers to engage in the practice of telehealth while acting within the state of their VA employment and authorize a VA licensed health care provider to practice telemedicine at any location in any state, regardless of where the provider or patient is located and whether or not the patient or provider is on federal government property. The Committee believes that the continued expansion of telemedicine across the VA healthcare system will aid veterans in receiving timely, quality care from VA and in achieving improved health outcomes. Further, the Committee concurs with the American Medical Association that providing VA healthcare providers the authority to practice telemedicine across state lines would “address the significant and unique need to expand access to health care services for veterans being treated within the VA system while also ensuring that important patient protections remain in place, including the direct oversight, accountability, training, and quality control specific to VA-employed physi-

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ *Ibid.*

⁵⁷ United States Cong. House Committee on Veterans' Affairs. *Legislative Hearing*. October 24, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from the Honorable David Shulkin M.D., Secretary of Veterans Affairs).

cians and other health care professionals.”⁵⁸ Section 206 of the bill would also require VA to submit a report to Congress on the Department’s telemedicine programs, which would allow the effectiveness of VA telemedicine to be better understood.

Section 207. Establishment of processes to ensure safe opioid prescribing practices by non-Department of Veterans Affairs health care providers

Overdose deaths involving prescriptions have quintupled since 1999. Between 1999 and 2016 more than 200,000 deaths were attributed to overdoses from prescription drugs.⁵⁹ The opioid epidemic has impacted veterans and overdose deaths among veterans remain elevated when compared to the civilian population. Due to the prevalence of chronic pain in the veteran population, many being treated with opioids, VA instituted the Opioid Safety Initiative (OSI), a program using evidence-based management guidelines, including dosing and monitoring guidelines, to treat pain and to mitigate the risks of prescription opioids.⁶⁰

Over the past several years, VA has implemented purchased care programs to enable veterans to access care by non-department providers in the community. This care includes the management of chronic pain conditions for which veterans are prescribed opioids.⁶¹ This raises the potential for inconsistencies in management between the community provider and guidelines promulgated by VA increasing risk to the veteran. Moreover, medical information may not be shared between the community provider and VA further exacerbating such risks.⁶² GAO recommended that community providers receive and review the guidelines in the OSI, that VA implement a process to share up to date veterans’ medication records with community providers, require community providers to submit opioid prescriptions to a VA pharmacy with recordation of the prescription in the VA electronic health record, and to ensure that if a community provider’s provider prescribing practices are in conflict OSI guidelines, that actions are taken to ensure the safety of the veteran.⁶³

The Committee believes that VA must take steps to ensure safe opioid prescribing practices are adhered to when a veteran is sent to the community for care. Accordingly, section 207 of the bill would require VA to provide OSI guidelines to community providers and certify that the community providers have reviewed the guidelines and to implement a process to ensure that community providers receive a veteran’s relevant history including all medications. It would further require that opioid prescriptions be filled at a VA pharmacy, or at a community pharmacy only if prior authorization has been received (with an exception for certain urgent or emergent circumstances). Section 2017 would also require that

⁵⁸ United States Cong. House Committee on Veterans’ Affairs. *Legislative Hearing*. October 24, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement for the record from the American Medical Association).

⁵⁹ Prescription Opioid Overdose Data, Centers for Disease Control and Prevention; <https://www.cdc.gov/drugoverdose/data/overdose.html>.

⁶⁰ Department of Veterans Affairs, Office of Inspector General report no. 17-01846-316, Healthcare Inspection: Opioid Prescribing to high-Risk Veterans Receiving VA Purchased Care, July 3, 2017.

⁶¹ *Ibid.*

⁶² *Ibid.*

⁶³ *Ibid.*

opioid prescriptions be recorded in the electronic health record and that community providers whose prescribing practices are inconsistent with OSI requirements or violate licensing guidelines are removed from VA community care networks.

Section 208. Assessment of health care furnished by the Department to veterans who live in territories

Veterans in Puerto Rico, the U.S. Virgin Islands, the American Samoa, Guam, and the Northern Mariana Islands face a number of barriers to timely, accessible VA care and benefits. The principle barrier these veterans face is the lack of VA care at home, which often necessitates lengthy travel to VA medical centers and clinics in other areas. In light of the unique challenges that veterans residing in these territories face accessing VA services, section 208 of the bill would require VA to report on the care provided to veterans in Puerto Rico, the U.S. Virgin Islands, the American Samoa, Guam, and the Northern Mariana Islands and include whether it would be feasible for VA to establish a medical facility in any territory that does not contain such a facility.

Section 209. Oversight and accountability of financial processes of Department of Veterans Affairs

Since Choice was established in 2014, VA has returned to Congress several times seeking additional, “emergency” appropriations to keep the program operational in the face of funding shortfalls. Most recently, on December 12, 2017, Secretary Shulkin predicted without additional funding by the end of the year, veterans would see a “dramatic impact” on their overall healthcare.⁶⁴ The Committee contends that these repeated requests for additional appropriations are outside the scope what would typically constitute an “emergency” designation and believe VA must improve its community care accounting, bringing all projections for care purchased from the community back into the standard budget request process. Section 209 of the bill would require VA to submit a justification to any request for supplemental appropriations, based upon sound actuarial analysis. It would require VA’s Chief Financial Officer to certify the sufficiency, to the extent possible, of VA’s annual budget submission to provide benefits and health services to veterans, as required by law.

Sec. 210. Authority for Department of Veterans Affairs Center for Innovation for Care and Payment

As a nationwide system, VA has struggled to maximize efficiency of payment and care in its clinics and hospitals. Some areas have seen improvement, while others have fallen behind. Section 210 of the bill would address this by amending subchapter I of chapter 17, as amended by section 122, by authorizing a “Center for Innovation for Care and Payment.” Through this center, the Secretary could carry out pilot programs to develop innovative approaches to testing payment and service delivery models to reduce expenditures while preserving or improving the quality of care. The programs

⁶⁴ December 12, 2017. Letter from the Honorable David J. Shulkin M.D., Secretary of the U.S. Department of Veterans Affairs to the Honorable David P. Roe, Chairman of the Committee on Veterans’ Affairs of the U.S. House of Representatives. <https://veterans.house.gov/uploadedfiles/roe.pdf>.

could be carried out in locations appropriate for the intended purpose of the programs, and no pilot shall last longer than five years. The Secretary would be required to obtain advice from the VA special Medical Advisory Group in the development and implementation of any pilot. In implementing the pilot programs, the Secretary would be authorized to waive any requirements under Title 38 only after submitting a report to Congress explaining the authorities to be waived and the reasons for such requirement. The Secretary would only be allowed to act upon any such waiver after Congress enacts a bill or joint resolution approving the action. The Secretary would be required to conduct an evaluation of each model tested and make such information public.

TITLE III—IMPROVEMENTS TO RECRUITMENT OF PHYSICIANS

Section 301—Designated scholarships for physicians and dentists under Department of Veterans Affairs Health Professional Scholarship Program

VA currently has several programs to address recruiting in its professional ranks. These programs include the Education Debt Repayment Program (EDRP) and the Health Professions Scholarship Program (HPSP). Physician remains the top position in VA's mission critical positions shortage despite these programs, with VA indicating a need to hire more than one thousand additional physicians in fiscal year 2017.⁶⁵ VA's considerable recruitment and retention issues are worsened by an aging workforce that is becoming increasingly retirement-eligible.⁶⁶

To help alleviate the shortage of physicians and increases the number of young physicians working at VA, section 301 would provide scholarships to medical students in exchange for service to VA. A minimum of two to four year scholarships for medical and dental students would be required so long as the shortage of those positions exceed 500. Once the number falls below 500, the minimum number of scholarships provided annually would be at least ten percent of the number of positions deemed in shortage. The obligation requirement for the scholarship is successful completion of residency training leading to board eligibility in a specialty and 18 months of clinical service at a VA facility for each year of scholarship support. Section 301 would also authorize VA to provide preference to veterans and require VA to conduct annual advertising to educational institutions.

Section 302—Establishment of Department of Veterans Affairs Specialty Education Loan Re-payment Program

The average medical education debt is approximately \$192,000 for a 2017 graduate.⁶⁷ VA's current loan repayment program is offered just before a resident completes training or has completed training in exchange for service at a VA facility. The Veterans Integrated Service Network (VISN) determines how much EDRP funds

⁶⁵ United States Cong. House Committee on Veterans' Affairs. Oversight Hearing. March 22, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (Question for the Record response from the U.S. Department of Veterans Affairs.)

⁶⁶ United States Cong. House Committee on Veterans' Affairs. Legislative Hearing. March 16, 2016. 114th Cong. 2nd sess. Washington: GPO, 2016. (Testimony from the Partnership for Public Service.)

⁶⁷ AAMC Medical School Graduation Questionnaire. <https://www.aamc.org/download/481784/data/2017gallschoolssummaryreport.pdf>.

are allotted to each facility and each facility director is authorized to offer up to \$24,000 annually in exchange for service. The timing of the offer presents potential obstacles as VA is competing with other professional and financial opportunities for physicians. The salaries offered by other practices are competitive with VA, and the anticipated salary is high enough so that the burden of a loan payment may not appear onerous.⁶⁸ Moreover, because of VHA human resource policies for hiring physicians, for example, firm offers cannot be made until physical examinations and credentialing are completed, the earliest of which are 120 days prior to starting a position, many senior resident physicians are offered positions earlier than VA⁶⁹ thus obviating the ability to present the EDRP to potential hires. Lastly, the EDRP program is effectuated at the local level based on local needs, therefore does not have a mechanism for VA to direct funds to recognized needed specialties on a national level.

Section 302 would establish a new loan repayment program for medical or osteopathic student educational loans for newly graduated medical students, or residents with at least 2 years of training remaining, who are training in specialties deemed by VA to be experiencing a shortage. The loan repayment would be \$40,000 per year for a maximum of \$160,000. In exchange for the loan repayment, the recipient would agree to obtain a license to practice medicine, complete training leading to board eligibility in a specialty, and to serve in clinical practice at a VA facility for a period of 12 months for each \$40,000 of loan repayment with a minimum of 24 months of obligated service. Because resident salaries are much lower than salaries for fully trained clinicians, this would make the loan repayment is more economically meaningful and allow VA to fund specialty positions in shortage areas, develop a predictable future physician workforce, and ensure a cadre of young physicians are able to join VA's physician workforce.

Section 303—Veterans Healing Veterans Medical Access and Scholarship Program

In order to assist VA in recruiting veteran physicians, section 303 would establish a pilot program for supporting four years of medical school education costs for two veterans at each of the five Teague-Cranston Schools and the four traditional black medical schools. The covered medical schools would include Texas A&M College of Medicine, Quillen College of Medicine at East Tennessee State University, Boonshoft School of Medicine at Wright State University, Edwards School Medicine at Marshall University, the University of South Carolina School of Medicine, Drew University of Medicine and Science, Howard University of Medicine, Meharry Medical College, and Morehouse School of Medicine. The medical schools that opt to participate in the program would be required to reserve two seats each in the class of 2019. Eligible veteran scholarship recipients would be those within ten years of military discharge who are not eligible for GI Bill benefits but who meet the minimum admission requirement for medical school and apply for

⁶⁸ Medscape Physician Compensation Report 2917. <https://www.medscape.com/slideshow/compensation-2017-overview-6008547#4>.

⁶⁹ Darves, B, *Physician Job-Search Timeline: Delayed Approach Not Advised*; The New England Journal of Medicine, October 8, 2014.

the entering class of 2019. The scholarship recipients would agree to successfully complete medical school, obtain a license to practice medicine, complete post-graduate training leading to board eligibility in a specialty applicable to VA, and after training, serve in clinical practice at a VA facility for four years.

HEARINGS

There were no Subcommittee hearings held on H.R. 4242, as amended.

On October 24, 2017, the full Committee conducted a legislative hearing on a number of bills including a draft bill that was later introduced as H.R. 4242.

The following witnesses testified:

The Honorable Jim Banks, U.S. House of Representatives, 3rd District, Indiana; The Honorable Mike Gallagher, U.S. House of Representatives, 8th District, Wisconsin; The Honorable John R. Carter, U.S. House of Representatives, 31st District, Texas; The Honorable Glenn Thompson, U.S. House of Representatives, 5th District, Pennsylvania; The Honorable Neal P. Dunn, U.S. House of Representatives, 2nd District, Florida; The Honorable Andy Barr, U.S. House of Representatives, 6th District, Kentucky; The Honorable David J. Shulkin, M.D., Secretary, U.S. Department of Veterans Affairs, who was accompanied by Carolyn Clancy M.D, the Executive in Charge of the Veterans Health Administration, and Laurie Zephyrin M.D., MPH, MBA, the Acting Deputy Under Secretary for Health for Community Care for the Veterans Health Administration; Adrian M. Atizado, Deputy National Legislative Director, Disabled American Veterans; Roscoe G. Butler, Deputy Director for Health Care, Veterans Affairs and Rehabilitation Division, The American Legion; and, Kayda Keleher, Associate Director, National Legislative Service, Veterans of Foreign Wars of the United States.

Statements for the record were submitted by:

American Federation of Government Employees, AFL-CIO; American Health Care Association; American Medical Association; AMVETS; Concerned Veterans of America; Fleet Reserve Association; Got Your 6; Health IT Now; Iraq and Afghanistan Veterans of America; Military Officers Association of America; Military Order of the Purple Heart; National Alliance on Mental Illness; National Guard Association of the United States; Nurses Organization of Veterans Affairs/Association of VA Psychologist Leaders/Association of VA Social Workers/Veterans Healthcare Action Campaign; Paralyzed Veterans of America; Reserve Officers Association; University of Pittsburgh; Vietnam Veterans of America; and, the Wounded Warrior Project.

SUBCOMMITTEE CONSIDERATION

There was no Subcommittee consideration of H.R. 4242, as amended.

COMMITTEE CONSIDERATION

On December 19, 2017, the full Committee met in open markup session, a quorum being present, and ordered H.R. 4242, as amended, to be reported favorably to the House of Representatives by roll call vote.

During consideration of the bill, the following amendments were considered en bloc and agreed to via voice:

An amendment offered by Representative John Rutherford of Florida to improve VA's ability to recruit physicians and dentists through scholarship and educational loan repayment programs.

An amendment offered by Representative Neal Dunn of Florida to authorize veterans to obtain a transplant outside such veteran's Organ Procurement and Transplantation Network region if veteran's primary care provider opines that there is a medically compelling reason and authorize VA to support the cost of a donor transplant operation for a live donor who is not a veteran but who is donating an organ to a veteran.

An amendment offered by Representative Mike Coffman of Colorado to require community care providers to be aware of and comply with VA's Opioid Safety Initiative.

An amendment offered by Representative Jenniffer González-Colón of Puerto Rico to require VA to report on health services provided veterans in the Northern Mariana Islands, Puerto Rico, American Samoa, Guam, and the Virgin Islands.

An amendment offered by Representative Julia Brownley of California to require VA to use actuarial analysis based on accurate demand forecasting, to certify financial projections, to limit supplemental budget requests unless absolutely necessary, and—when requesting supplemental appropriations or any other request outside the standard budget process—to provide justification for such request.

An amendment offered by Representative Gus Bilirakis of Florida to require VA to certify that community care providers have not been excluded from participating in federally funded health programs.

During consideration of the bill, the following amendments were considered:

An amendment offered and then withdrawn by Representative Elizabeth Esty of Connecticut to require VA to establish a center of excellence for the prevention, diagnosis, mitigation, treatment, and rehabilitation of health conditions related to exposure to burn pits and other environmental exposures.

An amendment offered and then withdrawn by Representative Elizabeth Esty of Connecticut to expand the

Comprehensive Assistance for Family Caregivers program to caregivers of pre-9/11 veterans.

An amendment offered by Representative David P. Roe of Tennessee, the Chairman of the full Committee, to: (1) authorize, rather than require, VA to provide deference to a veteran when resolving disputes regarding primary care provider designations; (2) establish a process to transition veterans between VA and community primary care providers; and (3) authorize VA to incorporate values-based productivity models and take non-clinical duties like training and research into account when establishing performance standards. The amendment was agreed to by voice vote.

An amendment offered and then withdrawn by Representative David P. Roe of Tennessee, the Chairman of the full Committee, to set a community care authorization level for fiscal years 2019 through 2022.

An amendment offered by Representative David P. Roe of Tennessee, the Chairman of the full Committee, to create a Center for Innovation for Care and Payment. The amendment was agreed to by voice vote.

An amendment offered by Representative Mark Takano of California to require Veteran Care Agreements to be subject to Federal Acquisition Regulations. The amendment was not agreed to by voice vote.

An amendment offered by Representative Mark Takano of California to set the minimum level of VA employees at 405,386 as of September 30, 2019. The amendment was not agreed to by a recorded vote of 9 yeas to 14 noes.

An amendment offered by Representative Mark Takano of California to establish an Office of Non-VA Delivered Medical Care Accountability. The amendment was not agreed to by voice vote.

An amendment offered by Representative Ann Kuster of New Hampshire to require VA to consider whether a veteran resides in a state with no VA medical center when establishing eligibility criteria for any program that furnishes primary or specialty care through a community provider. The amendment was agreed to by voice vote.

An amendment offered by Representative Julia Brownley of California to amend the authorization of appropriations for VA major medical facility leases by requiring the Committees on Veterans' Affairs of the Senate and House of Representatives to adopt resolutions approving the leases. The amendment was not agreed to by a recorded vote of 9 yeas to 14 noes.

An amendment in the nature of a substitute offered by Representative Tim Walz of Minnesota, the Ranking Member of full Committee. The amendment in the nature of a substitute was not agreed to by a recorded vote of 9 yeas to 14 noes.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives require the Committee to list the recorded votes on motions to report legislation and amendments thereto. During the full Committee markup of H.R. 4242, as amended, on December 19, 2017, four recorded votes were taken and are described below.

An amendment offered by Representative Mark Takano of California to set the minimum level of VA employees at 405,386 as of September 30, 2019, was not agreed to by a recorded vote of 9 yeas to 14 noes. The names of the Members who voted for and against are as follows:

ONE HUNDRED AND FIFTEENTH CONGRESS
 U.S. STATES HOUSE OF REPRESENTATIVES
 COMMITTEE ON VETERANS' AFFAIRS
 HON. DAVID P. ROE, M.D., CHAIRMAN

FULL COMMITTEE ROLL CALL VOTES

Date: December 19, 2017

Subject: H.R. 4242, the VA Care in the Community Act (Rep. Roe)

Roll call vote #1

Amendment: Takano Amendment # 2 to H.R. 4242, offered by Mr. Takano of California

NAME	YEA/AYE	NAY/NO	NOTES
Dr. Roe, TN, Chairman		X	
Mr. Bilirakis, FL		X	
Mr. Coffman, CO		X	
Dr. Wenstrup, OH		X	
Ms. Radewagen, AS		X	
Mr. Bost, IL		X	
Mr. Poliquin, ME		X	
Dr. Dunn, FL		X	
Mr. Arrington, TX		X	
Mr. Rutherford, FL		X	
Mr. Higgins, LA		X	
Mr. Bergman, MI		X	
Mr. Banks, IN		X	
Ms. Gonzalez-Colon, PR		X	
MINORITY MEMBERS			
Mr. Walz, MN, Ranking Member	X		
Mr. Takano, CA	X		
Ms. Brownley, CA	X		
Ms. Kuster, NH	X		
Mr. O'Rourke, TX	X		
Miss Rice, NY	X		
Mr. Correa, CA	X		
Mr. Sablan, Northern Marian Islands			absent
Ms. Esty, CT	X		
Mr. Peters, CA	X		
Total	9	14	

Mr. Chairman, the vote is 9 Yeas and 14 Noes 1 Not voting
 The amendment is not agreed to.

