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VA MAINTAINING INTERNAL SYSTEMS AND STRENGTHENING INTEGRATED OUTSIDE NETWORKS ACT OF 2018

MAY 11, 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. 5674]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 5674) to establish a permanent community care program for veterans, to establish a commission for the purpose of making recommendations regarding the modernization or realignment of facilities of the Veterans Health Administration, to improve construction of the Department of Veterans Affairs, to make certain improvements in the laws administered by the Secretary of Veterans Affairs relating to the home loan program of the Department of Veterans Affairs, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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PURPOSE AND SUMMARY

H.R. 5674, the "VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018" or the "VA MISSION Act of 2018" would strengthen and improve the Department of Veterans Affairs (VA) healthcare system for the benefit of the nation's veterans. The bill would consolidate VA's multiple community care programs and authorities and provide further funding for the Choice Program. It would establish an Asset and Infrastructure Review (AIR) process to recommend actions to modernize and realign VA's massive medical infrastructure. It would also expand VA's Family Caregiver Program to pre-9/11 veterans and increase VA's internal capacity to care for veteran patients in VA medical facilities through improvements to various recruitment and retention programs. The bill represents a negotiated agreement between the Committee on Veterans' Affairs of the U.S. House of Representatives and the Committee on Veterans' Affairs of the U.S. Senate and combines various elements of H.R. 4242, as amended, H.R. 4243, as amended, and S. 2193, as amended. Representative David P. Roe of Tennessee, the Chairman of the full Committee, introduced H.R. 5674 on May 3, 2018.

BACKGROUND AND NEED FOR LEGISLATION

TITLE I—CARING FOR OUR VETERANS

Subtitle A—Developing an Integrated High-Performing Network

VA operates the nation's largest integrated healthcare system and provides care to approximately nine million veteran patients.[1] The majority of the health care that veterans receive through the VA health care system is provided through medical professionals and support staff employed by VA and working in VA facilities that are managed and overseen by the Veterans Health Administration (VHA). However, since 1945, VA has also collaborated with medical professionals and support staff in the community—who are not VA employees and who do not work in VA facilities—to provide veterans with timely, accessible, high-quality care.[2] 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 various community care programs to care for veteran patients when a needed clinical service cannot be provided by a given VA facility and the veteran cannot be transferred to another VA facility, when VA cannot re-

[1] *About VHA*. Veterans Health Administration. https://www.va.gov/health/aboutVHA.asp. Accessed November 14, 2017.
[2] January 11, 2017, MyVA Advisory Committee Meeting, Georgetown University, Washington, D.C.

cruit 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 program 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) (the Choice Act). Choice expanded the availability of community care to veteran patients by setting specific triggers upon which VA would be required 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 facility within 30 days or if they reside more than 40 miles from the nearest VA facility. Through Choice, veteran patients are referred to regional networks of community providers who are managed by Third Party Administrators (TPAs). However, under other community care programs, VA refers veteran patients to community providers through agreements with the Indian Health Service, the Department of Defense, academic affiliates, or other entities; through the Patient Centered Community Care program; or through national or local contracts or sharing agreements.[3]

Each of VA's current community care programs and authorities contain different eligibility criteria, different reimbursement rates, different payment structures, different referral and authorization requirements, and different contracting approaches.[4] 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."[5] 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."[6] 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."[7]

That imperative has been exacerbated by a significant increase in veteran demand for community care in recent years. Since Choice was established in fiscal year 2014, community care appointments increased by 61 percent overall and by 41 percent as a percentage of total VA appointments through fiscal year 2016.[8] That upward trend continued in fiscal year 2017, with the number of completed appointments across the VA healthcare system that

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[3] 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).

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

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

[6] Ibid.

[7] Ibid.

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

occur in the community rising from 31 percent in fiscal year 2016 to 36 percent in fiscal year 2017.[9]

Despite the increased demand for and utilization of community care, VA has struggled to effectively administer community care programs and, consequently, veterans have not always received timely care in the community. For many years, the VA Inspector General (IG) 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.[10] This led the IG to conclude in 2017 that, "our audits, reviews, and inspections have highlighted that VA has had a history of challenges in administering its purchased care programs [and] veteran's access to care, proper expenditure of funds, timely payment of providers, and continuity of care are at risk to the extent that VA lack[s] adequate processes to manage funds and oversee program execution."[11] The Government Accountability Office (GAO) has found similar problems with VA's management of community care programs. For example, in March 2017, GAO found that veterans who were referred to Choice for routine care because such care was not available through a VA facility in a timely manner could potentially wait up to 81 calendar days to obtain Choice care.[12] GAO also found that VA had failed to establish standardized processes and procedures for Choice, to issue program guidance regarding Choice, and to track or monitor how long it took VA medical centers to refer veterans to Choice (a process which GAO found was duplicative and could take up to 21 days).[13]