An amendment offered by Representative Julia Brownley of California to amend the authorization of appropriations for VA major medical facility leases by requiring the Committees on Veterans' Affairs of the Senate and House of Representatives to adopt resolutions approving the leases was not agreed to by a recorded vote of 9 yeas to 14 noes. The names of the Members who voted for and against are as follows:

ONE HUNDRED AND FIFTEENTH CONGRESS
 U.S. STATES HOUSE OF REPRESENTATIVES
 COMMITTEE ON VETERANS' AFFAIRS
 HON. DAVID P. ROE, M.D., CHAIRMAN

FULL COMMITTEE ROLL CALL VOTES

Date: December 19, 2017

Subject: H.R. 4242, the VA Care in the Community Act (Rep. Roe)

Roll call vote #2

Amendment: Brownley Amendment # 1 to H.R. 4242, offered by Ms. Brownley of California

NAME	YEA/AYE	NAY/NO	NOTES
Dr. Roe, TN, Chairman		X	
Mr. Bilirakis, FL		X	
Mr. Coffman, CO		X	
Dr. Wenstrup, OH		X	
Ms. Radewagen, AS		X	
Mr. Bost, IL		X	
Mr. Poliquin, ME		X	
Dr. Dunn, FL		X	
Mr. Arrington, TX		X	
Mr. Rutherford, FL		X	
Mr. Higgins, LA		X	
Mr. Bergman, MI		X	
Mr. Banks, IN		X	
Ms. Gonzalez-Colon, PR		X	
MINORITY MEMBERS			
Mr. Walz, MN, Ranking Member	X		
Mr. Takano, CA	X		
Ms. Brownley, CA	X		
Ms. Kuster, NH	X		
Mr. O'Rourke, TX	X		
Miss Rice, NY	X		
Mr. Correa, CA	X		
Mr. Sablan, Northern Marian Islands			absent
Ms. Esty, CT	X		
Mr. Peters, CA	X		
Total	9	14	

Mr. Chairman, the vote is 9 Yeas and 14 Noes 1 Not voting
 The amendment is not agreed to.

An amendment in the nature of a substitute offered by Representative Tim Walz of Minnesota, the Ranking Member of full Committee, was not agreed to by a recorded vote of 9 yeas to 14 noes. The names of the Members who voted for and against are as follows:

ONE HUNDRED AND FIFTEENTH CONGRESS
 U.S. STATES HOUSE OF REPRESENTATIVES
 COMMITTEE ON VETERANS' AFFAIRS
 HON. DAVID P. ROE, M.D., CHAIRMAN

FULL COMMITTEE ROLL CALL VOTES

Date: December 19, 2017

Subject: H.R. 4242, the VA Care in the Community Act (Rep. Roe)

Roll call vote #3

Amendment: Amendment in the Nature of a Substitute, offered by Mr. Walz of Minnesota

NAME	YEA/AYE	NAY/NO	NOTES
Dr. Roe, TN, Chairman		X	
Mr. Bilirakis, FL		X	
Mr. Coffman, CO		X	
Dr. Wenstrup, OH		X	
Ms. Radewagen, AS		X	
Mr. Bost, IL		X	
Mr. Poliquin, ME		X	
Dr. Dunn, FL		X	
Mr. Arrington, TX		X	
Mr. Rutherford, FL		X	
Mr. Higgins, LA		X	
Mr. Bergman, MI		X	
Mr. Banks, IN		X	
Ms. Gonzalez-Colon, PR		X	
MINORITY MEMBERS			
Mr. Walz, MN, Ranking Member	X		
Mr. Takano, CA	X		
Ms. Brownley, CA	X		
Ms. Kuster, NH	X		
Mr. O'Rourke, TX	X		
Miss Rice, NY	X		
Mr. Correa, CA	X		
Mr. Sablan, Northern Marian Islands			absent
Ms. Esty, CT	X		
Mr. Peters, CA	X		
Total	9	14	

Mr. Chairman, the vote is 9 Yeas and 14 Noes 1 Not voting
 The amendment is not agreed to.

A motion by Representative Gus Bilirakis of Florida, the Vice Chairman of the Committee on Veterans' Affairs, to report H.R. 4242, as amended, favorably to the House of Representatives was agreed to by a recorded vote of 14 yeas and 9 noes. The names of the Members who voted for and against the motion are as follows:

ONE HUNDRED AND FIFTEENTH CONGRESS
 U.S. STATES HOUSE OF REPRESENTATIVES
 COMMITTEE ON VETERANS' AFFAIRS
 HON. DAVID P. ROE, M.D., CHAIRMAN

FULL COMMITTEE ROLL CALL VOTES

Date: December 19, 2017

Subject: H.R. 4242, the VA Care in the Community Act (Rep. Roe)

Roll call vote #4

Motion to Report H.R. 4242, as amended

NAME	YEA/AYE	NAY/NO	NOTES
Dr. Roe, TN, Chairman	X		
Mr. Bilirakis, FL	X		
Mr. Coffman, CO	X		
Dr. Wenstrup, OH	X		
Ms. Radewagen, AS	X		
Mr. Bost, IL	X		
Mr. Poliquin, ME	X		
Dr. Dunn, FL	X		
Mr. Arrington, TX	X		
Mr. Rutherford, FL	X		
Mr. Higgins, LA	X		
Mr. Bergman, MI	X		
Mr. Banks, IN	X		
Ms. Gonzalez-Colon, PR	X		
MINORITY MEMBERS			
Mr. Walz, MN, Ranking Member		X	
Mr. Takano, CA		X	
Ms. Brownley, CA		X	
Ms. Kuster, NH		X	
Mr. O'Rourke, TX		X	
Miss Rice, NY		X	
Mr. Correa, CA		X	
Mr. Sablan, Northern Marian Islands			absent
Ms. Esty, CT		X	
Mr. Peters, CA		X	
Total	14	9	

Mr. Chairman, the vote is 14 Yeas and 9 Noes 1 Not voting
 The motion to report H.R. 4242, as amended, is agreed to and favorably reported to
 the House of Representatives.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII and clause (2)(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the descriptive portions of this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee's performance goals and objectives are to improve the provision of timely, quality care to veteran patients through both VA medical facilities and VA community care providers.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARKS AND TAX AND TARIFF BENEFITS

H.R. 4242, as amended, does not contain any Congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI of the Rules of the House of Representatives.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate on H.R. 4242, as amended, prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate for H.R. 4242, as amended, provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, February 15, 2018.

Hon. PHIL ROE, M.D.,
*Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4242, the VA Care in the Community Act.

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

Sincerely,

KEITH HALL,
Director.

Enclosure.

H.R. 4242—VA Care in the Community Act

Summary: H.R. 4242 would increase the use of community health care and long-term care by the Department of Veterans Affairs (VA) by broadening eligibility for such care and allowing VA to enter into agreements with health care providers in the private sector without complying with the Federal Acquisition Regulation (FAR). The bill also would change VA's coverage of ambulance services and transplant operations at nondepartment facilities. In addition, H.R. 4242 would allow VA to repay loans for and provide scholarships to its medical staff. In total, CBO estimates that implementing the bill would cost \$38.8 billion over the 2018–2022 period, assuming appropriation of the necessary amounts.

Enacting the bill would not affect direct spending or revenues; therefore, pay-as-you-go procedures do not apply.

CBO estimates that enacting H.R. 4242 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

H.R. 4242 would impose an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) by preempting state laws that prohibit VA physicians from practicing telemedicine to treat veterans across state lines. Although it would limit the application of state regulations, that mandate would impose no duty on state governments that would result in additional spending or any significant loss of revenues.

The bill contains no private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: The estimated budgetary effects of H.R. 4242 are shown in the following table. The costs of this legislation fall within budget function 700 (veterans benefits and services).

	By fiscal year, in millions of dollars—					
	2018	2019	2020	2021	2022	2018–2022
INCREASES IN SPENDING SUBJECT TO APPROPRIATION						
VA Care in the Community Program:						
Estimated Authorization Level	200	2,000	4,200	6,700	8,800	21,900
Estimated Outlays	200	1,700	3,900	6,200	8,300	20,300
Veterans Care Agreements:						
Estimated Authorization Level	*	4,400	4,500	4,700	4,800	18,400
Estimated Outlays	*	3,800	4,300	4,500	4,700	17,300
Agreements for State Veterans Homes:						
Estimated Authorization Level	0	80	110	130	160	480
Estimated Outlays	0	70	100	130	150	450
Center for Innovation for Care and Payment:						
Estimated Authorization Level	2	3	86	131	128	350
Estimated Outlays	2	3	75	122	124	326
Ambulance Services:						
Estimated Authorization Level	0	57	78	80	83	298
Estimated Outlays	0	50	73	77	81	281
Transplant Donors:						
Estimated Authorization Level	2	17	35	47	49	150

	By fiscal year, in millions of dollars—					
	2018	2019	2020	2021	2022	2018–2022
Estimated Outlays	2	15	32	44	47	140
Health Professional Scholarship Program:						
Estimated Authorization Level	0	0	4	6	6	16
Estimated Outlays	0	0	3	6	6	15
Loan Repayment for Medical Specialists:						
Estimated Authorization Level	1	3	3	3	3	13
Estimated Outlays	1	3	3	3	3	13
Health Care Productivity:						
Estimated Authorization Level	1	2	2	2	2	9
Estimated Outlays	1	2	2	2	2	9
Scholarship Program:						
Estimated Authorization Level	0	2	2	2	2	8
Estimated Outlays	0	2	2	2	2	8
Total Changes in Spending Subject to Ap- propriation:						
Estimated Authorization Level	206	6,564	9,020	11,801	14,033	41,624
Estimated Outlays	206	5,645	8,490	11,086	13,415	38,842

* = between zero and \$500,000; VA = Department of Veterans Affairs.

Basis of estimate: For this estimate, CBO assumes that the bill will be enacted early in calendar year 2018 and that the estimated amounts will be appropriated each year. Estimated outlays are based on historical spending patterns for the affected programs.

VA Care in the Community Program. Section 102 would establish the VA Care in the Community Program. Through that program, the department would establish networks of health care providers outside of VA to furnish hospital care, medical services, and extended-care services to veterans enrolled in the VA health care system. Under the program, subject to appropriations, VA would be required to pay for care through those networks if VA cannot assign the veteran to a suitable primary care physician or a Patient Aligned Care Team (PACT) at a VA medical facility. Assignment may be unsuitable in the following situations:

- The veteran would face excessive challenges in receiving care at a VA medical facility because of geographic, environmental, or medical factors;
- The veteran believes that the assignment to a particular primary care physician or PACT at a VA medical facility would result in unsatisfactory health care;
- The veteran would face long wait times for care at a VA medical facility; or
- The veteran resides in a state without a full-service medical facility (such as Alaska, Hawaii, or New Hampshire).

Veterans may later choose to receive care at a VA medical facility if VA notifies them that a primary care provider or a PACT has become available.

The bill would require VA to promulgate regulations to implement the program within one year.

The VA Care in the Community Program is similar to the Veterans Choice Program (VCP), which CBO expects will end in 2018. The VCP provides community care to veterans who face excessive wait times or live 40 miles or more from a VA medical facility. CBO estimated the costs for the VA Care in the Community Program based on information about the VCP.

CBO expects that the VA Care in the Community Program would cost more than the VCP for the following reasons:

- Veterans would make more visits for community health care because once they are referred for community care they could see network providers for primary care for at least one year without additional authorization from VA.

- Veterans would be eligible for community care under the new program in more circumstances.

However, there are several factors that CBO expects would constrain that cost growth:

- Diverting more veterans to community care could shorten wait times at VA facilities and thus reduce the number of veterans who would need to be referred to community care because VA care was not available in a timely fashion.

- Regulations that need to be written to implement the program could curtail use.

- Veterans would need approval from VA to receive certain specialty services.

- The size and scope of community care networks could be limited, particularly in rural areas, reducing the accessibility of such care.

- VA might implement the program slowly, as it did the VCP.

CBO expects that the new program would be implemented gradually and by 2022, usage of the new program would be 30 percent greater than for the VCP. CBO estimates that eventually usage of the new program would be about 75 percent greater than that of the VCP.

In 2017, VA processed 8.7 million claims at a total cost of \$5 billion for community health care under the VCP. After accounting for the increase in usage, inflation, and underlying growth in enrollment in the VA health system, CBO estimates that the new program would cost \$8.3 billion by 2022. In total, implementing section 102 would cost \$20.3 billion over the 2018–2022 period, CBO estimates.

Veterans Care Agreements. Section 103 would allow VA to enter into Veterans Care Agreements with health care providers in the community to provide hospital care, medical services, or extended care to eligible veterans. The authorization for such agreements would exempt VA from using the competitive bidding procedures as required under the FAR. The FAR is an extensive and complex set of rules governing the federal government's purchasing processes.

Under current law, VA must comply with the FAR for agreements and contracts with community health care and extended-care providers.

According to VA, the FAR's requirements are appropriate for large and long-term agreements for contracted health care services but may not be practical for case-by-case arrangements in all regions of the United States. H.R. 4242 would allow VA to use other agreements for certain health care services and extended care provided outside the VA system.

For 2018, the Congress has provided roughly \$10 billion for community health care at VA (excluding the VCP). Using information from VA, CBO estimates that implementing section 103 would give VA the legal authority to continue to provide about 40 percent (or roughly \$4 billion annually) of that community health care. After adjusting for inflation and accounting for existing appropriations,

CBO estimates that implementing this section would cost \$17.3 billion over the 2018–2022 period.

Agreements for State Veterans Homes. Section 104 would waive the requirements of the FAR for contracts and agreements that VA enters into with state-run nursing homes for veterans. Under current law, the state veterans' homes (SVHs) must fill 75 percent of their beds with veterans. Under a contract or agreement, VA pays SVHs the full cost of care for veterans with a service-connected disability (SCD) rating of 70 percent or more. For all other veterans, VA pays SVHs a fixed daily allowance.

According to VA, in 2015 the department used such agreements to reimburse state-run nursing homes at a daily rate of \$380 for each veteran with an SCD of 70 percent or more—at an annual cost of roughly \$350 million (or 37 percent of the total reimbursed to SVHs). However, those agreements do not comply with the FAR, and VA does not expect to be able to enter into new FAR-compliant agreements with any of the SVHs. In the absence of this legislation, CBO expects that VA would gradually phase out the use of such agreements as veterans who are currently under that payment structure die or leave the SVHs. Those veterans would probably be replaced by veterans under the lower daily allowance rate of roughly \$100 per patient. By allowing VA to enter into agreements outside of the FAR framework, CBO estimates, this proposal would more than triple VA's reimbursements to SVHs for veterans with SCDs of 70 percent or more.

As a result, after factoring in a gradual phaseout of existing non-FAR agreements, CBO estimates that enacting this provision would cost \$450 million over the 2018–2022 period. The additional costs from waiving the FAR requirements would begin in 2019. Because appropriations already have been provided for such agreements in 2018, no additional funding would be necessary in that year.

Center for Innovation for Care and Payment. Section 210 would require VA to establish the Center for Innovation for Care and Payment, which would evaluate ways to reduce costs and increase efficiency at VA medical facilities. CBO expects that the center would pursue programs similar to those that were tested by the Center for Medicare and Medicaid Innovation (CMMI) operated by the Centers for Medicare & Medicaid Services. CBO estimates that costs for the center would be similar to those for CMMI. CBO expects any savings that resulted from the center's efforts would not occur in the next five years.

In 2010, CMMI received \$5 million to develop models for reducing health care costs and increasing efficiency for Medicare. CBO expects that VA would need similar resources to establish its program. On the basis of information from the department regarding the availability of necessary staff, CBO expects that it would take VA two years to establish the center at an estimated cost of \$5 million over the 2018–2019 period.

CMMI received \$10 billion over the 2011–2019 period to test its models. CBO expects that VA's costs would be proportional. VA Health Administration costs are approximately one-tenth those of Medicare. After factoring in a gradual implementation period similar to that of CMMI, CBO estimates that the costs for the center would be \$321 million over the 2020–2022 period.

In total, CBO estimates that implementing section 210 would cost \$326 million over the 2018–2022 period.

Ambulance Services. Section 201 would require VA to reimburse veterans for ambulance services under certain conditions. Currently, VA can choose to reimburse veterans for ambulance services when they receive emergency care at nondepartment medical facilities. H.R. 4242 would require VA to cover the cost of ambulance services if a delay in providing immediate medical attention could result in death or harm to the veteran.

Using data from the National Institutes of Health and VA, CBO estimates that VA would reimburse veterans for about 165,000 ambulance trips each year, at an average cost of \$480 per trip. The bill would require VA to pay for ambulance trips after January 1, 2019. Thus, CBO estimates that implementing section 201 would cost \$281 million over the 2018–2022 period.

Transplant Donors. Section 109 would allow VA to cover costs related to organ transplant procedures incurred by veterans and their living donors for procedures at nondepartment facilities. Currently, VA covers the medical and service expenses (such as transportation and lodging) for veterans and their living donors only for procedures performed at the Department of Veterans Affairs Transplant Centers (VATCs). Otherwise, VA reimburses donors only for transportation and lodging. In 2017, VA provided 560 organ transplants, most at VATCs. Of those operations, about 200 were kidney transplants and about 20 involved living donors.

Section 109 would authorize VA to pay for transplant procedures at various locations nationwide with minimal out-of-pocket expenses for veterans and their living donors. As a result, CBO expects more veterans would use VA for such procedures and more people would be willing to donate organs. In determining the additional number of transplant procedures, CBO considered the other sources of health care coverage carried by enrolled veterans and the likelihood, under this proposal, that those veterans would instead use VA for their transplant procedures.

Using information from the Census Bureau, VA, and the Department of Health and Human Services, CBO estimates that under section 109, roughly 60 additional veterans would undergo transplants at nondepartment facilities each year, at an average cost of \$750,000 per patient. CBO estimates that VA would cover the medical expenses of an additional 50 living donors (some for procedures that will occur under current law but for which VA would not pay medical expenses) each year, at an average cost of \$80,000 per donor. In addition, CBO believes that implementing this section would allow veterans to undergo transplants closer to home. As a result, CBO estimates a reduction in transportation reimbursements of about \$4 million each year. Based on the expectation that VA would implement the bill gradually, CBO estimates that implementing section 109 would have a net cost of \$140 million over the 2018–2022 period.

Health Professional Scholarship Program. Section 301 would extend the Health Professional Scholarship Program, currently set to expire on December 31, 2019, through December 31, 2033. At an annual cost of \$5 million, the program subsidizes tuition and educational fees and provides monthly stipends to medical students who pursue careers at VA. After accounting for rising tuition costs,

CBO estimates that implementing section 301 would cost \$15 million over the 2019–2022 period.

Loan Repayment for Medical Specialists. Section 302 would authorize VA to repay the education loans of practitioners in medical specialties for which the department has difficulty recruiting. In exchange, those specialists would commit to work for VA for two to four years. The payments could not exceed \$40,000 for each year worked or a total of \$160,000 over four years. Those limits could be waived for medical positions for which a shortage exists because of the location or requirements of the position.

Under a similar loan repayment program, VA can reimburse up to \$120,000 for tuition and educational fees for medical personnel at the department. In 2016, roughly 2,000 employees (or less than 1 percent of total employees) received an average award of about \$15,000. On the basis of participation rates and costs of that program, CBO estimates that roughly 120 medical practitioners in specialty areas would participate in the new program each year and would receive an average annual award of \$23,000. After factoring in a gradual implementation period and growth in tuition, CBO estimates that implementing section 302 would cost \$13 million over the 2018–2022 period.

Health Care Productivity. Section 205 would require that VA develop standards for using relative-value units (RVUs) to evaluate medical services. It also would require VA to train its health care providers to use and adhere to those standards. RVUs are tools used by physicians participating in Medicare to rank on a common scale the resources (such as medical supplies) used to provide health care.

On the basis of information from VA regarding its ability to train personnel to use RVUs in all department facilities, CBO estimates that VA would need to hire the equivalent of 10 full-time clinicians at an average annual compensation of \$150,000 to develop standards and provide ongoing training and support. CBO expects that VA would develop an internal website to train its medical providers to use RVUs. CBO estimates that development of the website would cost less than \$500,000.

As a result, CBO estimates that implementing section 205 would cost \$9 million over the 2018–2022 period.

Scholarship Program. Section 303 would require VA to fully cover the costs of medical school for 18 eligible veterans. Under this scholarship program, VA would pay for tuition, books, fees, technical equipment, rotations, and reasonable living expenses for newly separated veterans who enter medical school in 2019. Veterans who are entitled to other education benefits provided by VA would not be eligible. Participating veterans would be required to agree to work full time at a VA medical facility for four years after completing medical school.

On the basis of the average costs to attend a private medical school, which includes tuition, books, fees, and technical equipment, CBO estimates that annual costs would average \$69,000 per awardee. After adjusting for growth in the costs of medical school, CBO estimates that such education expenses would cost \$5 million over the 2019–2022 period.