The Committee is aware of the concerns expressed by VA, the IG, and GAO regarding the challenging nature of many current VA community care programs and the potential adverse consequences veteran patients could face if those concerns are not expeditiously addressed. The Committee believes that a robust, consolidated VA community care program is vital to the long-term stability and success of the VA healthcare system in at least two significant ways. First, an effective VA community care program augments the care provided in VA medical facilities and, therefore, increases VA's capacity to serve the nation's veterans. Second and most importantly, an effective VA community care program helps to ensure that veterans have access to timely, quality care and—as such—provides them with improved health outcomes, patient satisfaction, care coordination, and efficiency.[14]

Accordingly, title I of the bill would establish a robust, consolidated VA community care program, the Veterans Community Care

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[9] United States Cong. House Committee on Veterans' Affairs. *"U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2019"* February 15, 2018. 115th Cong. 2nd sess. Washington: GPO, 2018 (Testimony of the the Honorable David Shulkin M.D., Secretary, U.S. Department of Veterans Affairs).

[10] 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 the Honorable Michael Missal, Inspector General, U.S. Department of Veterans Affairs).

[11] Ibid.

[12] 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).

[13] Ibid.

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

Program (the Program). Through the Program, veterans who are enrolled in the VA healthcare system or otherwise entitled to VA care would be granted access to care in the community under certain circumstances, which are detailed below. VA would be responsible for managing and overseeing the Program as well as coordinating the care that veterans receive through the Program, including ensuring that appointments are scheduled in a timely manner and that continuity of care is preserved.

Access to community care would be required under the Program if VA does not offer the care or services the veteran requires, if VA does not operate a full-service medical facility in the state in which a given veteran resides, if a given veteran was eligible for care in the community under the Choice 40-mile rule and meets certain other criteria, or if a given veteran and the referring clinician agree that furnishing care in the community is in the best medical interest of the veteran after considering certain criteria. Access to community care would also be required if VA is not able to furnish care within designated access standards developed by VA after consultation with certain other entities and published in the Federal Register and on VA's website. Such designated access standards would be reviewed at a minimum of every three years and veterans would be able to request a determination at any time regarding whether they are eligible to receive community care as a result of such access standards.

Access to community care would be authorized under the Program if a given medical service line within a VA facility fails to meet certain VA quality standards developed by VA after consultation with certain other entities and published on the Center for Medicare and Medicaid's Hospital Compare website. VA would be required to provide a plan to Congress detailing how VA intends to remediate medical service lines that fall below such quality standards and VA's authority to refer veterans to the Program due to a failure to meet such quality standards would be limited to no more than 36 service lines nationally and three service lines per facility.

Access to community care would also be authorized under this title to veterans in need of an organ or bone marrow transplant if, in the opinion of the veteran's primary care provider, the veteran has 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; 98 STAT. 2339). This provision is in accordance with the Committee's belief that veterans in need of an organ or bone marrow transplant have highly complex needs that may impede their ability to travel for care more than other veterans and necessitate care in the community using a lower eligibility threshold than otherwise provided for through the Program. The Committee's further thoughts regarding the provision of transplant care through VA are explained in the descriptive portion of section 153 below. However, the Committee believes that veterans with amputations have similar needs to veterans in need of transplants and are deserving of a similarly lower threshold for community care. In particular, the Committee remains supportive of VA's long-standing practice to allow veterans with amputations to access prosthetic

and orthotic care through community providers and encourages VA to continue that practice unabated.

Access to community care would also be authorized through the Program for veterans in need of walk-in care. Veterans who have used VA health care services in the 24-month period prior would be eligible pursuant to this authority to seek walk-in care through community providers and Federally-qualified health centers who have entered into a contract or agreement with VA to provide such care. Veterans who are not required to make a copayment at a VA facility would be entitled to two walk-in care visits without a copayment though VA would be authorized to charge such veterans an adjustable copayment for subsequent walk-in care visits. Veterans who are required to make a copayment at a VA facility would pay such copayment for the first two walk-in care visits though VA would be authorized to charge an adjusted copayment for subsequent walk-in care visits.

To resolve disputes regarding eligibility for care in the community under the Program, title I of the bill would require VA to provide veterans with a clinical appeal process to review community care eligibility determinations but prohibit such appeals from being appealed to the Board of Veterans Appeals. Title 1 of the bill would also require VA to develop and administer a number of training programs to ensure that veterans, VA employees, and community providers are fully aware of and educated on the Program, the VA healthcare system, and mental and physical health conditions that are common among veterans.

To carry out the Program, VA would be required to enter into a contract or contracts to establish a network of community care providers and authorized to establish tiered networks pursuant to such contract or contracts but would be prohibited from prioritizing providers in one tier over another in a manner that limits a veteran's choice of providers. In order to ensure quality of the community care provider networks, VA would be authorized to deny, suspend, or revoke the eligibility of a community provider to participate in the community care program if the provider was previously removed from VA employment or had their medical license revoked.

In recognition of the fact that veterans may sometimes require services from community providers who have not entered into a contract or agreement with VA, title I of the bill would authorize VA to pay for services not subject to a contract or agreement but deemed necessary by VA nevertheless. In such cases, VA would be required to take reasonable efforts to enter into a formal agreement, contract, or other legal arrangement to ensure that future care and services provided by the provider in question are covered.

Title I of the bill would also allow for the continuity of existing memorandums of understanding and memorandums of agreement that were in effect on the day before enactment of the bill between VA and the American Indian and Alaska Native healthcare systems as established under the terms of the VA and Indian Health Service Memorandum of Understanding, signed October 1, 2010, the National Reimbursement Agreement, signed December 5, 2012, arrangements under section 405 of the Indian Health Care Improvement Act, and agreements entered into under sections 102

and 103 of the Choice Act to enhance the collaboration between VA and the Native Hawaiian health care system.

Title I of the bill would require VA, to the extent practicable, to reimburse community care providers under the Program at Medicare rates. However, the Committee recognizes that such rates may not always be sufficient to yield an adequate provider network that is available to treat veteran patients, particularly in rural areas. As such, title I of the bill would authorize VA to pay higher rates in highly rural areas, to pay in accordance with the Alaska Fee Schedule for providers in Alaska, and to pay in accordance with applicable All-Payer Model Agreements in relevant states. What's more, title 1 would also authorize VA to incorporate value-based reimbursement models to the extent practicable to promote high-quality care. The Committee encourages VA to utilize such models to provide dialysis care in the community to veterans pursuant to the national dialysis contracts that have been in place for the last several years and of which the Committee continues to strongly support.

The Committee strongly believes that VA's ability to timely and accurately process payments to community providers is critical to the Program's success and to ensuring access to community care for the increasing number of veterans who rely on it. The Committee also recognizes that VA's ability to promptly reimburse community providers for the services they provide to veteran patients has significantly fallen short of expectations in recent years, which has hampered the viability of VA's community care provider networks. 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.[15] 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.[16] These findings were echoed in GAO testimony 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."[17] As such, title I of the bill would establish a prompt payment process that would require VA to pay for, or deny payment for, services within 30 calendar days of receipt of a clean electronic claim or within 45 calendar days of receipt of a clean paper claim. In the case of a denial, VA would have to notify the provider of the reason for denying the claim and what, if any, additional information would be required to process the claim. Upon the receipt of the additional information, VA would have to pay, deny, or otherwise adjudicate the claim within 30 calendar days. Any claim that has not been denied, made pending, or paid within the specified time periods would be considered overdue and subject to interest payment penalties. Community care entities or providers would be required

[15] 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.

[16] Ibid.

[17] 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).

to submit a claim to VA within 180 days of providing care or services.

The Committee recognizes that VA may be best served by delegating claims processing to a thirty party entity. As such, title I would authorize VA to enter into an agreement with a third party entity to electronically process claims from community providers and would require an independent review of VA's capacity to process claims in a timely manner and a cost benefit analysis comparing VA's performance with a third party claims processing entity. It would also require that VA conduct a study on whether to establish a funding mechanism for a VA contractor to act as a fiscal intermediary for the Federal Government to pay claims.