The Department of Defense pays monthly stipends for living expenses to recipients of similar scholarships that currently average

\$2,229 a month. On that basis, CBO estimates that individual stipends would total roughly \$25,000 over a 10.5-month school year. After adjusting for inflation, CBO estimates that such stipends would cost a total of \$2 million over the 2019–2022 period. In addition, CBO estimates that the costs of residency fees, off-site rotations, and reports would cost \$1 million over 2020–2022 period.

In total, CBO estimates that implementing section 303 would cost \$8 million over the 2019–2022 period.

Pay-As-You-Go considerations: None.

Increase in long-term direct spending and deficits: CBO estimates that enacting H.R. 4242 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

Mandates: H.R. 4242 would impose an intergovernmental mandate as defined in UMRA by preempting state laws that prohibit VA physicians from practicing telemedicine to treat veterans across state lines. Although it would limit the application of state regulations, that mandate would impose no duty on state governments that would result in additional spending or any significant loss of revenues.

The bill contains no private-sector mandates as defined in UMRA.

Previous CBO estimates: On January 17, 2018, CBO transmitted a cost estimate for S. 2193, the Caring for Our Veterans Act of 2017, as ordered reported by the Senate Committee on Veterans' Affairs on December 5, 2017. Sections 102, 103, and 242 in S. 2193 are similar to sections 103, 104, and 109 of H.R. 4242 and the estimated costs for those sections are the same for each bill.

Estimate prepared by: Federal costs: Ann E. Futrell; Mandates: Andrew Laughlin.

Estimate approved by: Leo Lex; Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 4242, as amended, prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act would be created by H.R. 4242, as amended.

STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to Article I, section 8 of the United States Constitution, H.R. 4242, as amended is authorized by Congress' power to "provide for the common Defense and general Welfare of the United States."

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that H.R. 4242, as amended, does not relate to the terms and conditions of employment or access to public serv-

ices or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

STATEMENT ON DUPLICATION OF FEDERAL PROGRAMS

Pursuant to section 3(g) of H. Res. 5, 115th Cong. (2017), the Committee finds that no provision of H.R. 4242, as amended, establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULEMAKING

Pursuant to section 3(i) of H. Res. 5, 115th Cong. (2017), the Committee estimates that H.R. 4242, as amended, contains no directed rulemaking that would require the Secretary to prescribe regulations.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

TITLE I—IMPROVED ACCESS FOR VETERANS TO NONDEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE

Sec 101. Assignment of veterans to primary care providers

Section 101 of the bill would amend Section 1706 of Title 38, U.S.C., by adding a new subsection (d).

Section 1706(d) requires VA to assign each eligible veteran to a PACT team of the Department, or a dedicated primary care provider of the department. This section also defines the term “eligible veteran”.

Section 102. Establishment of VA Care in the Community Program

Section 102(a) of the bill would amend section 1703 of title 38, U.S.C., by inserting after section 1703 a new section 1703A:

Section 1703A(a) of the bill would establish a permanent authority for the VA Care in the Community program to provide hospital care, medical services and extended care to eligible veterans through contracts and agreements. Under this section, VA would coordinate the care provided to eligible veterans through regional networks of community providers, which are to be periodically assessed for capacity.

Section 1703A(b) allows for a veteran to choose a provider from among network providers located in a regional network (or adjacent network, if closer) if VA does not have an available or accessible primary care provider for the veteran. Upon this election, a veteran may utilize this primary care provider for a period of one year and shall not be counted twice against a VA primary care provider’s panel size. Should a VA primary care provider become available, the veteran will be given an option to be reassigned. This section requires VA to consider the following when determining if a VA provider is available for assignment: if the veteran faces unusual excessive burden such as geographical challenges, environmental factors, or medical conditions; if the veteran reasonably believes the assigned care team is detrimental to the patient-provider rela-

tionship and/or could result in suboptimal care; if the panel size of the team is such a number that it would prevent timely access to care or lead to sub-optimal results; or the veteran resides in a State where the Department does not operate a full medical facility. In an appeal of VA's assignment under this section, VA may give deference to the veteran if the veteran reasonably believes that their assignment would result in suboptimal care. Under this section, specialty care requires a referral from the veteran's primary care provider, with the ability for the Secretary to make exceptions. VA shall determine whether specialty care is to be sourced from a nearby VA facility, through a network provider, or pursuant to other agreements—with preference given to VA facilities subject to various factors of veteran accommodation. This section requires referrals to be processed in a standardized manner to include the organization of a program office at each facility. The Secretary shall establish a process to review any disagreements between the veteran, the Department, or provider as to eligibility for care or services under this section. This section also requires VA to establish procedures for transitioning a veteran to a different primary care provider so as to not adversely impact continuity of care, to include the appointment of a contact to resolve issues, transfer of relevant records, continued and coordinated treatment for chronic or current episodes of care.

Section 1703A(c) establishes that care shall be authorized through the completion of an episode of care to include all specialty and ancillary services deemed necessary. This section requires VA to provide case management for the veteran, when appropriate, and allows for case management to be provided through the network. Under this section, VA is authorized to pay non-network providers who provide care as part of an episode of care and VA shall take reasonable efforts to enter into contracts or agreements with them.

Section 1703A(d) establishes that the rates for non-VA care shall not exceed Medicare rates, with exceptions for highly rural states that require adjusted rates. This section allows for VA to incorporate value-based reimbursement models and for VA to establish a schedule of fees for care not covered under Medicare. VA may also negotiate higher rates pursuant to an agreement with a tribal or federal entity.

Section 1703A(e) establishes a 180 day requirement for claim submissions and states that all parties shall pay or notify of denial of a claim no later than 45 days for "clean" claims and 30 days for electronic claims with an additional 30 days to respond. If a claim is overdue, the penalty will be prorated daily, accrue from overdue date, computed at U.S. Treasury interest rate, and shall be resolved in subsequent billing or no later than 30 days of determination. This section states that the receipt of medical records is not required for payment, but the provider must attest to the provision of care or services.

Section 1703A(f) establishes that veterans who would pay a copay within the VA system would pay the same amount if receiving care from the community network. This section also requires VA to seek reimbursement from other non-government health care plans for non-service-connected condition care.

Section 1703A(g) requires network providers to provide medical records to veterans upon request and to the VA upon completion of care. Likewise, VA shall provide medical records as needed to network providers. VA shall also ensure medical records can be shared in an electronic format and community providers can have access to them.

Section 1703A(h) requires VA to ensure that existing VA identification cards are sufficient for receiving community care and specifically prohibits VA from creating a separate card for the program.

Section 1703A(i) states that formulary prescriptions can be submitted by community providers to the VA in the same manner, utilizing the same credentials, as community providers would submit to any retail pharmacy.

Section 1703A(j) requires the Secretary to use the quality of care standards as set by the Centers for Medicare & Medicaid Services (CMS) or other standards as determined by the Secretary.

Section 1703A(k) requires VA to assess, no less than once every three years, the capacity of each department medical center, identify gaps and how they will be filled, and forecast short and long term demands and how they impact network composition. VA shall also include commercial health care market assessment for services available within designated catchment areas.

Section 1703A(l) requires VA to plan for the allocation of funds within the Medical Community Care accounts.

Section 1703A(m) requires VA to provide an annual report for the next three years detailing rates paid as an exception to the Medicare rates.

Section 1703A(n) establishes definitions for the terms: clean claim, covered claimant, covered payer, eligible veteran, and fraudulent claim.

Section 102(b) provides conforming amendments to the bill.

Section 102(c) provides definitions for the following terms: Network Provider, VA Care in the Community.

Section 102(d) requires that the bill may not be construed to affect obligations entered into via prior agreements or contracts.

Sec. 103. Veterans Care Agreements

Section 103 of the bill would amend Section 1706 of Title 38, U.S.C., by inserting after section 1703A, added by section 102, a new section 1703B—Veterans Care Agreements with non-network providers:

Section 1703B(a) authorizes the use of provider agreements in addition to contracts for care and services when contracts are impractical or inadvisable. This section requires VA to review each agreement once during the 18-month period beginning six months after entering an agreement and each four-year period after any agreement that exceeds \$3 million for a provider that furnishes homemaker or home health aide services, or \$1 million for any other provider.

Section 1703B(b) establishes the requirements for network provider participation under the program.

Section 1703B(c) requires VA to establish a process for certification of network providers under the program or to adopt a process already administered by another Federal department or agency.

Section 1703B(d) requires that agreements be applied in the same manner as Section 1703A of Title 38, U.S.C.

Section 1703B(e) stipulates that network providers are not subject to any provision that providers of Medicare and Medicaid are not subject to, as well as other provisions of law regarding integrity, ethics, fraud, protection of whistleblowers, and Title VII of the Civil Rights Act of 1964.

Section 1703B(f) states that agreements can be terminated by VA or the provider at such time and upon such notice as required by the Secretary.

Section 1703B(g) requires VA to establish administrative procedures to handle disputes, and states that entities must exhaust administrative procedures before pursuing judicial review.

Section 1703B(h) states that, in the course of an episode of care, VA may compensate a non-network provider who provides care as part of that treatment.

Section 1703B(i) requires VA to submit a report at the beginning of each fiscal year on all provider agreements entered into the prior year. The reporting requirement sunsets five years after the date of enactment.

Section 1703B(j) requires VA to utilize quality of care standards set forth by CMS or as determined by the Secretary.

Section 1703B(k) states that the authority to enter into and terminate agreements shall not be delegated to below the VISN Director or Director of a Network Contracting Office.

Section 1703B(l) provides definitions for the following terms: Appropriate Congressional Committees, Eligible Veteran.

Section 103(b) provides a clerical amendment to this section.

Sec. 104. Modification of authority to enter into agreements with state homes to provide nursing home care

Section 104(a) allows for the use of agreements under the program.

Section 104(b) exempts VA from certain competitive procedures and states that providers are not subject to any provision that providers of Medicare or Medicaid are not subject to. This section also states that other provisions of law regarding integrity, ethics, or fraud apply.

Section 104(c) requires VA to establish, through regulations, an effective date to be published in the Federal Register no later than 30 days prior to such date.

Sec. 105. Electronic interface for processing of claims

Section 105(a) establishes requirements for VA's Chief Information Officer to put in place an IT system to receive, process, and pay claims and outlines the capabilities required of such an IT system.

Section 105(b) ensures that all federal information protection requirements are met.

Section 105(c) allows for VA to enter into a contract for the purposes of this section.

Section 105(d) sets definitions for the following terms: electronic protected health information, covered non-department health care providers, secure development requirements, VA Care in the Community Program.

Sec. 106. Funding for VA Care in the Community Program

Section 106(a) requires all funds for Section 1703B to be derived from the Medical Community Care Account.

Section 106(b) requires that all unobligated amounts from Sec. 802 of PL 113–146 shall be transferred to the Medical Community Care Account on the later of the following: one year after enactment; or, the date on which the Secretary certifies implementation of Section 1703A to Congress.

Section 106(c) defines the VA Care in the Community Program.

Sec. 107. Termination of certain provisions authorizing care to veterans through non-Department of Veterans Affairs providers

Section 107(a)(1) of the bill would amend Section 1703 of Title 38, U.S.C., adding a new subsection (e):

Section 1703(e) of title 38, U.S.C., terminates Section 1703 of Title 38, U.S.C., upon VA's certification that 1703A is fully implemented. This section also includes conforming amendments regarding dental care, readjustment counseling, death in a department facility and Medicare provider agreements.

Section 107(b) repeals an authority for VA to contract for scarce medical specialists.

Section 107(c) sets an effective date for amendments under this section of the date on which the Secretary certifies that Section 1073A of Title 38 is fully implemented.

Sec. 108. Implementation and transitions

Section 108(a) states that implementation of Sections 1703A and 1703B of title 38, U.S.C., shall commence no later than one year after enactment and that VA shall prescribe interim final rules. The same date applies to the transfer of funds, as required by section 106(b).

Section 108(b) requires the Secretary to certify that providers and employees are trained to furnish care and services under this program. This section requires VA to establish written guidance on policies and procedures for the program.

Sec. 109. Transplant procedures with live donors and related services

Section 109(a) of the bill would amend subchapter I of chapter 17 of title 38, U.S.C. by inserting after Section 1703B of title 38, U.S.C., Section 1703C—“Transplant Procedures with Live Donors and Related Services.”

Section 1703C(a) of subchapter I, if a veteran is eligible for a transplant procedure from the Department, the Secretary may provide for a transplant operation on a live donor notwithstanding the live donor's eligibility for health care from the VA.

Section 1703C(b) of subchapter I authorizes VA to support the cost of a donor transplant operation, including perioperative care for a live donor who is not a veteran but who is donating an organ for a veteran.

Section 1703C(c) of subchapter I would allow for non-VA facilities to be used for transplant operations on living donors as long as the transplant center is in compliance with regulations prescribed by the Centers for Medicare and Medicaid Services.

TITLE II—OTHER ADMINISTRATIVE MATTERS

Sec. 201. Reimbursement for emergency ambulance services

Section 201(a) of the bill amends Section 1725(c) of title 38, U.S.C., by adding at the end a new paragraph:

Section 1725(c)(5) of title 38, U.S.C., delineates circumstances for reimbursement of ambulance services and sets a prudent layperson determination of the need for ambulance services.

Section 201(b) sets an effective date of January 1, 2019.

Sec. 202. Improvement of care coordination for veterans through exchange of certain medical records

Section 202 amends Section 7332(b) of title 38, U.S.C. to allow for the provision of medical health information to non-Department entities to provide treatment and to any third party in order to recover or collect charges for non-service connected care.

Sec. 203. Elimination of copay offset

Section 203(a) amends Section 7329(a) of title 38, U.S.C., to eliminate the offset of a veteran copay from amounts covered from a third party.

Section 203(b) sets an effective date on the date of enactment.

Sec. 204. Use of Department of Veterans Affairs Medical Care Collections Fund for certain improvements in collections

Section 204 amends Section 1729A(c)(1)(B) of title 38, U.S.C., to allow funds to be utilized for automatic data processing or IT improvements.

Sec. 205. Department of Veterans Affairs health care productivity improvement

Section 205(a) amends Subchapter I of chapter 17 of title 38, U.S.C., by inserting after Section 1705A a new section, Section 1705B—“Management of health care”:

Section 1705B(a) requires VA to track relative value units for all VA providers.

Section 1705B(b) requires VA providers to attend coding training.

Section 1705B(c) requires VA to establish performance standards based on nationally recognized relative value unit standards.

Section 1705B(d) defines the following terms: department provider, relative value unit.

Section 205(b) provides a clerical amendment for this section.

Section 205(c) requires VA to submit a report regarding implementation of this section by no later than one year after enactment.

Sec. 206. Licensure of Health Care Professionals of the Department of Veterans Affairs Providing Treatment via Telemedicine

Section 206(a) amends Chapter 17 of title 38, U.S.C., by inserting after section 1730A a new section, Section 1730B—“Licensure of Health Care Professionals Providing Treatment via Telemedicine.”

Section 1730B(a) provides that any licensed covered professional may provide telemedicine services in any state regardless of where the provider or patient is located.

Section 17030B(b) states that the authorities under this section applies regardless of whether the covered provider or patient is located in a Federal facility.

Section 1730B(c) states that all provisions of the Controlled Substances Act apply.

Section 1730B(d) defines the term “covered health care professional.”

Section 206(b) provides a clerical amendment for this section.

Section 206(c) requires VA, by no later than one year after enactment, to submit a report to Congress on the effectiveness of telemedicine within VA. This report shall include an assessment of patient and provider satisfaction, the effect on access, patient utilization, productivity, wait times, and utilization of facilities. This report shall include amount of and types of appointments, as well as any savings achieved.

Sec. 207 Establishment of processes to ensure safe opioid prescribing practices by non-Department of Veterans Affairs health care providers

Section 207(a) of the bill would require VA to provide Opioid Safety Initiative (OSI) guidelines to community providers and certify that the community providers have reviewed the guidelines.

Section 207(b) would implement a process to ensure that community providers receive a veteran’s relevant history including all medications.

Section 207(c) would further require that opioid prescriptions be filled at a VA pharmacy or a community pharmacy only if prior authorization has been received (with an exception for certain urgent or emergent circumstances), that opioid prescriptions be recorded in the electronic health record and monitored.

Section 207(d) requires that community providers whose prescribing practices are inconsistent with OSI requirements or violate licensing guidelines are removed from VA community care networks.

Section 207(e) authorizes VA to revoke or deny eligibility under this bill for providers who violate do not comply with the Opioid Safety Initiative.

Section 207(f) defines the term “Covered Health Care Provider.”

Sec. 208 Assessment of health care furnished by the Department to Veterans who live in the territories

Section 208 requires VA to submit a report, by no later than 180 days after enactment of this bill, on the health services provided to veterans in the US territories: Northern Mariana Islands, Puerto Rico, American Samoa, Guam, and the Virgin Islands. The report will also address the feasibility of constructing any medical facilities in any of the above territories that do not have such a facility.

Sec. 209 Oversight and accountability of financial processes of Department of Veterans Affairs

Section 209(a) of the bill would require VA to submit a justification to any request for supplemental appropriations, based upon sound actuarial analysis.

Section 209(b) requires that whenever the Secretary submits a supplemental funding request, 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 and how long the requested appropriations are expected to meet the needs of VA.

Section 209(c) would require VA's Chief Financial Officer to certify the sufficiency, to the extent possible, of VA's annual budget submission to provide benefits and health services to veterans, as required by law.

Sec. 210 Authority for Department of Veterans Affairs Center for Innovation for Care and Payment

Section 210(a) amends subchapter I of chapter 17, as amended by section 122, by inserting after section 1703B of title 38, U.S.C., as added by section 103, Section 1703C of title 38, U.S.C.,—"Center for Innovation for Care and Payment."

Section 1703C(a) authorizes the Secretary to carry out pilot programs to develop innovative approaches to testing payment and service delivery models to reduce expenditures while preserving or improving the quality of care.

Section 1703C(b) requires that no pilot under this section shall last longer than five years.

Section 1703C(c) requires that the programs be carried out in locations appropriate for the intended purpose of the programs.

Section 1703C(d) states that the funding for the pilot programs shall come from appropriations provided in advance for VHA and IT systems.

Section 1703C(e) requires the Secretary to publish information and take all reasonable action to give notice to veterans eligible to participate in the pilot programs.

Section 1703C(f) authorizes the Secretary to waive any requirements under Title 38 only after submitting a report to Congress explaining the authorities to be waived and the reasons for such requirement. The Secretary would only be allowed to act upon any such waiver after Congress enacts a bill or joint resolution approving the action.

Section 1703C(g) states that if the Secretary fails to follow the waiver provisions, the waiver shall not apply.

Section 1703C(h) requires the Secretary to conduct an evaluation of each model tested, and Section 1703C(i) requires the Secretary to coordinate and consult with the Under Secretary for Health and the VA Special Medical Advisory Group regarding the pilot programs.

Section 1703C(j) states that should the program be positively evaluated according to subsection (f) the Secretary may, through rulemaking, expand the duration and scope of the model being tested.

TITLE III—IMPROVEMENTS TO RECRUITMENT OF PHYSICIANS

Sec. 301 Designated scholarships for physicians and dentists under Department of Veterans Affairs Health Professional Scholarship Program

Section 301(a) of this bill will amend section 7612(b) of title 38, U.S.C., by inserting at the end new paragraph (6).

Section 7612(b)(6)(A) would require the Secretary to award no fewer than 50 scholarships a year to individuals who are enrolled or have accepted enrollment in a physician or dentist program. The number of awarded scholarships must be at least 50 a year until the Secretary determines that staffing shortage of dentists and physicians is lower than 500.

Section 7612(b)(6)(B) requires the Secretary to award scholarships in an amount equal to not less than 10 percent of the staffing shortage.

Section 7612(b)(6)(C) States that the Secretary's agreement to provide scholarship will be provided for a designated number of school years (two to four years). The agreement will mandate the participant's service for 18 months for every school year of scholarship funding.

Section 7612(b)(6)(D) The Secretary may give preference to applicants who are veterans.

Section 7612(b)(6)(E) On an annual basis, the Secretary shall provide to appropriate educational institutions information material about the availability of scholarships.

Section 301(b) amends Section 7617 of title 38, U.S.C., to authorize VA to recoup a debt owed from scholarship recipients who fail to successfully complete post-graduate training leading to eligibility for board certification in a specialty.

Section 301(c) extends the effective date from December 21, 2019, to December 31, 2033.

Sec. 302 Establishment of Department of Veterans Affairs Specialty Education Loan Repayment Program

Section 302(a) would amend Chapter 76 of title 38, U.S.C., by inserting after subchapter VII the following new subchapter: "Subchapter VIII—Specialty Education Loan Repayment Program."

Section 7691 of subchapter VIII establishes a loan repayment program to incentivize individuals employed in the Veterans Health Administration to pursue education and training in medical specialties for which the Secretary determines there is a shortage.

Section 7692 of subchapter VIII outlines the purpose of the Specialty Education Loan Repayment Program.

Section 7693(a) of subchapter VIII outlines eligibility for the participation in the Specialty Education Loan Repayment Program.

Section 7693(b) of subchapter VIII states that the Secretary may give preference to veterans in this program.

Section 7693(c) of subchapter VIII outlines which expenses are allowed to be covered under this section.

Section 7694 of subchapter VIII outlines the manner in which the Specialty Education Loan Repayment Program are to be made.

Section 7695 of subchapter VIII allows each participant who completes their residency to select their location of employment from a list of medical facilities of the VHA.

Section 7696(a) of subchapter VIII outlines the terms of the service obligation for the Specialty Education Loan Repayment Program.

Section 7696(b) of subchapter VIII states that 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 terms 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.

Section 7696(c) of subchapter VIII defines the formula by which VA may seek monetary collections from an employee who violates the terms of obligated service under this section.

Section 7697 of subchapter VIII allows for participants of the Specialty Education Loan Repayment Program to concurrently participate in the Educational Assistance Program. This section also includes conforming and technical amendments, as well as requires VA to match participants with the projected needs of the VA and to publicize the availability of the program.

Sec. 303 Veterans Healing Veterans Medical Access and Scholarship Program

Section 303(a) establishes that the Secretary 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.

Section 303(b) outlines the eligibility requirements for the Veterans Healing Veterans Medical Access and Scholarship Program.

Section 303(c) requires that each covered medical school, if it opts to join the program, shall reserve two seats in the entering class of 2019 for eligible veterans with the highest admissions rankings for said class. Each eligible veteran shall receive funding at an amount equal to the cost of (A) tuition for four years; (B) books, fees, and technical equipment; (C) fees associated with the National Residency Match Program; (D) two away rotations performed during the fourth year at a VA medical facility; and (E) a monthly stipend for the four-year period. Funds shall be distributed to eligible veterans at other covered medical schools should one covered school not have two eligible veteran applicants.

Section 303(d)(1) outlines the terms of the agreement for eligible veterans who accept funding for medical education under this section.

Section 303(d)(2) states that, if the eligible veteran breaches the above agreement, the U.S. shall be entitled to recover an amount equal to the total amount of funding received by the veteran.

Section 303(e) allows covered schools to accept more than two eligible veterans for the entering class of 2019.

Section 303(f) states that no later than December 31, 2020, and annually thereafter for three years, the Secretary shall submit to Congress a full report on the pilot program.

Section 303(g) defines “covered medical schools” as Teague-Cranston medical schools and the medical schools of Historically Black Colleges and Universities.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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PART II—GENERAL BENEFITS

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**CHAPTER 17—HOSPITAL, NURSING HOME,
DOMICILIARY, AND MEDICAL CARE**

SUBCHAPTER I—GENERAL

Sec.

- 1701. Definitions.
- 1702. Presumptions: psychosis after service in World War II and following periods of war; mental illness following service in the Persian Gulf War.
- 1703. Contracts for hospital care and medical services in non-Department facilities.
- 1703A. *VA Care in the Community Program.*
- 1703B. *Veterans Care Agreements with non-network providers.*
- 1703C. *Center for Innovation for Care and Payment.*
- 1703C. *Transplant procedures with live donors and related services.*
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- 1705A. Management of health care: information regarding health-plan contracts.
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- 1706. Management of health care: other requirements.
- 1707. Limitations.
- 1708. Temporary lodging.
- 1709. Comprehensive policy on reporting and tracking sexual assault incidents and other safety incidents.
- 1709A. Teleconsultation.
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SUBCHAPTER II—HOSPITAL, NURSING HOME, OR DOMICILIARY CARE AND
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- 1710. Eligibility for hospital, nursing home, and domiciliary care.
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- 1710D. Traumatic brain injury: comprehensive program for long-term rehabilitation.
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- 1711. Care during examinations and in emergencies.
- 1712. Dental care; drugs and medicines for certain disabled veterans; vaccines.
- 1712A. Eligibility for readjustment counseling and related mental health services.
- 1712C. Dental insurance plan for veterans and survivors and dependents of veterans.
- 1712B. Counseling for former prisoners of war.
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- 1714. Fitting and training in use of prosthetic appliances; guide dogs; service dogs.
- 1715. Tobacco for hospitalized veterans.
- 1716. Hospital care by other agencies of the United States.
- 1717. Home health services; invalid lifts and other devices.
- 1718. Therapeutic and rehabilitative activities.
- 1719. Repair or replacement of certain prosthetic and other appliances.
- 1720. Transfers for nursing home care; adult day health care.
- 1720A. Treatment and rehabilitative services for persons with drug or alcohol dependency.
- 1720B. Respite care.
- 1720C. Noninstitutional alternatives to nursing home care.
- 1720D. Counseling and treatment for sexual trauma.
- 1720E. Nasopharyngeal radium irradiation.
- 1720F. Comprehensive program for suicide prevention among veterans.
- 1720G. Assistance and support services for caregivers.
- 1720H. Mental health treatment for veterans who served in classified missions.

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL
AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

- 1721. Power to make rules and regulations.
- 1722. Determination of inability to defray necessary expenses; income thresholds.
- 1722A. Copayment for medications.
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- 1723. Furnishing of clothing.
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- 1725. Reimbursement for emergency treatment.
- 1726. Reimbursement for loss of personal effects by natural disaster.
- 1727. Persons eligible under prior law.
- 1728. Reimbursement of certain medical expenses.
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- 1729A. Department of Veterans Affairs Medical Care Collections Fund.
- 1729B. Consolidated patient accounting centers.
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SUBCHAPTER VIII—HEALTH CARE OF PERSONS OTHER THAN VETERANS

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- 1783. Bereavement counseling.
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- 1784A. Examination and treatment for emergency medical conditions and women in labor.
- 1785. Care and services during certain disasters and emergencies.
- 1786. Care for newborn children of women veterans receiving maternity care.
- 1787. Health care of family members of veterans stationed at Camp Lejeune, North Carolina.

SUBCHAPTER I—GENERAL

* * * * *

§ 1701. Definitions

For the purposes of this chapter—

- (1) The term “disability” means a disease, injury, or other physical or mental defect.
- (2) The term “veteran of any war” includes any veteran awarded the Medal of Honor.
- (3) The term “facilities of the Department” means—
- (A) facilities over which the Secretary has direct jurisdiction;
 - (B) Government facilities for which the Secretary contracts; and
 - (C) public or private facilities at which the Secretary provides recreational activities for patients receiving care under section 1710 of this title.
- (4) The term “non-Department facilities” means facilities other than Department facilities.
- (5) The term “hospital care” includes—
- (A)(i) medical services rendered in the course of the hospitalization of any veteran, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title;
 - (B) such mental health services, consultation, professional counseling, marriage and family counseling, and training for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as the Secretary considers appropriate for the effective treatment and rehabilitation of a veteran or dependent or survivor of a veteran receiving care under the last sentence of section 1781(b) of this title; and
 - (C)(i) medical services rendered in the course of the hospitalization of a dependent or survivor of a veteran receiving care under the last sentence of section 1781(b) of this title, and (ii) travel and incidental expenses for such dependent or survivor under the terms and conditions set forth in section 111 of this title.
- (6) The term “medical services” includes, in addition to medical examination, treatment, and rehabilitative services, the following:
- (A) Surgical services.
 - (B) Dental services and appliances as described in sections 1710 and 1712 of this title.
 - (C) Optometric and podiatric services.
 - (D) Preventive health services.
 - (E) Noninstitutional extended care services, including alternatives to institutional extended care that the Secretary may furnish directly, by contract, or through provision of case management by another provider or payer.
 - (F) In the case of a person otherwise receiving care or services under this chapter—
 - (i) wheelchairs, artificial limbs, trusses, and similar appliances;
 - (ii) special clothing made necessary by the wearing of prosthetic appliances; and
 - (iii) such other supplies or services as the Secretary determines to be reasonable and necessary.
 - (G) Travel and incidental expenses pursuant to section 111 of this title.
- (7) The term “domiciliary care” includes necessary medical services and travel and incidental expenses pursuant to the provisions of section 111 of this title.

(8) The term “rehabilitative services” means such professional, counseling, and guidance services and treatment programs as are necessary to restore, to the maximum extent possible, the physical, mental, and psychological functioning of an ill or disabled person.

(9) The term “preventive health services” means—

- (A) periodic medical and dental examinations;
- (B) patient health education (including nutrition education);
- (C) maintenance of drug use profiles, patient drug monitoring, and drug utilization education;
- (D) mental health preventive services;
- (E) substance abuse prevention measures;
- (F) immunizations against infectious diseases, including each immunization on the recommended adult immunization schedule at the time such immunization is indicated on that schedule;
- (G) prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature;
- (H) genetic counseling concerning inheritance of genetically determined diseases;
- (I) routine vision testing and eye care services;
- (J) periodic reexamination of members of likely target populations (high-risk groups) for selected diseases and for functional decline of sensory organs, together with attendant appropriate remedial intervention; and
- (K) such other health-care services as the Secretary may determine to be necessary to provide effective and economical preventive health care.

(10) The term “recommended adult immunization schedule” means the schedule established (and periodically reviewed and, as appropriate, revised) by the Advisory Committee on Immunization Practices established by the Secretary of Health and Human Services and delegated to the Centers for Disease Control and Prevention.

(11) *The term “network provider” means any of the following health care providers that have entered into a contract or agreement under which the provider 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 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.*

(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 Secretary for purposes of such section.*

(12) The term “VA Care in the Community Program” 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.

* * * * *

§ 1703. Contracts for hospital care and medical services in non-Department facilities

(a) When Department facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Secretary, as authorized in section 1710 of this title, may contract with non-Department facilities in order to furnish any of the following:

(1) Hospital care or medical services to a veteran for the treatment of—

(A) a service-connected disability;

(B) a disability for which a veteran was discharged or released from the active military, naval, or air service; or

(C) a disability of a veteran who has a total disability permanent in nature from a service-connected disability.

(2) Medical services for the treatment of any disability of—

(A) a veteran described in section 1710(a)(1)(B) of this title;

(B) a veteran who (i) has been furnished hospital care, nursing home care, domiciliary care, or medical services, and (ii) requires medical services to complete treatment incident to such care or services; or

(C) a veteran described in section 1710(a)(2)(E) of this title, or a veteran who is in receipt of increased pension, or additional compensation or allowances based on the need of regular aid and attendance or by reason of being permanently housebound (or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance), if the Secretary has determined, based on an examination by a physician employed by the Department (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in Department facilities.

(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a Department facility or nursing home care under section 1720 of this title until such time following the furnishing of care in the non-Department facility as the veteran can be safely transferred to a Department facility.

(4) Hospital care for women veterans.

(5) Hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State (other than the Commonwealth of Puerto Rico) not contiguous to the contiguous States, except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense of the De-

partment in Government and non-Department facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the furnishing of medical services for veterans hospitalized or treated by the Department within the 48 contiguous States and the Commonwealth of Puerto Rico.

(6) Diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent Department out-patient clinics to obviate the need for hospital admission.

(7) Outpatient dental services and treatment, and related dental appliances, for a veteran described in section 1712(a)(1)(F) of this title.

(8) Diagnostic services (on an inpatient or outpatient basis) for observation or examination of a person to determine eligibility for a benefit or service under laws administered by the Secretary.

(b) In the case of any veteran for whom the Secretary contracts to furnish care or services in a non-Department facility pursuant to a provision of subsection (a) of this section, the Secretary shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.

(c) The Secretary shall include in the budget documents which the Secretary submits to Congress for any fiscal year a detailed report on the furnishing of contract care and services during the most recently completed fiscal year under this section, sections 1712A, 1720, 1720A, 1724, and 1732 of this title, and section 115 of the Veterans' Benefits and Services Act of 1988 (Public Law 100-322; 102 Stat. 501).

(d)(1) The Secretary shall conduct a program of recovery audits for fee basis contracts and other medical services contracts for the care of veterans under this section, and for beneficiaries under sections 1781, 1782, and 1783 of this title, with respect to overpayments resulting from processing or billing errors or fraudulent charges in payments for non-Department care and services. The program shall be conducted by contract.

(2) Amounts collected, by setoff or otherwise, as the result of an audit under the program conducted under this subsection shall be available, without fiscal year limitation, for the purposes for which funds are currently available to the Secretary for medical care and for payment to a contractor of a percentage of the amount collected as a result of an audit carried out by the contractor.

(3) The Secretary shall allocate all amounts collected under this subsection with respect to a designated geographic service area of the Veterans Health Administration, net of payments to the contractor, to that region.

(4) The authority of the Secretary under this subsection terminates on September 30, 2020.

(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.*

§ 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 determines 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 operate 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 facilities 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 determination 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 Medicare 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 Federal 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 Secretary 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 subparagraph (A).*

(e) **PROMPT PAYMENT STANDARD.**—(1) *The Secretary 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 subsection, regardless of whether such claims are—*

(A) *made by a network provider to the Secretary;*

(B) made by a network provider to a regional network operated by a contractor pursuant to subsection (a)(4)(B); or
 (C) made by such a regional network to the Secretary.

(2) A covered claimant that seeks payment for hospital care, medical services, or extended care services furnished 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 provider, 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 network operated by a contractor, 180 days after the date on which the contractor pays the network provider 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 before 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 co-

payment 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 electronic 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 Department, or successor system, for the purpose of furnishing 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 pharmaceutical agents on the formulary of the Department to pharmacies of the Department in a manner that is substantially 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 payment 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.*

§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 furnishes home-maker 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 services, 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.*

(C) *Procedures for assessing eligible providers based on the risk of fraud, waste, and abuse of such providers similar to the level of screening under section 1866(j)(2)(B) of the Social Security Act (42 U.S.C. 1395(j)(2)(B)) and the standards set forth under section 9.104 of title 48, Code of Federal Regulations, or any successor regulation.*

(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. 1320a-7b(f))) 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 Management, or any successor system.

(E) Procedures by which a provider whose certification is denied or revoked under the procedures established under this subsection will be identified as an excluded source on the list maintained in the System for Award Management, or successor system, if the Secretary determines that such exclusion is appropriate.

(2) To the extent practicable, the Secretary shall establish the procedures under paragraph (1) in a manner that takes into account any certification process administered by another department or agency of the Federal Government 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 excluded 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.

§ 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.

§ 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 expenditures 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 of-

ferred 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.*

* * * * *

§ 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 facility 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 models; and*

(B) *take into account non-clinical duties, including with respect to training and research.*

(d) *DEFINITIONS.—In this section:*

(1) *The term “Department provider” means an employee of the Department whose primary responsibilities include furnishing hospital care or medical services, including a physician, a dentist, an optometrist, a podiatrist, a chiropractor, an advanced practice registered nurse, and a physician’s assistant acting 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.*

§ 1706. Management of health care: other requirements

(a) *In managing the provision of hospital care and medical services under section 1710(a) of this title, the Secretary shall, to the extent feasible, design, establish and manage health care programs in such a manner as to promote cost-effective delivery of health care services in the most clinically appropriate setting.*

(b)(1) *In managing the provision of hospital care and medical services under such section, the Secretary shall ensure that the De-*

partment (and each geographic service area of the Veterans Health Administration) maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs, and (B) ensures that overall capacity of the Department to provide such services is not reduced below the capacity of the Department (and each geographic service area of the Veterans Health Administration), nationwide, to provide those services, as of October 9, 1996. The Secretary shall carry out this paragraph in consultation with the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans.

(2) For purposes of paragraph (1), the capacity of the Department (and each geographic service area of the Veterans Health Administration) to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, traumatic brain injury, blindness, prosthetics and sensory aids, and mental illness) within distinct programs or facilities shall be measured for seriously mentally ill veterans as follows (with all such data to be provided by geographic service area and totaled nationally):

(A) For mental health intensive community-based care, the number of discrete intensive care teams constituted to provide such intensive services to seriously mentally ill veterans and the number of veterans provided such care.

(B) For opioid substitution programs, the number of patients treated annually and the amounts expended.

(C) For dual-diagnosis patients, the number treated annually and the amounts expended.

(D) For substance-use disorder programs—

(i) the number of beds (whether hospital, nursing home, or other designated beds) employed and the average bed occupancy of such beds;

(ii) the percentage of unique patients admitted directly to outpatient care during the fiscal year who had two or more additional visits to specialized outpatient care within 30 days of their first visit, with a comparison from 1996 until the date of the report;

(iii) the percentage of unique inpatients with substance-use disorder diagnoses treated during the fiscal year who had one or more specialized clinic visits within three days of their index discharge, with a comparison from 1996 until the date of the report;

(iv) the percentage of unique outpatients seen in a facility or geographic service area during the fiscal year who had one or more specialized clinic visits, with a comparison from 1996 until the date of the report; and

(v) the rate of recidivism of patients at each specialized clinic in each geographic service area of the Veterans Health Administration.

(E) For mental health programs, the number and type of staff that are available at each facility to provide specialized mental health treatment, including satellite clinics, outpatient programs, and community-based outpatient clinics, with a comparison from 1996 to the date of the report.

(F) The number of such clinics providing mental health care, the number and type of mental health staff at each such clinic, and the type of mental health programs at each such clinic.

(G) The total amounts expended for mental health during the fiscal year.

(3) For purposes of paragraph (1), the capacity of the Department (and each geographic service area of the Veterans Health Administration) to provide for the specialized treatment and rehabilitative needs of disabled veterans within distinct programs or facilities shall be measured for veterans with spinal cord dysfunction, traumatic brain injury, blindness, or prosthetics and sensory aids as follows (with all such data to be provided by geographic service area and totaled nationally):

(A) For spinal cord injury and dysfunction specialized centers and for blind rehabilitation specialized centers, the number of staffed beds and the number of full-time equivalent employees assigned to provide care at such centers.

(B) For prosthetics and sensory aids, the annual amount expended.

(C) For traumatic brain injury, the number of patients treated annually and the amounts expended.

(4) In carrying out paragraph (1), the Secretary may not use patient outcome data as a substitute for, or the equivalent of, compliance with the requirement under that paragraph for maintenance of capacity.

(5)(A) Not later than April 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the Secretary's compliance, by facility and by service-network, with the requirements of this subsection. Each such report shall include information on recidivism rates associated with substance-use disorder treatment.

(B) In preparing each report under subparagraph (A), the Secretary shall use standardized data and data definitions.

(C) Each report under subparagraph (A) shall be audited by the Inspector General of the Department, who shall submit to Congress a certification as to the accuracy of each such report.

(6)(A) To ensure compliance with paragraph (1), the Under Secretary for Health shall prescribe objective standards of job performance for employees in positions described in subparagraph (B) with respect to the job performance of those employees in carrying out the requirements of paragraph (1). Those job performance standards shall include measures of workload, allocation of resources, and quality-of-care indicators.

(B) Positions described in this subparagraph are positions in the Veterans Health Administration that have responsibility for allocating and managing resources applicable to the requirements of paragraph (1).

(C) The Under Secretary shall develop the job performance standards under subparagraph (A) in consultation with the Advisory Committee on Prosthetics and Special Disabilities Programs

and the Committee on Care of Severely Chronically Mentally Ill Veterans.

(c) The Secretary shall ensure that each primary care health care facility of the Department develops and carries out a plan to provide mental health services, either through referral or direct provision of services, to veterans who require such services.