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 Choice Act 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 some community providers. 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."[18] 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."[19] 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. VA has requested legislative authority to enter into non FAR-based provider agreements since 2015.[20] Accordingly, title I of the bill would authorize VA to enter into provider agreements called Veterans Care Agreements (VCAs). VCAs would not be subject to competition or other requirements associated with federal contracts and the same affirmative action moratorium that applies to TRICARE contractors and subcontractors pursuant to OFCCP Directive 2014–01 would apply to VCA contractors and subcontractors. Veteran eligibility for care under VCAs would be subject to the same terms as VA care itself and the

[18] January 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

[19] 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 Health Care Association).

[20] January 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

rates paid under VCAs would, to the extent practicable, be in accordance with rates specified for the Program above.

Title I of the bill would also authorize VA to enter into VCAs with State Veterans Homes and eliminate competitive contracting actions and other requirements associated with federal contracts for State Veterans Homes. While not considered federal contactors for the purposes of this section, State Veterans Homes would still be required to follow federal laws related to employment, fraud, waste, and abuse.

Finally, title I of the bill would require VA to perform market area assessments on a number of key factors at least once every four years. VA would be required to submit the assessments to Congress and to use them to determine the capacity of the Program's provider networks and access and quality standards. VA would also be required to submit a strategic plan to Congress, no later than one year after the date of enactment and at least every four years thereafter. The strategic plan would be required to specify the demand for care and the capacity to meet such demand both at each VA medical center and in the community. VA would be required to take a number of elements into consideration when developing the strategic plan and to identify emerging issues, challenges, and opportunities and recommendations to address them. The Committee believes the market area assessments and strategic plan will assist VA in successfully implementing the Program and in ensuring appropriate ongoing administration, management, and oversight of the Program by VA.

Chapter 4—Other Matters Relating to Non-Department of Veterans Affairs Providers

Section 131. Establishment of processes to ensure safe opioid prescribing practices by non-Department of Veterans Affairs health care providers

Between 1999 and 2016 more than 200,000 deaths were attributed to overdoses from prescription drugs.[21] Overdose deaths remain elevated within the civilian population and veterans have certainly not immune to that crisis or to the opioid epidemic. 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.[22] However, as demand for community care among veterans continues to grow, the Committee is concerned about the potential for inconsistencies in the management of opioid prescriptions between VA and community providers. 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 131 of the bill would require VA to provide OSI guidelines to community providers participating in the Program, certify that such providers have reviewed the guidelines, and implement a process to ensure

[21] Prescription Opioid Overdose Data, Centers for Disease Control and Prevention; https://www.cdc.gov/drugoverdose/data/overdose.html.

[22] 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.

that such providers receive a veteran's relevant history including all prescribed medications. It would further require that prescriptions for opioids be filled at a VA pharmacy (or at a community pharmacy only if prior authorization has been received with exceptions for certain urgent or emergent circumstances). It would also require opioid prescriptions to be recorded in the electronic health record and VA to remove from the Program provider networks any community provider whose prescribing practices are inconsistent with OSI or who violate licensing guidelines. The Committee believes this would ensure an equitable provision of care in VA and in the community and ensure safe and appropriate opioid prescriptions are provided to veteran patients regardless of where they receive VA care.

Section 132. Improving information sharing with community providers

The Committee believes that it is vital for VA and community providers to be able to share pertinent medical record information about the veteran patients they are jointly treating in order to ensure that the care veterans receive in the community is safe, effective, coordinated and of the highest quality. This is particularly important given the dramatic and growing increase in community care appointments in the last several years, a trend the Committee expects to continue under the Program. Section 132 of the bill would clarify that VA could share medical record information with community providers for the purpose of providing health care to patients or performing other health care related activities and remove certain restrictions on VA's ability to recover funds from third parties for the cost of non-service-connected care. 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 133. Competency standard for non-Department of Veterans Affairs health care providers

While noting the growing importance of an effective community care network on the overall strength and success of the VA healthcare system, the Committee nevertheless acknowledges that community providers are likely not as familiar with or competent in military- and veteran-specific conditions and concerns as VA providers are. To ensure that veterans are able to access culturally competent care from care through the Program, section 133 of the bill would require VA to establish competency standards for community providers. Such standards would include information regarding injuries and illnesses that VA has a special expertise in, such as post-traumatic stress disorder, traumatic brain injury, and military sexual trauma. All community providers, to the extent practicable as determined by VA, would be required to meet these standards before furnishing care to veterans under the Program.

Section 134. Department of Veterans Affairs participation in national network of State-based prescription drug monitoring programs

The Centers for Disease Control and Prevention (CDC) defines a PDMP as an electronic database that tracks controlled substance prescriptions in a state and provides information about prescribing and patient patterns and behaviors.[23] PDMPs have been shown to improve prescribing, inform clinical practice, protect at-risk patients, and decrease substance abuse treatment admissions.[24] In 2011, the National Association of Boards of Pharmacy (NABP) developed and launched the Prescription Monitoring Program (PMP) InterConnect to facilitate the secure exchange of information across state lines by PDMPs.[25] According to NABP, PDMPs are, ". . . are enhanced by PMP InterConnect because [it] provides the means for physicians and pharmacists to more easily identify patients with prescription drug abuse and misuse problems, especially if those patients are crossing state lines to obtain drugs."[26] Currently 44 states and Washington, D.C. participate in PMP InterConnect with several additional states intending to begin sharing data using PMP InterConnect.[27,28]

Section 5701(l) of title 38 United States Code (U.S.C.) requires VA to disclose information to PDMPs for either a veteran or the dependent of a veteran who is prescribed a controlled substance through VA "to the extent necessary to prevent misuse or diversion of prescription medications." Veterans Health Administration (VHA) Directive 1306 provides VA national policy for querying PDMPs.[29] It requires PDMPs to be queried prior to initiating therapy with a controlled substance, annually at a minimum, and more often when clinically indicated unless the patient is enrolled in hospice care or receives a controlled substance prescription for five days or less without refills.[30] The results of such query are required to be documented in the patient's medical record and are subject to limitations imposed by state law, in which case providers and prescribers are required to conform to the policies and recommendations of their state licensure.[31] According to VA, this policy allows providers to identify patients receiving controlled substances from multiple providers which may assist in preventing accidental or intentional misuse or diversion and in the detection, prevention, and early treatment of substance use disorders.[32] However, the policy does not allow VA to track controlled substance

[23] *What States Need to Know about PDMPs*. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/pdmp/states.html. Accessed April 30, 2018.
[24] Ibid
[25] *NABP PMP InterConnect: The Only National Network of State-Based PMPs.* National Association of Boards of Pharmacy. https://nabp.pharmacy/initiatives/pmp-interconnect/. Accessed April 30, 2018.
[26] Ibid.
[27] United States Cong. House Committee on Veterans' Affairs. *Legislative Hearing*. April 17, 2018. 115th Cong. 2nd sess. Washington: GPO, 2018 (statement from the Honorable Neal Dunn, U.S. House of Representatives, 2nd District, Florida).
[28] *NABP PMP InterConnect: The Only National Network of State-Based PMPs.* National Association of Boards of Pharmacy. https://nabp.pharmacy/initiatives/pmp-interconnect/. Accessed April 30, 2018.
[29] VHA Directive 1306. Query State Prescription Drug Monitoring Programs. October 19, 2016.
[30] Ibid.
[31] Ibid.
[32] Ibid.

prescriptions across multiple states since VA lacks the authority to use a system like PMP InterConnect.

Section 134 of the bill would require VA to enter into an agreement with a national network of PDMPs to allow for the monitoring of controlled substance prescriptions written in participating states. It would also require VA health care providers practicing in states that do not have a PDMP to join the network of the closest state that does have a PDMP.

Chapter 5—Other Non-Department Health Care Matters

Section 141. Plans for use of supplemental appropriations required

Since the passage of the Choice Act in 2014, Congress has acted numerous times to address unexpected shortfalls in the Choice Fund and in VA's other medical care accounts as a result of higher than expected demand for care in the community and cost overruns as a result of the Denver replacement medical center project in Aurora, Colorado. Some of those instances are detailed in the descriptive portion of section 510 below. The Committee is concerned about VA's seeming inability to anticipate funding requirements and utilization timelines and the impact such inability may have on the provision of care to veteran patients and the appropriate use of taxpayer dollars. Section 141 of the bill would require VA to submit a justification to Congress for any new supplemental appropriations request submitted outside of the standard budget process. Such justification would be required no later than 45 days before the date on which a budgetary issue would start affecting a program or service. It would be required to contain a detailed strategic plan for how VA intends to use the requested appropriation and for how long the requested funds are expected to meet the need.