(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.*

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SUBCHAPTER II—HOSPITAL, NURSING HOME, OR DOMICILIARY CARE AND MEDICAL TREATMENT

* * * * *

§ 1712. Dental care; drugs and medicines for certain disabled veterans; vaccines

(a)(1) Outpatient dental services and treatment, and related dental appliances, shall be furnished under this section only for a dental condition or disability—

- (A) *which is service-connected and compensable in degree;*
- (B) *which is service-connected, but not compensable in degree, but only if—*

(i) the dental condition or disability is shown to have been in existence at the time of the veteran's discharge or release from active military, naval, or air service;

(ii) the veteran had served on active duty for a period of not less than 180 days or, in the case of a veteran who served on active duty during the Persian Gulf War, 90 days immediately before such discharge or release;

(iii) application for treatment is made within 180 days after such discharge or release, except that (I) in the case of a veteran who reentered active military, naval, or air service within 90 days after the date of such veteran's prior discharge or release from such service, application may be made within 180 days from the date of such veteran's subsequent discharge or release from such service, and (II) if a disqualifying discharge or release has been corrected by competent authority, application may be made within 180 days after the date of correction; and

(iv) the veteran's certificate of discharge or release from active duty does not bear a certification that the veteran was provided, within the 90-day period immediately before the date of such discharge or release, a complete dental examination (including dental X-rays) and all appropriate dental services and treatment indicated by the examination to be needed;

(C) which is a service-connected dental condition or disability due to combat wounds or other service trauma, or of a former prisoner of war;

(D) which is associated with and is aggravating a disability resulting from some other disease or injury which was incurred in or aggravated by active military, naval, or air service;

(E) which is a non-service-connected condition or disability of a veteran for which treatment was begun while such veteran was receiving hospital care under this chapter and such services and treatment are reasonably necessary to complete such treatment;

(F) from which a veteran who is a former prisoner of war is suffering;

(G) from which a veteran who has a service-connected disability rated as total is suffering; or

(H) the treatment of which is medically necessary (i) in preparation for hospital admission, or (ii) for a veteran otherwise receiving care or services under this chapter.

(2) The Secretary concerned shall at the time a member of the Armed Forces is discharged or released from a period of active military, naval, or air service of not less than 180 days or, in the case of a veteran who served on active duty during the Persian Gulf War, 90 days provide to such member a written explanation of the provisions of clause (B) of paragraph (1) of this subsection and enter in the service records of the member a statement signed by the member acknowledging receipt of such explanation (or, if the member refuses to sign such statement, a certification from an officer designated for such purpose by the Secretary concerned that the member was provided such explanation).

(3) The total amount which the Secretary may expend for furnishing, during any twelve-month period, outpatient dental serv-

ices, treatment, or related dental appliances to a veteran under this section through private facilities for which the Secretary has contracted [under clause (1), (2), or (5) of section 1703(a) of this title] *under the VA Care in the Community Program* may not exceed \$1,000 unless the Secretary determines, prior to the furnishing of such services, treatment, or appliances and based on an examination of the veteran by a dentist employed by the Department (or, in an area where no such dentist is available, by a dentist conducting such examination under a contract or fee arrangement), that the furnishing of such services, treatment, or appliances at such cost is reasonably necessary.

(4)(A) Except as provided in subparagraph (B) of this paragraph, in any year in which the President's Budget for the fiscal year beginning October 1 of such year includes an amount for expenditures for contract dental care under the provisions of this subsection [and section 1703 of this title] *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)* during such fiscal year in excess of the level of expenditures made for such purpose during fiscal year 1978, the Secretary shall, not later than February 15 of such year, submit a report to the appropriate committees of the Congress justifying the requested level of expenditures for contract dental care and explaining why the application of the criteria prescribed [in section 1703 of this title] *under the VA Care in the Community Program* for contracting with private facilities and in the second sentence of section 1710(c) of this title for furnishing incidental dental care to hospitalized veterans will not preclude the need for expenditures for contract dental care in excess of the fiscal year 1978 level of expenditures for such purpose. In any case in which the amount included in the President's Budget for any fiscal year for expenditures for contract dental care under such provisions is not in excess of the level of expenditures made for such purpose during fiscal year 1978 and the Secretary determines after the date of submission of such budget and before the end of such fiscal year that the level of expenditures for such contract dental care during such fiscal year will exceed the fiscal year 1978 level of expenditures, the Secretary shall submit a report to the appropriate committees of the Congress containing both a justification (with respect to the projected level of expenditures for such fiscal year) and an explanation as required in the preceding sentence in the case of a report submitted pursuant to such sentence. Any report submitted pursuant to this paragraph shall include a comment by the Secretary on the effect of the application of the criteria prescribed in the second sentence of section 1710(c) of this title for furnishing incidental dental care to hospitalized veterans.

(B) A report under subparagraph (A) of this paragraph with respect to a fiscal year is not required if, in the documents submitted by the Secretary to the Congress in justification for the amounts included for Department programs in the President's Budget, the Secretary specifies with respect to contract dental care described in such subparagraph—

- (i) the actual level of expenditures for such care in the fiscal year preceding the fiscal year in which such Budget is submitted;

- (ii) a current estimate of the level of expenditures for such care in the fiscal year in which such Budget is submitted; and
- (iii) the amount included in such Budget for such care.

(b) Dental services and related appliances for a dental condition or disability described in paragraph (1)(B) of subsection (a) shall be furnished on a one-time completion basis, unless the services rendered on a one-time completion basis are found unacceptable within the limitations of good professional standards, in which event such additional services may be afforded as are required to complete professionally acceptable treatment.

(c) Dental appliances, wheelchairs, artificial limbs, trusses, special clothing, and similar appliances to be furnished by the Secretary under this section may be procured by the Secretary either by purchase or by manufacture, whichever the Secretary determines may be advantageous and reasonably necessary.

(d) The Secretary shall furnish to each veteran who is receiving additional compensation or allowance under chapter 11 of this title, or increased pension as a veteran of a period of war, by reason of being permanently housebound or in need of regular aid and attendance, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran. The Secretary shall continue to furnish such drugs and medicines so ordered to any such veteran in need of regular aid and attendance whose pension payments have been discontinued solely because such veteran's annual income is greater than the applicable maximum annual income limitation, but only so long as such veteran's annual income does not exceed such maximum annual income limitation by more than \$1,000.

(e) In order to assist the Secretary of Health and Human Services in carrying out national immunization programs under other provisions of law, the Secretary may authorize the administration of immunizations to eligible veterans who voluntarily request such immunizations in connection with the provision of care for a disability under this chapter in any Department health care facility. Any such immunization shall be made using vaccine furnished by the Secretary of Health and Human Services at no cost to the Department. For such purpose, notwithstanding any other provision of law, the Secretary of Health and Human Services may provide such vaccine to the Department at no cost. Section 7316 of this title shall apply to claims alleging negligence or malpractice on the part of Department personnel granted immunity under such section.

§ 1712A. Eligibility for readjustment counseling and related mental health services

(a)(1)(A) Upon the request of any individual referred to in subparagraph (C), the Secretary shall furnish counseling, including by furnishing counseling through a Vet Center, to the individual—

- (i) in the case of an individual referred to in clauses (i) through (iv) of subparagraph (C), to assist the individual in readjusting to civilian life; and
- (ii) in the case of an individual referred to in clause (v) of such subparagraph who is a family member of a veteran or member described in such clause—

- (I) in the case of a member who is deployed in a theater of combat operations or an area at a time during which hostilities are occurring in that area, during such deployment to assist such individual in coping with such deployment; and
 - (II) in the case of a veteran or member who is readjusting to civilian life, to the degree that counseling furnished to such individual is found to aid in the readjustment of such veteran or member to civilian life.
- (B) Counseling furnished to an individual under subparagraph (A) may include a comprehensive individual assessment of the individual's psychological, social, and other characteristics to ascertain whether—
- (i) in the case of an individual referred to in clauses (i) through (iv) of subparagraph (C), such individual has difficulties associated with readjusting to civilian life; and
 - (ii) in the case of an individual referred to in clause (v) of such subparagraph, such individual has difficulties associated with—
 - (I) coping with the deployment of a member described in subclause (I) of such clause; or
 - (II) readjustment to civilian life of a veteran or member described in subclause (II) of such clause.
- (C) Subparagraph (A) applies to the following individuals:
- (i) Any individual who is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who served on active duty in a theater of combat operations or an area at a time during which hostilities occurred in that area.
 - (ii) Any individual who is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who provided direct emergency medical or mental health care, or mortuary services to the casualties of combat operations or hostilities, but who at the time was located outside the theater of combat operations or area of hostilities.
 - (iii) Any individual who is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who engaged in combat with an enemy of the United States or against an opposing military force in a theater of combat operations or an area at a time during which hostilities occurred in that area by remotely controlling an unmanned aerial vehicle, notwithstanding whether the physical location of such veteran or member during such combat was within such theater of combat operations or area.
 - (iv) Any individual who received counseling under this section before the date of the enactment of the National Defense Authorization Act for Fiscal Year 2013.
 - (v) Any individual who is a family member of any—
 - (I) member of the Armed Forces, including a member of a reserve component of the Armed Forces, who is serving on active duty in a theater of combat operations or in an area at a time during which hostilities are occurring in that area; or
 - (II) veteran or member of the Armed Forces described in this subparagraph.

(2) Upon request of an individual described in paragraph (1)(C), the Secretary shall provide the individual a comprehensive individual assessment as described in paragraph (1)(B) as soon as practicable after receiving the request, but not later than 30 days after receiving the request.

(b)(1) If, on the basis of the assessment furnished under subsection (a) of this section, a licensed or certified mental health care provider employed by the Department (or, in areas where no such licensed or certified mental health care provider is available, a licensed or certified mental health care provider carrying out such function under a contract or fee arrangement with the Secretary) determines that the provision of mental health services to such veteran is necessary to facilitate the successful readjustment of the veteran to civilian life, such veteran shall, within the limits of Department facilities, be furnished such services on an outpatient basis. For the purposes of furnishing such mental health services, the counseling furnished under subsection (a) of this section shall be considered to have been furnished by the Department as a part of hospital care. Any hospital care and other medical services considered necessary on the basis of the assessment furnished under subsection (a) of this section shall be furnished only in accordance with the eligibility criteria otherwise set forth in this chapter (including the eligibility criteria set forth in section 1784 of this title).

(2) Mental health services furnished under paragraph (1) of this subsection may, if determined to be essential to the effective treatment and readjustment of the veteran, include such consultation, counseling, training, services, and expenses as are described in sections 1782 and 1783 of this title.

(c) Upon receipt of a request for counseling under this section from any individual who has been discharged or released from active military, naval, or air service but who is not otherwise eligible for such counseling, the Secretary shall—

(1) provide referral services to assist such individual, to the maximum extent practicable, in obtaining mental health care and services from sources outside the Department; and

(2) if pertinent, advise such individual of such individual's rights to apply to the appropriate military, naval, or air service, and to the Department, for review of such individual's discharge or release from such service.

(d) The Under Secretary for Health may provide for such training of professional, paraprofessional, and lay personnel as is necessary to carry out this section effectively, and, in carrying out this section, may utilize the services of paraprofessionals, individuals who are volunteers working without compensation, and individuals who are veteran-students (as described in section 3485 of this title) in initial intake and screening activities.

(e)(1) In furnishing counseling and related mental health services under subsections (a) and (b) of this section, the Secretary shall have available the same authority to enter into contracts with private facilities that is available to the Secretary [(under sections 1703(a)(2) and 1710(a)(1)(B) of this title)] (*under the VA Care in the Community Program*) in furnishing medical services to veterans suffering from total service-connected disabilities.

(2) Before furnishing counseling or related mental health services described in subsections (a) and (b) of this section through a con-

tract facility, as authorized by this subsection, the Secretary shall approve (in accordance with criteria which the Secretary shall prescribe by regulation) the quality and effectiveness of the program operated by such facility for the purpose for which the counseling or services are to be furnished.

(3) The authority of the Secretary to enter into contracts under this subsection shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

(f) The Secretary, in cooperation with the Secretary of Defense, shall take such action as the Secretary considers appropriate to notify veterans who may be eligible for assistance under this section of such potential eligibility.

(g) In carrying out this section and in furtherance of the Secretary's responsibility to carry out outreach activities under chapter 63 of this title, the Secretary may provide for and facilitate the participation of personnel employed by the Secretary to provide services under this section in recreational programs that are—

- (1) designed to encourage the readjustment of veterans described in subsection (a)(1)(C); and
- (2) operated by any organization named in or approved under section 5902 of this title.

(h) For the purposes of this section:

(1) The term "Vet Center" means a facility which is operated by the Department for the provision of services under this section and which is situated apart from Department general health care facilities.

(2) The term "Department general health-care facility" means a health-care facility which is operated by the Department for the furnishing of health-care services under this chapter, not limited to services provided through the program established under this section.

(3) The term "family member", with respect to a veteran or member of the Armed Forces, means an individual who—

(A) is a member of the family of the veteran or member, including—

- (i) a parent;
- (ii) a spouse;
- (iii) a child;
- (iv) a step-family member; and
- (v) an extended family member; or

(B) lives with the veteran or member but is not a member of the family of the veteran or member.

* * * * *

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

* * * * *

§ 1725. Reimbursement for emergency treatment

(a) GENERAL AUTHORITY.—(1) Subject to subsections (c) and (d), the Secretary shall reimburse a veteran described in subsection (b) for the reasonable value of emergency treatment furnished the veteran in a non-Department facility.

(2) In any case in which reimbursement is authorized under subsection (a)(1), the Secretary, in the Secretary's discretion, may, in lieu of reimbursing the veteran, make payment of the reasonable value of the furnished emergency treatment directly—

(A) to a hospital or other health care provider that furnished the treatment; or

(B) to the person or organization that paid for such treatment on behalf of the veteran.

(b) ELIGIBILITY.—(1) A veteran referred to in subsection (a)(1) is an individual who is an active Department health-care participant who is personally liable for emergency treatment furnished the veteran in a non-Department facility.

(2) A veteran is an active Department health-care participant if—

(A) the veteran is enrolled in the health care system established under section 1705(a) of this title; and

(B) the veteran received care under this chapter within the 24-month period preceding the furnishing of such emergency treatment.

(3) A veteran is personally liable for emergency treatment furnished the veteran in a non-Department facility if the veteran—

(A) is financially liable to the provider of emergency treatment for that treatment;

(B) has no entitlement to care or services under a health-plan contract (determined, in the case of a health-plan contract as defined in subsection (f)(2)(B) or (f)(2)(C), without regard to any requirement or limitation relating to eligibility for care or services from any department or agency of the United States);

(C) has no other contractual or legal recourse against a third party that would, in whole, extinguish such liability to the provider; and

(D) is not eligible for reimbursement for medical care or services under section 1728 of this title.

(c) LIMITATIONS ON REIMBURSEMENT.—(1) The Secretary, in accordance with regulations prescribed by the Secretary, shall—

(A) establish the maximum amount payable under subsection (a);

(B) delineate the circumstances under which such payments may be made, to include such requirements on requesting reimbursement as the Secretary shall establish; and

(C) provide that in no event may a payment under that subsection include any amount for which the veteran is not personally liable.

(2) Subject to paragraph (1), the Secretary may provide reimbursement under this section only after the veteran or the provider of emergency treatment has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such treatment.

(3) Payment by the Secretary under this section on behalf of a veteran to a provider of emergency treatment shall, unless rejected and refunded by the provider within 30 days of receipt, extinguish any liability on the part of the veteran for that treatment. Neither the absence of a contract or agreement between the Secretary and the provider nor any provision of a contract, agreement, or assign-

ment to the contrary shall operate to modify, limit, or negate the requirement in the preceding sentence.

(4)(A) If the veteran has contractual or legal recourse against a third party that would only, in part, extinguish the veteran's liability to the provider of the emergency treatment, and payment for the treatment may be made both under subsection (a) and by the third party, the amount payable for such treatment under such subsection shall be the amount by which the costs for the emergency treatment exceed the amount payable or paid by the third party, except that the amount payable may not exceed the maximum amount payable established under paragraph (1)(A).

(B) In any case in which a third party is financially responsible for part of the veteran's emergency treatment expenses, the Secretary shall be the secondary payer.

(C) A payment in the amount payable under subparagraph (A) shall be considered payment in full and shall extinguish the veteran's liability to the provider.

(D) The Secretary may not reimburse a veteran under this section for any copayment or similar payment that the veteran owes the third party or for which the veteran is responsible under a health-plan contract.

(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.

(d) INDEPENDENT RIGHT OF RECOVERY.—(1) In accordance with regulations prescribed by the Secretary, the United States shall have the independent right to recover any amount paid under this section when, and to the extent that, a third party subsequently makes a payment for the same emergency treatment.

(2) Any amount paid by the United States to the veteran (or the veteran's personal representative, successor, dependents, or survivors) or to any other person or organization paying for such treatment shall constitute a lien in favor of the United States against any recovery the payee subsequently receives from a third party for the same treatment.

(3) Any amount paid by the United States to the provider that furnished the veteran's emergency treatment shall constitute a lien against any subsequent amount the provider receives from a third

party for the same emergency treatment for which the United States made payment.

(4) The veteran (or the veteran's personal representative, successor, dependents, or survivors) shall ensure that the Secretary is promptly notified of any payment received from any third party for emergency treatment furnished to the veteran. The veteran (or the veteran's personal representative, successor, dependents, or survivors) shall immediately forward all documents relating to such payment, cooperate with the Secretary in the investigation of such payment, and assist the Secretary in enforcing the United States right to recover any payment made under subsection (c)(3).

(e) WAIVER.—The Secretary, in the Secretary's discretion, may waive recovery of a payment made to a veteran under this section that is otherwise required by subsection (d)(1) when the Secretary determines that such waiver would be in the best interest of the United States, as defined by regulations prescribed by the Secretary.

(f) DEFINITIONS.—For purposes of this section:

(1) The term "emergency treatment" means medical care or services furnished, in the judgment of the Secretary—

(A) when Department or other Federal facilities are not feasibly available and an attempt to use them beforehand would not be reasonable;

(B) when such care or services are rendered in a medical emergency of such nature that a prudent layperson reasonably expects that delay in seeking immediate medical attention would be hazardous to life or health; and

(C) until—

(i) such time as the veteran can be transferred safely to a Department facility or other Federal facility and such facility is capable of accepting such transfer; or

(ii) such time as a Department facility or other Federal facility accepts such transfer if—

(I) at the time the veteran could have been transferred safely to a Department facility or other Federal facility, no Department facility or other Federal facility agreed to accept such transfer; and

(II) the non-Department facility in which such medical care or services was furnished made and documented reasonable attempts to transfer the veteran to a Department facility or other Federal facility.

(2) The term "health-plan contract" includes any of the following:

(A) An insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement under which health services for individuals are provided or the expenses of such services are paid.

(B) An insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of that Act (42 U.S.C. 1395j).

- (C) A State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.).
- (D) A workers' compensation law or plan described in section 1729(a)(2)(A) of this title.
- (3) The term "third party" means any of the following:
 - (A) A Federal entity.
 - (B) A State or political subdivision of a State.
 - (C) An employer or an employer's insurance carrier.
 - (D) An automobile accident reparations insurance carrier.
 - (E) A person or entity obligated to provide, or to pay the expenses of, health services under a health-plan contract.

* * * * *

§ 1729. Recovery by the United States of the cost of certain care and services

(a)(1) Subject to the provisions of this section, in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect reasonable charges for such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

(2) Paragraph (1) of this subsection applies to a non-service-connected disability—

(A) that is incurred incident to the veteran's employment and that is covered under a workers' compensation law or plan that provides for payment for the cost of health care and services provided to the veteran by reason of the disability;

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

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

(D) that is incurred by a veteran—

- (i) who does not have a service-connected disability; and
- (ii) who is entitled to care (or payment of the expenses of care) under a health-plan contract; or

(E) for which care and services are furnished before September 30, 2019, under this chapter to a veteran who—

- (i) has a service-connected disability; and
- (ii) is entitled to care (or payment of the expenses of care) under a health-plan contract.

(3) In the case of a health-plan contract that contains a requirement for payment of a deductible or copayment by the veteran—

(A) the veteran's not having paid such deductible or copayment with respect to care or services furnished under this

chapter shall not preclude recovery or collection under this section; and

(B) the amount that the United States may collect or recover under this section shall be reduced by the appropriate deductible or copayment amount, or both.

(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)(1) As to the right provided in subsection (a) of this section, the United States shall be subrogated to any right or claim that the veteran (or the veteran's personal representative, successor, dependents, or survivors) may have against a third party.

(2)(A) In order to enforce any right or claim to which the United States is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by the veteran (or the veteran's personal representative, successor, dependents, or survivors) against a third party.

(B) The United States may institute and prosecute legal proceedings against the third party if—

(i) an action or proceeding described in subparagraph (A) of this paragraph is not begun within 180 days after the first day on which care or services for which recovery is sought are furnished to the veteran by the Secretary under this chapter;

(ii) the United States has sent written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute such legal proceedings; and

(iii) a period of 60 days has passed following the mailing of such notice.

(C) A proceeding under subparagraph (B) of this paragraph may not be brought after the end of the six-year period beginning on the last day on which the care or services for which recovery is sought are furnished.

(c)(1) The Secretary may compromise, settle, or waive any claim which the United States has under this section.

(2)(A) The Secretary, after consultation with the Comptroller General of the United States, shall prescribe regulations for the purpose of determining reasonable charges for care or services under subsection (a)(1) of this section. Any determination of such charges shall be made in accordance with such regulations.

(B) Such regulations shall provide that the reasonable charges for care or services sought to be recovered or collected from a third-party liable under a health-plan contract may not exceed the amount that such third party demonstrates to the satisfaction of the Secretary it would pay for the care or services if provided by facilities (other than facilities of departments or agencies of the United States) in the same geographic area.

(C) Not later than 45 days after the date on which the Secretary prescribes such regulations (or any amendment to such regulations), the Comptroller General shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives the Comptroller General's comments on and recommendations regarding such regulations (or amendment).

(d) Any contract or agreement into which the Secretary enters with a person under section 3718 of title 31 for collection services to recover indebtedness owed the United States under this section shall provide, with respect to such services, that such person is subject to sections 5701 and 7332 of this title.

(e) A veteran eligible for care or services under this chapter—

(1) may not be denied such care or services by reason of this section; and

(2) may not be required by reason of this section to make any copayment or deductible payment in order to receive such care.

(f) No law of any State or of any political subdivision of a State, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under section 1784 of this title.

(h)(1) Subject to paragraph (3) of this subsection, the Secretary shall make available medical records of a veteran described in paragraph (2) of this subsection for inspection and review by representatives of the third party concerned for the sole purposes of permitting the third party to verify—

(A) that the care or services for which recovery or collection is sought were furnished to the veteran; and

(B) that the provision of such care or services to the veteran meets criteria generally applicable under the health-plan contract involved.

(2) A veteran described in this paragraph is a veteran who is a beneficiary of a health-plan contract under which recovery or collection is sought under this section from the third party concerned for the cost of the care or services furnished to the veteran.

(3) Records shall be made available under this subsection under such conditions to protect the confidentiality of such records as the Secretary shall prescribe in regulations.

(i) For purposes of this section—

(1)(A) The term “health-plan contract” means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid.

(B) Such term does not include—

(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);

(ii) a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.);

(iii) a workers’ compensation law or plan described in subparagraph (A) of subsection (a)(2) of this section; or

(iv) a program, plan, or policy under a law described in subparagraph (B) or (C) of such subsection.

(2) The term “payment” includes reimbursement and indemnification.

(3) The term “third party” means—

(A) a State or political subdivision of a State;

(B) an employer or an employer’s insurance carrier;

(C) an automobile accident reparations insurance carrier; or

(D) a person obligated to provide, or to pay the expenses of, health services under a health-plan contract.

§ 1729A. Department of Veterans Affairs Medical Care Collections Fund

(a) There is in the Treasury a fund to be known as the Department of Veterans Affairs Medical Care Collections Fund.

(b) Amounts recovered or collected under any of the following provisions of law shall be deposited in the fund:

- (1) Section 1710(f) of this title.
- (2) Section 1710(g) of this title.
- (3) Section 1711 of this title.
- (4) Section 1722A of this title.
- (5) Section 1725 of this title.
- (6) Section 1729 of this title.
- (7) Section 1784 of this title.
- (8) Section 8165(a) of this title.

(9) Section 113 of the Veterans Millennium Health Care and Benefits Act (Public Law 106-117; 38 U.S.C. 8111 note).

(10) Public Law 87-693, popularly known as the "Federal Medical Care Recovery Act" (42 U.S.C. 2651 et seq.), to the extent that a recovery or collection under that law is based on medical care or services furnished under this chapter.

(c)(1) Subject to the provisions of appropriations Acts, amounts in the fund shall be available, without fiscal year limitation, to the Secretary for the following purposes:

(A) Furnishing medical care and services under this chapter, to be available during any fiscal year for the same purposes and subject to the same limitations (other than with respect to the period of availability for obligation) as apply to amounts appropriated from the general fund of the Treasury for that fiscal year for medical care.

(B) Expenses of the Department for the identification, billing, auditing, and collection (*including with respect to automatic data processing or information technology improvements*) of amounts owed the United States by reason of medical care and services furnished under this chapter.

(2) Amounts available under paragraph (1) may not be used for any purpose other than a purpose set forth in subparagraph (A) or (B) of that paragraph.

(d) Of the total amount recovered or collected by the Department during a fiscal year under the provisions of law referred to in subsection (b) and made available from the fund, the Secretary shall make available to each Department health care facility of the Department an amount that bears the same ratio to the total amount so made available as the amount recovered or collected by such facility during that fiscal year under such provisions of law bears to such total amount recovered or collected during that fiscal year. The Secretary shall make available to each facility the entirety of the amount specified to be made available to such facility by the preceding sentence.

(e) Amounts recovered or collected under the provisions of law referred to in subsection (b) shall be treated for the purposes of sections 251 and 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901, 902) as offsets to discretionary

appropriations (rather than as offsets to direct spending) to the extent that such amounts are made available for expenditure in appropriations Acts for the purposes specified in subsection (c).

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§ 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.

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SUBCHAPTER V—PAYMENTS TO STATE HOMES

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§ 1745. Nursing home care and medications for veterans with service-connected disabilities

(a)(1) The Secretary shall enter into [a contract (or agreement under section 1720(c)(1) of this title)] *an agreement* with each State home for payment by the Secretary for nursing home care provided in the home, in any case in which such care is provided to any veteran as follows:

(A) Any veteran in need of such care for a service-connected disability.

(B) Any veteran who—

(i) has a service-connected disability rated at 70 percent or more; and

(ii) is in need of such care.

(2) Payment under each **【contract (or agreement)】** *agreement* between the Secretary and a State home under paragraph (1) shall be based on a methodology, developed by the Secretary in consultation with the State home, to adequately reimburse the State home for the care provided by the State home under the **【contract (or agreement)】** *agreement*.

(3) Payment by the Secretary under paragraph (1) to a State home for nursing home care provided to a veteran described in that paragraph constitutes payment in full to the State home for such care furnished to that veteran.

(4)(A) *An agreement under this section may be entered 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 prescribed 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 providers 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 person 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 agreement or arrangement other than under this section.*

(b) The Secretary shall furnish such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of illness or injury to any veteran as follows:

(1) Any veteran who—

(A) is not being provided nursing home care for which payment is payable under subsection (a); and

(B) is in need of such drugs and medicines for a service-connected disability.

(2) Any veteran who—

(A) has a service-connected disability rated at 50 percent or more;

(B) is not being provided nursing home care for which payment is payable under subsection (a); and

(C) is in need of such drugs and medicines.

(c) Any State home that requests payment or reimbursement for services provided to a veteran under this section shall provide to the Secretary such information as the Secretary considers necessary to identify each individual veteran eligible for payment under such section.

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CHAPTER 23—BURIAL BENEFITS

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§ 2303. Death in Department facility; plot allowance

(a)(1) When a veteran dies in a facility described in paragraph (2), the Secretary shall—

(A) pay the actual cost (not to exceed \$700 (as increased from time to time under subsection (c))) of the burial and funeral or, within such limits, may make contracts for such services without regard to the laws requiring advertisement for proposals for supplies and services for the Department; and

(B) when such a death occurs in a State, transport the body to the place of burial in the same or any other State.

(2) A facility described in this paragraph is—

(A) a facility of the Department (as defined in section 1701(3) of this title) to which the deceased was properly admitted for hospital, nursing home, or domiciliary care under section 1710 or 1711(a) of this title; or

(B) an institution at which the deceased veteran was, at the time of death, receiving—

(i) hospital care [in accordance with section 1703 of this title] *under the VA Care in the Community Program*;

(ii) nursing home care under section 1720 of this title; or

(iii) nursing home care for which payments are made under section 1741 of this title.

(b) In addition to the benefits provided for under section 2302 of this title and subsection (a) of this section, in the case of a veteran who is eligible for burial in a national cemetery under section 2402 of this title and who is not buried in a national cemetery or other cemetery under the jurisdiction of the United States—

(1) if such veteran is buried (without charge for the cost of a plot or interment) in a cemetery, or a section of a cemetery, that (A) is used solely for the interment of persons who are (i) eligible for burial in a national cemetery, and (ii) members of a reserve component of the Armed Forces not otherwise eligible for such burial or former members of such a reserve component not otherwise eligible for such burial who are discharged or released from service under conditions other than dishonorable, and (B) is owned by a State or by an agency or political subdivision of a State, the Secretary shall pay to such State, agency, or political subdivision the sum of \$700 (as increased from time to time under subsection (c)) as a plot or interment allowance for such veteran; and

(2) if such veteran is eligible for a burial allowance under section 2302 of this title or under subsection (a) of this section, or was discharged from the active military, naval, or air service for a disability incurred or aggravated in line of duty, and such veteran is buried in a cemetery, or a section of a cemetery, other than as described in clause (1) of this subsection, the Secretary shall pay a sum not exceeding \$700 (as increased from time to time under subsection (c)) as a plot or interment allowance to such person as the Secretary prescribes, except that if any part of the plot or interment costs of a burial to which this clause applies has been paid or assumed by a State, an agency or political subdivision of a State, or a former em-

ployer of the deceased veteran, no claim for such allowance shall be allowed for more than the difference between the entire amount of the expenses incurred and the amount paid or assumed by any or all of the foregoing entities.

(c) With respect to any fiscal year, the Secretary shall provide a percentage increase (rounded to the nearest dollar) in the maximum amount of burial and funeral expenses payable under subsection (a) and in the maximum amount of the plot or interment allowance payable under subsection (b), equal to the percentage by which—

(1) the Consumer Price Index (all items, United States city average) for the 12-month period ending on the June 30 preceding the beginning of the fiscal year for which the increase is made, exceeds

(2) the Consumer Price Index for the 12-month period preceding the 12-month period described in paragraph (1).

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PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 73—VETERANS HEALTH ADMINISTRATION - ORGANIZATION AND FUNCTIONS

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SUBCHAPTER III—PROTECTION OF PATIENT RIGHTS

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§ 7332. Confidentiality of certain medical records

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) To a public or private health care provider 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).

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

(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).

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

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

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

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

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

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

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

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

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

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CHAPTER 74—VETERANS HEALTH ADMINISTRATION - PERSONNEL

SUBCHAPTER I—APPOINTMENTS

Sec.

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§ 7409. Contracts for scarce medical specialist services.

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SUBCHAPTER I—APPOINTMENTS

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§ 7409. Contracts for scarce medical specialist services

[(a) The Secretary may enter into contracts with institutions and persons described in subsection (b) to provide scarce medical specialist services at Department facilities. Such services may include the services of physicians, dentists, podiatrists, optometrists, chiropractors, nurses, physician assistants, expanded-function dental auxiliaries, technicians, and other medical support personnel.

[(b) Institutions and persons with whom the Secretary may enter into contracts under subsection (a) are the following:

[(1) Schools and colleges of medicine, osteopathy, dentistry, podiatry, optometry, and nursing.

[(2) Clinics.

[(3) Any other group or individual capable of furnishing such scarce medical specialist services.]

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CHAPTER 76—HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

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SUBCHAPTER I—GENERAL

§ 7601. Establishment of program; purpose

(a) There is hereby established a program to be known as the Department of Veterans Affairs Health Professionals Educational Assistance Program (hereinafter in this chapter referred to as the “Educational Assistance Program”). The program consists of—

- (1) the scholarship program provided for in subchapter II of this chapter;
- (2) the tuition reimbursement program provided for in subchapter III of this chapter;
- (3) the Selected Reserve member stipend program provided for under subchapter V of this chapter;
- (4) the employee incentive scholarship program provided for in subchapter VI of this chapter; **[and]**
- (5) the education debt reduction program provided for in subchapter VII of this chapter~~].~~; *and*
- (6) *the specialty education loan repayment program provided for in subchapter VIII of this chapter.*

(b) The purpose of the Educational Assistance Program is to assist in providing an adequate supply of trained health-care personnel for the Department and the Nation.

* * * * *

§ 7603. Application and acceptance

(a)(1) To apply to participate in the Educational Assistance Program under subchapter II, III, V, ~~[or VI]~~ *VI, or VIII* of this chapter, an individual shall submit to the Secretary an application for such participation together with an agreement described in section 7604 of this title under which the participant agrees to serve a period of obligated service in the Veterans Health Administration as provided in the agreement in return for payment of educational assistance as provided in the agreement.

(2) To apply to participate in the Educational Assistance Program under subchapter VII of this chapter, an individual shall submit to the Secretary an application for such participation.

(b)(1) An individual becomes a participant in the Educational Assistance Program upon the Secretary's approval of the individual's application and the Secretary's acceptance of the agreement (if required).

(2) Upon the Secretary's approval of an individual's participation in the program, the Secretary shall promptly notify the individual of that approval. Such notice shall be in writing.

(c)(1) In distributing application forms and agreement forms to individuals desiring to participate in the Educational Assistance Program, the Secretary shall include with such forms the following:

(A) A fair summary of the rights and liabilities of an individual whose application is approved (and whose agreement is accepted) by the Secretary, including a clear explanation of the damages to which the United States is entitled if the individual breaches the agreement.

(B) A full description of the terms and conditions that apply to participation in the Educational Assistance Program and service in the Veterans Health Administration.

(2) The Secretary shall make such application forms and other information available to individuals desiring to participate in the Educational Assistance Program on a date sufficiently early to allow such individuals adequate time to prepare and submit such forms.

(d) In selecting applicants for acceptance in the Educational Assistance Program, the Secretary shall give priority to the applications of individuals who have previously received educational as-

sistance under the program and have not completed the course of education or training undertaken under such program.

§ 7604. Terms of agreement

An agreement between the Secretary and a participant in the Educational Assistance Program shall be in writing, shall be signed by the participant, and shall include the following provisions:

- (1) The Secretary’s agreement—
 - (A) to provide the participant with educational assistance as authorized in subchapter II, III, V, ~~VI~~ VI, or VIII of this chapter and specified in the agreement; and
 - (B) to afford the participant the opportunity for employment in the Veterans Health Administration (subject to the availability of appropriated funds for such purpose and other qualifications established in accordance with section 7402 of this title).
- (2) The participant’s agreement—
 - (A) to accept such educational assistance;
 - (B) to maintain enrollment and attendance in the course of training until completed;
 - (C) while enrolled in such course, to maintain an acceptable level of academic standing (as determined by the educational institution offering such course of training under regulations prescribed by the Secretary); and
 - (D) after completion of the course of training, to serve as a full-time employee in the Veterans Health Administration as specified in the agreement in accordance with subchapter II, III, V, ~~VI~~ VI, or VIII of this chapter.
- (3) A provision that any financial obligation of the United States arising out of an agreement entered into under this chapter, and any obligation of the participant which is conditioned on such agreement, is contingent upon funds being appropriated for educational assistance under this chapter.
- (4) A statement of the damages to which the United States is entitled under this chapter for the participant’s breach of the agreement.
- (5) Such other terms as are required to be included in the agreement under subchapter II, III, V, ~~VI~~ VI, or VIII of this chapter or as the Secretary may require consistent with the provisions of this chapter.

SUBCHAPTER II—SCHOLARSHIP PROGRAM

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§ 7612. Eligibility; application; agreement

(a)(1) Except as provided in paragraph (2) of this subsection, an individual must be accepted for enrollment or be enrolled (as described in section 7602 of this title) as a full-time student to be eligible to participate in the Scholarship Program.

(2) An individual who is an eligible Department employee may be accepted as a participant if accepted for enrollment or enrolled (as described in section 7602 of this title) for study on less than a full-time but not less than a half-time basis. (Such a participant is hereinafter in this subchapter referred to as a “part-time student”.)

(3) For the purposes of paragraph (2) of this subsection, an eligible Department employee is a full-time Department employee who is permanently assigned to a Department health-care facility on the date on which the individual submits the application referred to in section 7603 of this title and on the date on which the individual becomes a participant in the Scholarship Program.

(b)(1) A scholarship may be awarded under this subchapter only in a qualifying field of education or training.

(2) A qualifying field of education or training for purposes of this subchapter is education or training leading to employment as an appointee under paragraph (1) or (3) of section 7401 of this title.

(3) The Secretary may designate additional fields of education or training as qualifying fields of education or training if the education or training leads to employment in a position which would qualify the individual for increased basic pay under subsection (a)(1) of section 7455 of this title for personnel described in subsection (a)(2)(B) of such section.

(4) Before awarding the initial scholarship in a course of education or training other than medicine or nursing, the Secretary shall notify the Committees on Veterans' Affairs of the Senate and House of Representatives of the Secretary's intent to award a scholarship in such course of education or training. The notice shall include a statement of the reasons why the award of scholarships in that course of education or training is necessary to assist in providing the Department with an adequate supply of personnel in the health profession concerned. Any such notice shall be given not less than 60 days before the first such scholarship is awarded.

(5) In selecting applicants for the Scholarship Program, the Secretary—

(A) shall give priority to applicants who will be entering their final year in a course of training;

(B) shall give priority to applicants pursuing a course of education or training toward a career in an occupation for which the Inspector General of the Department has, in the most current determination published in the Federal Register pursuant to section 7412(a) of this title, determined that there is one of the largest staffing shortages throughout the Department with respect to such occupation; and

(C) shall ensure an equitable allocation of scholarships to persons enrolled in the second year of a program leading to an associate degree in nursing.

(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, 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 material about the availability of scholarships under this paragraph.*

(c)(1) An agreement between the Secretary and a participant in the Scholarship Program shall (in addition to the requirements set forth in section 7604 of this title) include the following:

(A) The Secretary's agreement to provide the participant with a scholarship under this subchapter for a specified number (from one to four) of school years during which the participant is pursuing a course of education or training described in section 7602 of this title.

(B) 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 one calendar year for each school year or part thereof for which the participant was provided a scholarship under the Scholarship Program, but for not less than two years.

(2) In a case in which an extension is granted under section 7614(3) of this title, the number of years for which a scholarship may be provided under this subchapter shall be the number of school years provided for as a result of the extension.

(3) In the case of a participant who is a part-time student—

(A) the period of obligated service shall be reduced in accordance with the proportion that the number of credit hours carried by such participant in any such school year bears to the number of credit hours required to be carried by a full-time student in the course of training being pursued by the participant, but in no event to less than one year; and

(B) the agreement shall include the participant's agreement to maintain employment, while enrolled in such course of education or training, as a Department employee permanently assigned to a Department health-care facility.

(4) If a participant's period of obligated service is deferred under section 7616(b)(3)(A)(i) of this title, the agreement terms under paragraph (1) of this subsection shall provide for the participant to

serve any additional period of obligated service that is prescribed by the Secretary under section 7616(b)(4)(B) of this title.

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§ 7617. Breach of agreement: liability

(a) A participant in the Scholarship Program (other than a participant described in subsection (b) of this section) who fails to accept payment, or instructs the educational institution in which the participant is enrolled not to accept payment, in whole or in part, of a scholarship under the agreement entered into under section 7603 of this title shall be liable to the United States for liquidated damages in the amount of \$1,500. Such liability is in addition to any period of obligated service or other obligation or liability under the agreement.

(b) A participant in the Scholarship Program shall be liable to the United States for the amount which has been paid to or on behalf of the participant under the agreement if any of the following occurs:

(1) The participant fails to maintain an acceptable level of academic standing in the educational institution in which the participant is enrolled (as determined by the educational institution under regulations prescribed by the Secretary).

(2) The participant is dismissed from such educational institution for disciplinary reasons.

(3) The participant voluntarily terminates the course of training in such educational institution before the completion of such course of training.