Section 142. Veterans Choice Fund flexibility

The Committee expects, based on numerous conversations with VA senior leaders and rank-and-file employees alike, that it will take one year from enactment for VA to implement the Program. As described in the descriptive portion of section 510 below, the Committee intends to provide sufficient funding in this bill to fund Choice and ensure access to timely, quality care in the community to veteran patients until that time. However, the Committee understands that, as the Program approaches the implementation date, VA may require funding flexibility to enable the Department of sufficiently balance community care accounts. As such, section 142 of the bill would authorize VA, beginning on March 1, 2019, to use funds remaining in the Choice Fund to pay for community care provided to veteran patients pursuant to Chapter 17 of title 38 U.S.C. at community facilities or through community providers furnishing care in VA facilities.

Section 143. Sunset of Veterans Choice Program

The Choice Act created and deposited $10 billion into the Veterans Choice Fund to fund the Choice program. It also stipulated that Choice would sunset either when the money in the Choice Fund was fully expended or three years after enactment of the Act. Since the law was enacted on August 7, 2014, three years after enactment of the Act would have been August 7, 2017. However, the

VA Choice and Quality Employment Act of 2017 (Public Law 115–26; 131 STAT. 129) amended the Choice Act to modify the termination date for Choice in April 2017 following testimony that VA expected to have money left in the Choice Fund on August 7, 2017.[33] Section 143 of the bill would provide a sunset date for the Veterans Choice Program one year after the date of enactment of this Act, upon which time the Committee expects the Program to be fully implemented.

Subtitle B—Improving Department of Veterans Affairs Health Care Delivery

Section 151. Licensure of health care professionals of the Department of Veterans Affairs providing treatment via telemedicine

As a national, integrated health care system, VHA has a responsibility to ensure that veteran patients receive the same level of and access to care no matter where the veteran patient is located.[34] 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.[35]

Telemedicine refers to "the use of telehealth technologies to provide clinical care in circumstances where distance separates those receiving services and those providing services."[36] 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.[37,38] 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."[39] 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 VA's total patient population.[40] Veteran patients who have had experience with VA telemedicine programs have demonstrated improved health outcomes, including decreases in hospital admissions.[41]

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

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[33] United States Cong. House Committee on Veterans' Affairs Oversight Hearing—"Care Where it Count: Assessing VA's Capital Asset Needs." March 7 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from the Honorable David Shulkin M.D, Secretary of Veterans Affairs).

[34] 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.

[35] Ibid.

[36] VA Telehealth Services. https://www.telehealth.va.gov/ Accessed October 30, 2017.

[37] Ibid.

[38] 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.

[39] Ibid.

[40] Ibid.

[41] Ibid.

the unauthorized practice of medicine.[42] 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.[43]

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.[44] 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."[45] Despite this rulemaking, VA testified during an October 24, 2017 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."[46]

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 physicians and other health care professionals."[47] As such, section 151 of the bill would 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, and 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. Section 151 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.

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[42] Ibid.
[43] Ibid.
[44] Ibid.
[45] Ibid.
[46] 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).
[47] 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).

Section 152. Authority for Department of Veterans Affairs Center for Innovation for Care and Payment

As the nation's largest integrated healthcare system, the Committee believes that VA has a unique ability to be a leader in the healthcare industry. However, all too often, VA has struggled to embrace innovation and private sector best practices that would allow VA facilities to maximize productivity, efficiency, and—most importantly—the provision of modern, high quality care. Section 152 of the bill would aid VA in this endeavor by authorizing a Center for Innovation for Care and Payment (the Center). Through the Center, VA would develop and test innovative approaches to testing payment and service delivery models to reduce expenditures while preserving or improving the quality of care. In doing so, VA would be authorize to waive any current statutory requirements but would first be required to submit a report to Congress explaining the authorities to be waived and the reasons for such a waiver and receive a bill or joint resolution approving such a waiver. VA would also be required to conduct an evaluation of each model tested and make such evaluation available to the public.

Section 153. Authorization to provide for operations on live donors for purposes of conducting transplant procedures for veterans

VA has offered solid organ transplant services for eligible veteran patients since 1962 and bone marrow transplant services for eligible veteran patients since 1982.[48] 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.[49]

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.[50] Mr. Nelson's non-veteran son, Austin, was willing and able to serve as Mr. Nelson's live donor.[51] 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 Choice program.[52]

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[48] VA National Transplant Program. https://www.va.gov/health/services/transplant/.Accessed October 30, 2017.

[49] Ibid.

[50] 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).

[51] Ibid.

[52] Ibid.