(4) *In the case of a participant who is enrolled in a program or education or training leading to employment as a physician, the participant fails to successfully complete post-graduate training leading to eligibility for board certification in a specialty.*

[(4)] (5) The participant fails to become licensed to practice medicine, osteopathy, dentistry, podiatry, or optometry in a State, fails to become licensed as a registered nurse in a State, or fails to meet any applicable licensure requirement in the case of any other health-care personnel who provide either direct patient-care services or services incident to direct patient-care services, during a period of time determined under regulations prescribed by the Secretary.

[(5)] (6) In the case of a participant who is a part-time student, the participant fails to maintain employment, while enrolled in the course of training being pursued by such participant, as a Department employee permanently assigned to a Department health-care facility.

Liability under this subsection is in lieu of any service obligation arising under the participant's agreement.

(c)(1) If a participant in the Scholarship Program breaches the agreement by failing (for any reason) to complete such participant's period of obligated service, the United States shall be entitled to recover from the participant an amount determined in accordance with the following formula: $A = 3\phi(t-s/t)$

In such formula:

(A) "A" is the amount the United States is entitled to recover.

(B) “<phi>” is the sum of (i) the amounts paid under this subchapter to or on behalf of the participant, and (ii) the interest on such amounts which would be payable if at the time the amounts were paid they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States.

(C) “t” is the total number of months in the participant’s period of obligated service, including any additional period of obligated service in accordance with section 7616(b)(4) of this title.

(D) “s” is the number of months of such period served by the participant in accordance with section 7613 of this title.

(2) Any amount of damages which the United States is entitled to recover under this section shall be paid to the United States within the one-year period beginning on the date of the breach of the agreement.

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§ 7619. Expiration of program

The Secretary may not furnish scholarships to new participants in the Scholarship Program after **[December 31, 2019]** *December 31, 2033*.

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SUBCHAPTER IV—ADMINISTRATIVE MATTERS

§ 7631. Periodic adjustments in amount of assistance

(a)(1) Whenever there is a general Federal pay increase, the Secretary shall increase the maximum monthly stipend amount, the maximum tuition reimbursement amount, the maximum Selected Reserve member stipend amount, the maximum employee incentive scholarship amount, **[and]** the maximum education debt reduction payments amount, *and the maximum specialty education loan repayment amount*. Any such increase shall take effect with respect to any school year that ends in the fiscal year in which the pay increase takes effect.

(2) The amount of any increase under paragraph (1) of this subsection is the previous maximum amount under that paragraph multiplied by the overall percentage of the adjustment in the rates of pay under the General Schedule made under the general Federal pay increase. Such amount shall be rounded to the next lower multiple of \$1.

(b) For purposes of this section:

(1) The term “maximum monthly stipend amount” means the maximum monthly stipend that may be paid to a participant in the Scholarship Program specified in section 7613(b) of this title and as previously adjusted (if at all) in accordance with this section.

(2) The term “maximum tuition reimbursement amount” means the maximum amount of tuition reimbursement provided to a participant in the Tuition Reimbursement Program specified in section 7622(e) of this title and as previously adjusted (if at all) in accordance with this section.

(3) The term “maximum Selected Reserve member stipend amount” means the maximum amount of assistance provided to a person receiving assistance under subchapter V of this chapter, as specified in section 7653 of this title and as previously adjusted (if at all) in accordance with this section.

(4) The term “maximum employee incentive scholarship amount” means the maximum amount of the scholarship payable to a participant in the Department of Veterans Affairs Employee Incentive Scholarship Program under subchapter VI of this chapter, as specified in section 7673(b)(1) of this title and as previously adjusted (if at all) in accordance with this section.

(5) The term “maximum education debt reduction payments amount” means the maximum amount of education debt reduction payments payable to a participant in the Department of Veterans Affairs Education Debt Reduction Program under subchapter VII of this chapter, as specified in section 7683(d)(1) of this title and as previously adjusted (if at all) in accordance with this section.

(6) The term “general Federal pay increase” means an adjustment (if an increase) in the rates of pay under the General Schedule under subchapter III of chapter 53 of title 5.

(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.*

§ 7632. Annual report

Not later than March 1 of each year, the Secretary shall submit to Congress a report on the Educational Assistance Program. Each such report shall include the following information:

(1) The number of students receiving educational assistance under the Educational Assistance Program, showing the numbers of students receiving assistance under the Scholarship Program, the Tuition Reimbursement Program, the Employee Incentive Scholarship Program, [and the Education Debt Reduction Program] *the Education Debt Reduction Program, and the Specialty Education Loan Repayment Program* separately, and the number of students (if any) enrolled in each type of health profession training under each program.

(2) The education institutions (if any) providing such training to students in each program.

(3) The number of applications filed under each program, by health profession category, during the school year beginning in such year and the total number of such applications so filed for all years in which the Educational Assistance Program (or predecessor program) has been in existence.

(4) The average amounts of educational assistance provided per participant in the Scholarship Program, per participant in the Tuition Reimbursement Program, per participant in the Employee Incentive Scholarship Program, [and per participant in the Education Debt Reduction Program] *per participant in*

the Education Debt Reduction Program, and per participant in the Specialty Education Loan Repayment Program.

(5) The amount of tuition and other expenses paid, by health profession category, in the aggregate and at each educational institution for the school year beginning in such year and for prior school years.

(6) The number of scholarships accepted, by health profession category, during the school year beginning in such year and the number, by health profession category, which were offered and not accepted.

(7) The number of participants who complete a course or course of training in each program each year and for all years that such program (or predecessor program) has been in existence.

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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 requirements 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 Administration provided by the Secretary, at which such facility the participant will work in a medical specialty described 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 Specialty 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 specialty;
- (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: $A=B \times ((T-S) \div T)$.

(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.

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**VETERANS ACCESS, CHOICE, AND ACCOUNTABILITY
ACT OF 2014**

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

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

(a) EXPANSION OF AVAILABLE CARE AND SERVICES.—

(1) FURNISHING OF CARE.—

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

specified in subparagraph (B) for the furnishing of such care and services to veterans.

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

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

(ii) Any Federally-qualified health center (as defined in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B))).

(iii) The Department of Defense.

(iv) The Indian Health Service.

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

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

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

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

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

(2) the veteran—

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

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

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

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

(i) with respect to a veteran who is seeking primary care, a medical facility of the Department, including a community-based outpatient clinic, that is able to pro-

vide such primary care by a full-time primary care physician; or

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

(C) resides—

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

(I) hospital care;

(II) emergency medical services; and

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

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

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

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

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

(aa) geographical challenges;

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

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

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

(c) ELECTION AND AUTHORIZATION.—

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

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

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

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

(2) ELECTRONIC WAITING LIST.—The electronic waiting list described in this paragraph shall be maintained by the Depart-

ment and allow access by each eligible veteran via www.myhealth.va.gov or any successor website (or other digital channel) for the following purposes:

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

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

(d) CARE AND SERVICES THROUGH AGREEMENTS.—

(1) AGREEMENTS.—

(A) IN GENERAL.—The Secretary shall enter into agreements for furnishing care and services to eligible veterans under this section with entities specified in subsection (a)(1)(B). An agreement entered into pursuant to this subparagraph may not be treated as a Federal contract for the acquisition of goods or services and is not subject to any provision of law governing Federal contracts for the acquisition of goods or services. Before entering into an agreement pursuant to this subparagraph, the Secretary shall, to the maximum extent practicable and consistent with the requirements of this section, furnish such care and services to such veterans under this section with such entities pursuant to sharing agreements, existing contracts entered into by the Secretary, or other processes available at medical facilities of the Department.

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

(2) RATES AND REIMBURSEMENT.—

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

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

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

(B) LIMIT ON RATES.—

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

(ii) EXCEPTION.—

(I) IN GENERAL.—The Secretary may negotiate a rate that is more than the rate paid by the United States as described in clause (i) with respect to the furnishing of care or services under this sec-

tion to an eligible veteran who resides in a highly rural area.

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

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

(C) LIMIT ON COLLECTION.—For the furnishing of care or services pursuant to an agreement under paragraph (1), an entity specified in subsection (a)(1)(B) may not collect any amount that is greater than the rate negotiated pursuant to subparagraph (A)(i).

(3) CERTAIN PROCEDURES.—

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

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

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

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

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

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

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

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

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

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

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

(e) RESPONSIBILITY FOR COSTS OF CERTAIN CARE.—

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

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

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

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

(3) RECOVERY OF COSTS FOR CERTAIN CARE.—

(A) IN GENERAL.—In any case in which an eligible veteran is furnished hospital care or medical services under this section for a non-service-connected disability described in subsection (a)(2) of section 1729 of title 38, United States Code, or for a condition for which recovery is authorized or with respect to which the United States is deemed to be a third party beneficiary under Public Law 87-693, commonly known as the “Federal Medical Care Recovery Act” (42 U.S.C. 2651 et seq.), the Secretary shall recover or collect from a third party (as defined in subsection (i) of such section 1729) reasonable charges for such care or services to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if

the care or services had not been furnished by a department or agency of the United States.

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

(f) VETERANS CHOICE CARD.—

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

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

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

(A) The name of the veteran.

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

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

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

(E) The following statement: “This card is for qualifying medical care outside the Department of Veterans Affairs. Please call the Department of Veterans Affairs phone number specified on this card to ensure that treatment has been authorized.”

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

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

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

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

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

(h) FOLLOW-UP CARE.—In carrying out this section, the Secretary shall ensure that, at the election of an eligible veteran who receives hospital care or medical services from a health care provider in an

episode of care under this section, the veteran receives such hospital care and medical services from such health care provider through the completion of the episode of care, including all specialty and ancillary services deemed necessary as part of the treatment recommended in the course of such hospital care or medical services.

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

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

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

(j) COST-SHARING.—

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

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

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

(k) CLAIMS PROCESSING SYSTEM.—

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

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

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

(4) ACCURACY OF PAYMENT.—

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

(B) QUARTERLY REPORT.—

(i) IN GENERAL.—The Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the

Committee on Veterans' Affairs of the House of Representatives a quarterly report on the accuracy of such system.

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

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

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

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

(1) MEDICAL RECORDS.—

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

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

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

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

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

(p) AUTHORITY TO FURNISH CARE AND SERVICES.—

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

(2) DATE SPECIFIED.—The date specified in this paragraph is the date on which the Secretary has exhausted all amounts de-

posited in the Veterans Choice Fund established by section 802.

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

(q) REPORTS.—

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

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

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

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

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

- (i) eligible veterans described in subsection (b)(2)(A);
- (ii) eligible veterans described in subsection (b)(2)(B);
- (iii) eligible veterans described in subsection (b)(2)(C); and
- (iv) eligible veterans described in subsection (b)(2)(D).

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

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

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

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

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

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

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

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

(2) ALTERNATE GOALS.—If the Secretary submits to Congress, not later than 60 days after the date of the enactment of this Act, a report stating that the actual wait-time goals of the Veterans Health Administration are different from the wait-time goals specified in paragraph (1)—

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

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

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

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TITLE II—HEALTH CARE ADMINISTRATIVE MATTERS

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SEC. 208. INFORMATION IN ANNUAL BUDGET OF THE PRESIDENT ON HOSPITAL CARE AND MEDICAL SERVICES FURNISHED THROUGH EXPANDED USE OF CONTRACTS FOR SUCH CARE.

The materials on the Department of Veterans Affairs in the budget of the President for a fiscal year, as submitted to Congress pursuant to section 1105(a) of title 31, United States Code, shall set forth the following:

(1) The number of veterans who received hospital care and medical services under [section 101] *section 1703A of title 38, United States Code* during the fiscal year preceding the fiscal year in which such budget is submitted.

(2) The amount expended by the Department on furnishing care and services under such section during the fiscal year preceding the fiscal year in which such budget is submitted.

(3) The amount requested in such budget for the costs of furnishing care and services under such section during the fiscal year covered by such budget, set forth in aggregate and by amounts for each account for which amounts are so requested.

(4) The number of veterans that the Department estimates will receive hospital care and medical services under such section during the fiscal years covered by the budget submission.

(5) The number of employees of the Department on paid administrative leave at any point during the fiscal year preceding the fiscal year in which such budget is submitted.

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TITLE VIII—OTHER MATTERS

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SEC. 802. VETERANS CHOICE FUND.

[(a) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the Veterans Choice Fund.

[(b) ADMINISTRATION OF FUND.—The Secretary of Veterans Affairs shall administer the Veterans Choice Fund established by subsection (a).

[(c) USE OF AMOUNTS.—

[(1) IN GENERAL.—Except as provided by paragraph (3), any amounts deposited in the Veteran Choice Fund shall be used by the Secretary of Veterans Affairs to carry out section 101, including, subject to paragraph (2), any administrative requirements of such section.

[(2) AMOUNT FOR ADMINISTRATIVE REQUIREMENTS.—

[(A) LIMITATION.—Except as provided by subparagraph (B), of the amounts deposited in the Veterans Choice Fund, not more than \$300,000,000 may be used for administrative requirements to carry out section 101.

[(B) INCREASE.—The Secretary may increase the amount set forth in subparagraph (A) with respect to the amounts used for administrative requirements if—

[(i) the Secretary determines that the amount of such increase is necessary to carry out section 101;

[(ii) the Secretary submits to the Committees on Veterans' Affairs and Appropriations of the House of Representatives and the Committees on Veterans' Affairs and Appropriations of the Senate a report described in subparagraph (C); and

[(iii) a period of 60 days has elapsed following the date on which the Secretary submits the report under clause (ii).

[(C) REPORT.—A report described in this subparagraph is a report that contains the following:

[(i) A notification of the amount of the increase that the Secretary determines necessary under subparagraph (B)(i).

[(ii) The justifications for such increased amount.

[(iii) The administrative requirements that the Secretary will carry out using such increased amount.

[(3) TEMPORARY AUTHORITY FOR OTHER USES.—

[(A) OTHER NON-DEPARTMENT CARE.—In addition to the use of amounts described in paragraph (1), of the amounts deposited in the Veterans Choice Fund, not more than \$3,348,500,000 may be used by the Secretary during the period described in subparagraph (C) for amounts obligated by the Secretary on or after May 1, 2015, to furnish health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities, including pursuant to non-Department provider programs other than the program established by section 101.

[(B) HEPATITIS C.—Of the amount specified in subparagraph (A), not more than \$500,000,000 may be used by the

Secretary during the period described in subparagraph (C) for pharmaceutical expenses relating to the treatment of Hepatitis C.

[(C) PERIOD DESCRIBED.—The period described in this subparagraph is the period beginning on the date of the enactment of the VA Budget and Choice Improvement Act and ending on October 1, 2015.

[(D) REPORTS.—Not later than 14 days after the date of the enactment of the VA Budget and Choice Improvement Act, and not less frequently than once every 14-day period thereafter during the period described in subparagraph (C), the Secretary shall submit to the appropriate congressional committees a report detailing—

[(i) the amounts used by the Secretary pursuant to subparagraphs (A) and (B); and

[(ii) an identification of such amounts listed by the non-Department provider program for which the amounts were used.

[(E) DEFINITIONS.—In this paragraph:

[(i) The term “appropriate congressional committees” means—

[(I) the Committee on Veterans’ Affairs and the Committee on Appropriations of the House of Representatives; and

[(II) the Committee on Veterans’ Affairs and the Committee on Appropriations of the Senate.

[(ii) The term “non-Department facilities” has the meaning given that term in section 1701 of title 38, United States Code.

[(iii) The term “non-Department provider program” has the meaning given that term in section 4002(d) of the VA Budget and Choice Improvement Act.

[(d) APPROPRIATION AND DEPOSIT OF AMOUNTS.—

[(1) IN GENERAL.—There is authorized to be appropriated, and is appropriated, to the Secretary of Veterans Affairs, out of any funds in the Treasury not otherwise appropriated \$10,000,000,000 to be deposited in the Veterans Choice Fund established by subsection (a). Such funds shall be available for obligation or expenditure without fiscal year limitation, and only for the program created under section 101(or for hospital care and medical services pursuant to subsection (c)(3) of this section).

[(2) AVAILABILITY.—The amount appropriated under paragraph (1) shall remain available until expended.

[(e) SENSE OF CONGRESS.—It is the sense of Congress that the Veterans Choice Fund is a supplement to but distinct from the Department of Veterans Affairs’ current and expected level of non-Department care currently part of Department’s medical care budget. Congress expects that the Department will maintain at least its existing obligations of non-Department care programs in addition to but distinct from the Veterans Choice Fund for each of fiscal years 2015 through 2017.]

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SURFACE TRANSPORTATION AND VETERANS HEALTH CARE CHOICE IMPROVEMENT ACT OF 2015

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TITLE IV—VETERANS PROVISIONS

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SEC. 4003. FUNDING ACCOUNT FOR NON-DEPARTMENT CARE.

Each budget of the President submitted to Congress under section 1105 of title 31, United States Code, for fiscal year 2017 and each fiscal year thereafter shall include an appropriations account **for non-Department provider programs (as defined in section 2(d)) to be comprised of—**

[(1) discretionary medical services funding that is designated for hospital care and medical services furnished at non-Department facilities; and]

[(2) any funds transferred for such purpose from the Veterans Choice Fund established by section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 128 Stat. 1802)] 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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SOCIAL SECURITY ACT

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART E—MISCELLANEOUS PROVISIONS

* * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES; ENROLLMENT PROCESSES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A)(i) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and (ii) not to impose any charge that is prohibited under section 1902(n)(3),

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to

have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1862(a), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of title XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1886, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a quality improvement organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided di-

rectly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews),

(ii) in the case of hospitals, critical access hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a quality improvement organization (which has a contract with the Secretary under part B of title XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A),

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2),

(H)(i) in the case of hospitals which provide services for which payment may be made under this title and in the case of critical access hospitals which provide critical access hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14), and other than services described by section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (I) that are furnished to an individual who is a patient of the hospital, and (II) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

(I) that are furnished to an individual who is a resident of the skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1861(s)(2)(D), that are furnished to such an individual without regard to such period), and

(II) for which the individual is entitled to have payment made under this title,

to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,

(I) in the case of a hospital or critical access hospital—

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1867 and to meet the requirements of such section,

(ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment

necessary to stabilize an individual with an emergency medical condition,

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code,

(K) not to charge any individual or any other person for items or services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B),

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care *under section 603 of title 38, United States Code*, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of **[such section]** *such program*,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,—and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals and critical access hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1842(h)(4)) for the area served by the hospital or critical access hospital,

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified par-

icipating physician who is listed in such a directory and from whom the patient may receive the necessary services,

(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1867 with respect to examination and treatment for emergency medical conditions and women in labor, and

(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicaid program under a State plan approved under title XIX,

(O) to accept as payment in full for services that are covered under this title and are furnished to any individual enrolled with a Medicare+Choice organization under part C, with a PACE provider under section 1894 or 1934, or with an eligible organization with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, which does not have a contract (or, in the case of a PACE provider, contract or other agreement) establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this title (less any payments under sections 1886(d)(11) and 1886(h)(3)(D)) if the individuals were not so enrolled,

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy care (described in section 1861(m)(5)), to offer to furnish such supplies to such an individual as part of their furnishing of home health services,

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives),

(R) to contract only with a health care clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the health care clearinghouse is required to comply with the standard or specification,

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1861(ee)(2)(H)(ii), or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

(i) the nature of such financial interest,

(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

(iii) the percentage of such individuals who received such services from such provider (or another such provider),
 (T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1886(d)(12) to carry out such section,

(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care both—

(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services,

(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated),

(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data to the Secretary in accordance with subsection (k),

(X) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary, and

(Y) beginning 12 months after the date of the enactment of this subparagraph, in the case of a hospital or critical access hospital, with respect to each individual who receives observation services as an outpatient at such hospital or critical access hospital for more than 24 hours, to provide to such individual not later than 36 hours after the time such individual begins receiving such services (or, if sooner, upon release)—

(i) such oral explanation of the written notification described in clause (ii), and such documentation of the provision of such explanation, as the Secretary determines to be appropriate;

(ii) a written notification (as specified by the Secretary pursuant to rulemaking and containing such language as

the Secretary prescribes consistent with this paragraph) which—

(I) explains the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reasons for such status of such individual;

(II) explains the implications of such status on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as implications for cost-sharing requirements under this title and for subsequent eligibility for coverage under this title for services furnished by a skilled nursing facility;

(III) includes such additional information as the Secretary determines appropriate;

(IV) either—

(aa) is signed by such individual or a person acting on such individual's behalf to acknowledge receipt of such notification; or

(bb) if such individual or person refuses to provide the signature described in item (aa), is signed by the staff member of the hospital or critical access hospital who presented the written notification and includes the name and title of such staff member, a certification that the notification was presented, and the date and time the notification was presented; and

(V) is written and formatted using plain language and is made available in appropriate languages as determined by the Secretary.

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge

under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A) and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in section 1834(a)(1)(B). In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5). In the case of services described in section 1833(a)(8) or section 1833(a)(9) for which payment is made under part B under section 1834(k), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2), except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of subparagraph (C), whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1813(a)(2).

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of section

1866(a)(2)(B)(ii), charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this title if the admitting physician has a direct or indirect financial interest in such provider.

(3)(A) Under the agreement required under paragraph (1)(F)(ii), the quality improvement organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1154(a)(4)(A) and under section 1154(a)(14) with respect to services, furnished by the hospital, critical access hospital, facility, or agency involved, for which payment may be made under this title.

(B) For purposes of payment under this title, the cost of such an agreement to the hospital, critical access hospital, facility, or agency shall be considered a cost incurred by such hospital, critical access hospital, facility, or agency in providing covered services under this title and shall be paid directly by the Secretary to the quality improvement organization on behalf of such hospital, critical access hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for a fiscal year—

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, critical access hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, critical access hospitals, or agencies under part B of title XI.

(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861,

(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A, or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the

Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this title becomes effective under section 1128(c).

(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(V) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(U) by a hospital that is subject to the provisions of such Act.

(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(c)(1) Where the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur.

(2) Where the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of such termination or nonrenewal.

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital, he may, in lieu of terminating his agreement with such hospital, decide that, with respect to any individual admitted to such hospital after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services. Such decision may be made effective only after such notice to the hospital and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) For purposes of this section, the term "provider of services" shall include—

(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1861), or if, in the case of

a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1861), but only with respect to the furnishing of outpatient physical therapy services (as therein defined), (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services, or (through the operation of section 1861(ll)(2)) with respect to the furnishing of outpatient speech-language pathology; and

(2) a community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)).

(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819(c)(2)(E), 1833(s), 1855(i), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services, Medicare+Choice organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the written policies of the provider or organization respecting the implementation of such rights;

(B) to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a skilled nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of an eligible organization (as defined in section 1876(b)) or an organization provided payments under section 1833(a)(1)(A) or a Medicare+Choice organization, at the time of enrollment of the individual with the organization.

(3) In this subsection, the term “advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(4) For construction relating to this subsection, see section 7 of the Assisted Suicide Funding Restriction Act of 1997 (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(g) Except as permitted under subsection (a)(2), any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed \$2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(h)(1)(A) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary’s final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.

(C)(i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which—

(I) the remedy of termination of participation has been imposed;

(II) a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) has been imposed, but only if such remedy has been imposed on an immediate basis; or

(III) a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a skilled nursing facility’s nurse aide training program.

(ii) Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).

(iii) Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.

(i)(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this title and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this title with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this title—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this title with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this title with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this title.

(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

(1) ENROLLMENT PROCESS.—

(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title. Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (5), the imposition of temporary enrollment moratoria in accordance with paragraph (7), and the establishment of compliance programs in accordance with paragraph (9).

(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the pro-

vider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

(2) PROVIDER SCREENING.—

(A) PROCEDURES.—Not later than 180 days after the date of enactment of this paragraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

(B) LEVEL OF SCREENING.—The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

(i) shall include a licensure check, which may include such checks across States; and

(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

(I) a criminal background check;

(II) fingerprinting;

(III) unscheduled and unannounced site visits, including preenrollment site visits;

(IV) database checks (including such checks across States); and

(V) such other screening as the Secretary determines appropriate.

(C) APPLICATION FEES.—

(i) INSTITUTIONAL PROVIDERS.—Except as provided in clause (ii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

(I) for 2010, \$500; and

(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(ii) HARDSHIP EXCEPTION; WAIVER FOR CERTAIN MEDICAID PROVIDERS.—The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom

the State demonstrates that imposition of the fee would impede beneficiary access to care.

(iii) USE OF FUNDS.—Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1128J.

(D) APPLICATION AND ENFORCEMENT.—

(i) NEW PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this title, title XIX, or title XXI as of the date of enactment of this paragraph, on or after the date that is 1 year after such date of enactment.

(ii) CURRENT PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enactment, on or after the date that is 2 years after such date of enactment.

(iii) REVALIDATION OF ENROLLMENT.—Effective beginning on the date that is 180 days after such date of enactment, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this title, title XIX, or title XXI.

(iv) LIMITATION ON ENROLLMENT AND REVALIDATION OF ENROLLMENT.—In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this title, title XIX, or title XXI on or after the date that is 3 years after such date of enactment.

(E) USE OF INFORMATION FROM THE DEPARTMENT OF TREASURY CONCERNING TAX DEBTS.—In reviewing the application of a provider of services or supplier to enroll or reenroll under the program under this title, the Secretary shall take into account the information supplied by the Secretary of the Treasury pursuant to section 6103(1)(22) of the Internal Revenue Code of 1986, in determining whether to deny such application or to apply enhanced oversight to such provider of services or supplier pursuant to paragraph (3) if the Secretary determines such provider of services or supplier owes such a debt.

(F) EXPEDITED RULEMAKING.—The Secretary may promulgate an interim final rule to carry out this paragraph.

(3) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND SUPPLIERS.—

(A) IN GENERAL.—The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not more than 1 year during which new pro-

viders of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

(B) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

(4) 90-DAY PERIOD OF ENHANCED OVERSIGHT FOR INITIAL CLAIMS OF DME SUPPLIERS.—For periods beginning after January 1, 2011, if the Secretary determines that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, in the case of a supplier of durable medical equipment who is within a category or geographic area under title XVIII identified pursuant to such determination and who is initially enrolling under such title, the Secretary shall, notwithstanding sections 1816(c), 1842(c), and 1869(a)(2), withhold payment under such title with respect to durable medical equipment furnished by such supplier during the 90-day period beginning on the date of the first submission of a claim under such title for durable medical equipment furnished by such supplier.

(5) INCREASED DISCLOSURE REQUIREMENTS.—

(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this title, title XIX, or title XXI on or after the date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in section 1128B(f)), has been excluded from participation under the program under this title, the Medicaid program under title XIX, or the CHIP program under title XXI, or has had its billing privileges denied or revoked.

(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

(6) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR MEDICARE OBLIGATIONS.—

(A) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any amount described in subparagraph

(B)(ii) due from such obligated provider of services or supplier.

(B) DEFINITIONS.—In this paragraph:

(i) IN GENERAL.—The term “applicable provider of services or supplier” means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this title than is assigned to the obligated provider of services or supplier.

(ii) OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term “obligated provider of services or supplier” means a provider of services or supplier that owes an amount that is more than the amount required to be paid under the program under this title (as determined by the Secretary).

(7) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS; NONPAYMENT.—

(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or otherwise, of a temporary moratorium imposed under subparagraph (A).

(C) NONPAYMENT.—

(i) IN GENERAL.—No payment may be made under this title or under a program described in subparagraph (A) with respect to an item or service described in clause (ii) furnished on or after October 1, 2017.

(ii) ITEM OR SERVICE DESCRIBED.—An item or service described in this clause is an item or service furnished—

(I) within a geographic area with respect to which a temporary moratorium imposed under subparagraph (A) is in effect; and

(II) by a provider of services or supplier that meets the requirements of clause (iii).

(iii) REQUIREMENTS.—For purposes of clause (ii), the requirements of this clause are that a provider of services or supplier—

(I) enrolls under this title on or after the effective date of such temporary moratorium; and

(II) is within a category of providers of services and suppliers (as described in subparagraph (A)) subject to such temporary moratorium.

(iv) PROHIBITION ON CHARGES FOR SPECIFIED ITEMS OR SERVICES.—In no case shall a provider of services or supplier described in clause (ii)(II) charge an individual or other person for an item or service described in clause (ii) furnished on or after October 1, 2017, to an individual entitled to benefits under part A or enrolled under part B or an individual under a program specified in subparagraph (A).

(8) COMPLIANCE PROGRAMS.—

(A) IN GENERAL.—On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.

(9) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

(k) QUALITY REPORTING BY CANCER HOSPITALS.—

(1) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

(2) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(3) QUALITY MEASURES.—

(A) IN GENERAL.—Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

* * * * *

DISSENTING VIEWS

I

Earlier this year, the House Committee on Veterans' Affairs (HVAC) began the arduous task of outlining what the future of community care at the Department of Veterans Affairs (VA) would look like. Community care, also sometimes referred to as non-VA care or fee-basis care, has long been the subject of numerous critical reports from bodies such as VA's Office of Inspector General (VAOIG), Government Accountability Office (GAO), the Independent Assessment,¹ and the Commission on Care.² These reports emphasized the challenges of maintaining six separate pathways, all with different eligibility criteria and payment rates, to send veterans into the community for care. Not only is this confusing to veterans, VA staff and community providers, it is also highly inefficient. H.R. 4242 would streamline eligibility and payment rates, among other things, into one easy to use and administer program that would allow VA to take advantage of economies of scale. While the Minority generally agrees with the broad policy that is outlined in H.R. 4242, we do have several concerns.

The most significant of these concerns is funding. The Congressional Budget Office (CBO) issued a preliminary score for H.R. 4242 on November 7, 2017, of nearly \$40 billion over five years. In recent years, leadership of both HVAC and the Senate Committee on Veterans' Affairs (SVAC) have required discretionary spending to be off-set before a bill can be voted out of committee. As written, H.R. 4242 provides no pay-for and was the main reason the bill was pulled from the November 8, 2017, markup agenda. A pay-for was not identified ahead of the December 19, 2017 markup either.

In an effort to address the score, during the December 19, 2017, markup Chairman Roe offered an amendment which would place caps on VA's Medical Community Care account. In effect, growth of the program would be restricted to just 3 percent a year. We believe that will not be sufficient and could lead to rationing of community care or diversion of funds from VA's Medical Care account. This belief is based on several factors, including the overall growth in community care spending (between Fiscal Year (FY) 2017 and FY 2018, obligation authorities are expected to grow by 8.3 percent);³ the steady increase in the number of authorizations for the Veterans Choice Program (VCP) (between March and May 2017, VA issued nearly 800,000 authorizations for VCP, which represented a 32% increase over the same time-period in 2016);⁴ and

¹ A congressional mandate outlined in Section 201 of Public Law P.L. 113-146.

² A congressional mandate outlined in Section 202 of P.L. 113-146.

³ Briefing from Department of Veterans Affairs' Office of Management, June 22, 2017.

⁴ United States Cong. House Committee on Veterans' Affairs, Subcommittee on Health Hearing—"Health Programs Budget Request for Fiscal Year 2018" June 22, 2017. 115th Cong. 1st

Continued

the projected demand for Long-Term Support and Service (LTSS), which include high-cost services such as nursing home care and adult day care that will continue to steadily increase as the number of 85-year-old enrollees in VA will almost double over the next 20 years.⁵

Additional factors that would significantly impact VA's ability to deliver care in the community on an artificially constrained budget that would include financial constraints on VA just as demand for care is likely to expand in response to the Republican tax plan, which not only undermines the Affordable Care Act but triggers Medicaid funding cuts. In fact, one in 10 veterans are on Medicaid, which is 1.75 million veterans.⁶ Furthermore, earlier this year, documents leaked by administration officials revealed a plan to merge the VCP with TRICARE, a health insurance program that service members and their families pay to use.⁷

Although we appreciate the Chairman's removal of his amendment, this legislation continues to lack a sustainable path to fund this permanent program. Playing tricks with authorizing caps, either in the hearing or when this bill is brought to the floor for final passage sends the wrong message to VA, community providers and the veterans we are supposed to serve. Moreover, without a plan to appropriately fund any future community care program, we are equally concerned that Congress will continue to kick the proverbial can down the road and will opt instead to carry on appropriating more funding for the flawed VCP that was only ever intended to be a temporary measure to address VA's access to care crisis.

In addition, we are concerned the changes made to H.R. 4242 by an amendment offered by Chairman Roe does not fully address the anxieties expressed by the Veteran Service Organizations (VSOs) and will ultimately lead to an uneven policy application across VA medical facilities. In mid-November, a number of VSOs raised their concerns with Majority and Minority staff about certain portions of the language in Section 102, Establishment of VA Care in the Community Program of H.R. 4242. In particular they were worried about language that from their perspective gave veterans access to "unfettered choice". VSOs have been highly critical of any attempt, or perceived attempt, to privatize VA care.

The amendment in question sought to change language related to veteran eligibility and the appeals process among other things. In particular, language in the underlying bill expressed that the Secretary "SHALL" give deference to the veteran with respect to reviewing a disagreement regarding the availability of and assignment to a patient aligned care team or dedicated primary care provider. The Roe amendment changed that to a "MAY".

Given the language now reflects an option rather than an imperative, we are concerned that this could lead to an uneven adminis-

sess. Washington. GPO, 2017 (Statement by Poonam Alaigh, Acting Under Secretary for Health, Veterans Health Administration, US Department of Veterans Affairs).

⁵ VA FY 2018 Budget Submission—Vol. 2, Pg. 369 <https://www.va.gov/budget/docs/summary/fy2018VAbudgetVolume1medicalProgramsAndInformationTechnology.pdf>.

⁶ Callow, Andrea. *Cutting Medicaid Would Hurt Veterans*. Families USA. May 2017. <http://familiesusa.org/product/cutting-medicaid-would-hurt-veterans>.

⁷ Yen, Hope. *VA exploring idea of merging health system with Pentagon*. Federal News Radio. November 17, 2017. <https://federalnewsradio.com/veterans-affairs/2017/11/vas-quiet-plan-to-widen-private-care-with-tricare-stirs-ire/>.

trative application of the provision. Within the veterans community there is a well-known saying to describe the Veterans Health Administration (VHA): “If you’ve been to one VA, you’ve been to *one* VA.” Despite the prolific use of directives and memos across VHA, countless stakeholders have observed the lack of standardized implementation and oversight of policy and procedures. In fact, it is one of the reasons VA was added to GAO’s high-risk list in 2015.⁸ Had the suggested language of the VSOs been adopted, “SHALL give the benefit of the doubt to the veteran when there is an approximate balance of positive and negative evidence,” additional opportunities for unclear policy application could have been avoided.

In addition, another amendment adopted during markup would create a new Center for Innovation for Care and Payment. Although we generally support looking at new methods of paying non-VA providers and new methods for delivering health care services to veterans to reduce expenditures and improve care quality, we remain concerned the process for developing the pilot program in the legislation gives the VA Secretary overly-broad authority to waive federal law. We are also concerned that resources intended for delivery of health care to veterans will be diverted to pay for the pilot program without a specific funding source designated.

The Roe amendment would not prohibit enrolled veterans with service-connected disabilities to be billed or charged for health care services related to service-connection under the pilot program. It also gives the VA Secretary broad authority to waive certain requirements under Chapter 17 of title 38 to implement the pilot program. This includes the authority to waive VA healthcare eligibility requirements, contracting requirements, and standard of care requirements for community care providers. Once granted, the waiver would not be subject to judicial review. This waiver could easily be granted via a privileged resolution or bill that would circumvent the House and Senate Veterans’ Affairs Committees and require only a majority vote in each Chamber to be granted. With this special procedure to grant a waiver, an identical procedure should at least exist for termination of the waiver.

No specific funding was authorized for the Center, which would be funded out of VHA’s Medical Services Accounts. Since the Center would be piloting new care delivery and billing models, the pilot program could yield higher costs for the delivery of care, which would take precious resources away from the direct delivery of care by VA. Any pilot in which new care delivery models are tested with community providers should be funded specifically for that purpose so that funds for direct delivery of care are not diverted to pay for pilot programs that pay non-VA providers for care.

If this amendment had been subject to Committee process, we would have requested views from VA and experts on the need for granting the VA Secretary such broad authority. We would have worked with Veteran Service Organizations to ensure the pilot programs grant preference to delivery models that also improve the coordination, quality, and efficiency of health care services furnished to veterans enrolled in the VA’s patient enrollment system. We also would have had the opportunity to determine the levels of specific

⁸ <https://www.gao.gov/assets/670/668415.pdf>.

purpose funding that would be appropriate to test care delivery models under the Center's pilot programs.

II

The continued near-flat line request for the Medical Services account will continue the trend of VA being unable to provide the needed services internally and forcing veterans into the community for care. Failure to adequately fund VA so that it is able to hire staff to fill over 45,000 provider vacancies and address its significant infrastructure needs will cause veterans to wait longer for appointments. Sending more veterans for care in the community is not the panacea for all of VA's access challenges. Community care is only intended to fill gaps in care that VA is unable to provide due to lack of capacity, and only accounts for approximately 30 percent of the care delivered by VA.⁹ Provider shortages exist throughout the U.S., and in many cases, community providers lack the expertise or cultural competency to provide quality care to veterans. A holistic, systems-based approach, not a narrow focus on sending veterans for care in the community is needed to address VHA's access-to-care challenges.

Democrats offered 7 amendments during markup that would have addressed VA's internal capacity. Unfortunately, only 2 of these 7 amendments were adopted. The 5 amendments not agreed to addressed VA's significant staffing and provider shortages, infrastructure needs, accountability measures for non-VA providers, expansion of the VA Family Caregiver Program to all generations of veterans, and authorized \$1 billion for educational assistance for providers, additional graduate medical education residency positions, and recruitment, relocation, and retention incentives for providers.

On November 29, 2017, the Senate Committee on Veterans' Affairs favorably reported to the Senate legislation to reform VA's community care program and address VA's access-to-care-challenges. This bipartisan legislation was favorably reported 14–1. The Senate legislation addresses VA's capacity and access challenges holistically by addressing infrastructure, provider shortages, expanding the Comprehensive Assistance for Family Caregiver Program, and reforming VA's community care programs. We agree with this approach. For this reason, the Senate's legislation and Title I of H.R. 4242 (with amendments requested by Veteran Service Organizations) formed the basis of Ranking Member Walz's amendment in the nature of a substitute to H.R. 4242 that was supported by Committee Democrats, but voted down by all Committee Republicans.

The A.N.S. offered by Ranking Member Walz would expand the Comprehensive Assistance for Family Caregiver Program to all generations of veterans. It would authorize \$1 billion to pay for up to \$240,000 per VA provider over 5 years in education debt reduction under the Education Debt Reduction Program,¹⁰ lift the limit

⁹The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs Integrated Report*, xii (2015), "VHA must adopt systems thinking to address its most challenging problems, including access, quality, cost, and patient experience."

¹⁰Clinical staff employed at Vet Centers would also be eligible for EDRP.

on annual awards for recruitment, relocation, or retention incentives, establish a higher maximum amount of basic pay for nurses, authorize a tuition reimbursement and loan repayment pilot program for providers at underserved facilities, and create an additional 1,500 graduate medical residency positions. It authorizes an additional \$4 billion for the Veterans Choice Fund to pay for community care. It would also give VA more flexibility over its construction programs by permitting VA to perform construction on projects costing under \$20 million without congressional approval, grants VA more flexibility to issue enhanced use leases, facilitates sharing of medical facilities with other agencies such as the Department of Defense, and authorizes construction on a medical facility realignment project in Livermore, California.

An amendment to H.R. 4242 offered by Representative Brownley would have streamlined approval for major construction of medical facilities by permitting approval via adoption of resolutions by the House and Senate Veterans' Affairs Committees. Amendments offered by Rep. Takano would have set firm hiring levels for VA so that it would be required to immediately address the provider shortage, required non-VA providers to follow the same contracting laws and regulations as other government contractors, and would have established an Office of Non-VA Delivered Medical Care Accountability in charge of overseeing, auditing, analyzing, and investigating non-VA delivered care. The majority did not support these amendments.

All amendments offered by Democrats did not seek to fundamentally alter the bipartisan community care eligibility language. Instead, these amendments sought to holistically address VA's access and capacity challenges by strengthening VA's internal capacity to deliver health care to veterans, and by reforming the community care programs—including the Choice Program—intended to supplement VA-delivered care. Without taking a systems approach, as recommended in the Independent Assessment, we cannot expect to address VHA's challenges by narrowly focusing only on offering veterans community care.

TIM WALZ,
Ranking Member.