[53] 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.[54] 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.[55]

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.[56] 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 and that, for veterans receiving a transplant from a live donor, any associated care for the live donor, should be covered by VA. Consistent with those goals, section 153 of the bill would authorize VA to provide for any care or services a live donor may require to carry out a transplant procedure in either a VA transplant center or medical facility or VA community care facility for an eligible veteran notwithstanding that the live donor may not be eligible for VA health care.

Subtitle C—Family Caregivers

Improvements in battlefield medicine and follow-up treatment have significantly improved survival rates for severely wounded servicemembers. However, servicemembers returning from battle with severe wounds that would have previously proved fatal may require lifelong medical intervention and supportive care and, as a result, family members and friends are increasingly being called upon to act as caregivers. The Committee acknowledges how integral caregivers are to the rehabilitation and recovery process for severely injured veterans as well as the significant physical, mental, and financial toll that caregiving can take.

In recognition of that, Congress passed the Caregivers and Veterans Omnibus Health Services Act (Public Law 111–163; 124 STAT. 1130), which established two programs to provide support to veteran caregivers. The first program is the General Caregiver Support Services Program. Under the General Caregiver Support Services Program, caregivers of veterans from all eras are eligible

[53] 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

[54] 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).

[55] Ibid.

[56] 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.

to receive peer support mentoring, caregiving training, and support through VA's National Caregiver Support line and website as well as through VA Caregiver Support Coordinators located at every VA medical center. The second program is the Program of Comprehensive Assistance for Family Caregivers (Family Caregiver Program), which is available to post-9/11 veterans only.

Under the Family Caregiver Program, approved family caregivers of post-9/11 veterans are eligible to receive a monthly, tax-free stipend paid directly to the caregiver; enrollment in VA's Civilian Health and Medical Program (CHAMPVA) if the caregiver is not already covered under an existing insurance plan; up to 30 days of respite care; and travel expenses when receiving initial caregiver training and during the veterans' medical appointments. Veterans (or servicemembers who are undergoing a medical discharge from the Armed Forces) are eligible for the Family Caregiver Program if they meet certain eligibility criteria, including: the presence of a serious injury incurred or aggravated in the line of duty on or after 9/11; a need for personal care services for at least six continuous months as a result of such serious injury; a clinical determination that participation in the Family Caregiver Program is in the veteran's best interest; the lack of simultaneous, regular provision of personal care services by or through another entity or program; and an agreement to receive ongoing care from a VA primary care team.

Veteran demand for the Family Caregiver Program has outpaced expectations by 550 percent leading to delays, workload concerns, and other issues.[57] Many of those concerns were detailed in a 2014 GAO report which found that staffing to support the Family Caregiver Program was insufficient to meet higher-than-expected demand at certain VA medical centers, with some Caregiver Support Coordinators managing a workload of up to 251 approved caregivers at a time.[58] These staffing shortages impeded the timeliness of key functions and negatively affected services to caregivers.[59] GAO also found that oversight of the Family Caregiver Program is impeded by information technology (IT) system limitations that prevented access to key workload and other data.[60] This led GAO to conclude that, "[a]fter 3 years of operation, it is clear that VHA needs to formally reassess and restructure key aspects of the Family Caregiver Program."[61] More than three years later, many of the recommendations that GAO made to address these findings remain open.

Given that, the Committee has concerns about the management and administration of the Family Caregiver Program. However, the Committee also acknowledges the inequity that currently exists between pre- and post-9/11 veterans and their caregivers regarding the Family Caregiver Program. To address this inequity and recognize the service and sacrifice of veteran caregivers of all ages and eras, subtitle C of the bill would expand eligibility for the Family

[57] United States Cong. House Committee on Veterans' Affairs. "VA Caregiver Support Program: Correcting Course for Veteran Caregivers." February 6, 2018. 115th Cong. 2nd sess. Washington: GPO, 2018 (Statement of the Honorable David P. Roe M.D., Chairman, Committee on Veterans' Affairs, U.S. House of Representatives).

[58] GAO–14–675, Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program. https://www.gao.gov/assets/670/665928.pdf.

[59] Ibid.

[60] Ibid.

[61] Ibid.

Caregiver Program to pre-9/11 veterans. It would also require VA to implement an IT system that fully supports the Family Caregiver Program and allows for data assessment and comprehensive monitoring. Subtitle C would further amend requirements for VA's annual report on the Family Caregiver Program to include a description of any barriers to accessing and receiving care and services through the Family Caregiver Program and an evaluation of the sufficiency and consistency of the training provided to family caregivers.

TITLE II—VA ASSET AND INFRASTRUCTURE REVIEW

Subtitle A—Asset and Infrastructure Review

VA is one of the federal government's largest property-holding entities with a capital asset portfolio that includes approximately 155 million square feet across more than 35,000 acres of land.[62] Unlike many other federal agencies, the majority—86 percent—of VA's capital asset portfolio is owned.[63] VA also controls approximately 24.6 million square feet of leased space.[64] In July 2017, VA testified before the Committee that "most of VA's infrastructure portfolio is dated, in need of repair/replacement, and requires considerable investment."[65] VA further testified that "the majority of VA facilities have out-lived their useful life-cycle," raising serious questions about VA's continued ability to meet the needs of veteran patients and beneficiaries.[66]

Most VA facilities are medical facilities that are operated by VHA. Nationally, VHA's portfolio includes 168 VA medical centers, 135 community living centers, 48 domiciliary centers, 737 community-based outpatient clinics, 22 health care centers, and 305 other outpatient facilities such as mobile treatment spaces.[67] The average VHA building is approaching 60 years old, more than five times older than the average building age of a not-for-profit hospital system in the United States.[68] These buildings were designed to meet an older, primarily inpatient, model of care.[69] Thus, they are not well suited to provide care in accordance with modern, primarily outpatient, care models or to meet the contemporary ambulatory care needs of veteran patients.[70]

VHA's capital asset portfolio also includes a significant number of vacant properties, which led the bipartisan Commission on Care to note in 2016 that "VHA's principal mission is to provide health care to veterans, yet over time it has acquired an ancillary mission:

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[62] United States Cong. House Committee on Veterans' Affairs Oversight Hearing—"Care Where it Count: Assessing VA's Capital Asset Needs." July 12, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from James M. Sullivan, Director of the Office of Asset Enterprise Management, U.S. Department of Veterans Affairs).

[63] Ibid.

[64] Ibid.

[65] Ibid.

[66] Ibid.

[67] GAO–17–349, April 2017, "VA Real Property: VA Should Improve Its Efforts to Align Facilities with Veterans' Needs," https://www.gao.gov/assets/690/683938.pdf.

[68] CMS Alliance to Modernize Healthcare Federally Funded Research and Development Center, September 1, 2015, "Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs," https://www.va.gov/opa/choiceact/documents/assessments/Integrated—Report.pdf.

[69] Commission on Care, June 30, 2016, "Commission on Care Final Report," https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

[70] Ibid.

caretaker of an extensive portfolio of vacant buildings."[71] The bipartisan Commission on Care also found that "maintaining outdated, vacant, and unused buildings, which require millions of dollars in maintenance even in mothball status, diminishes operating funds needed for patient care and yields no benefit to veteran patients."[72] VA announced in June 2017 that the Department would initiate reuse or disposal of approximately 430 vacant buildings totaling 5.9 million gross square feet over the next two years.[73] VA expects to save approximately $7 million annually as a result of this effort.[74] VA also intends to review approximately 784 underutilized buildings to determine if they can be reused or disposed of to yield additional savings.[75]

The amount of empty or underutilized spaces across the VA health care system has been exacerbated by VHA's struggle to align VA medical facilities with the veteran patient population. In 2015, the Independent Assessment of the Health Care Delivery Systems and Management Processes of VA (Independent Assessment) found that VA struggles to consistently allocate capital to projects that represent the greatest areas of veteran need in the most cost effective and timely manner.[76] The Independent Assessment argued that the misalignment of VA's properties with VA's patients was due, in part, to lengthy approval and funding timelines that hinder VA's ability to meet the identified space requirements to keep up with veteran demand and invest in facility updates that align with changing models for care.[77] GAO made a similar judgment in a 2017 report that found significant geographic shifts in the veteran patient population coupled with changes in the delivery of care, "antiquated" infrastructure, and serious limitations with VA's capital planning processes created, "an imperative for VA to better align its medical facilities and services."[78]

Even absent a serious realignment effort, VA has identified more than $50 billion in capital needs over the next decade to modernize and maintain the Department's infrastructure.[79] However, the capital requirement for VHA to maintain facilities and meet projected growth needs over the next decade is two to three times higher than anticipated funding levels, a gap which is expected to could continue to widen.[80] Furthermore, the Independent Assessment

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[71] Ibid.
[72] Ibid.
[73] United States Cong. House Committee on Veterans' Affairs Oversight Hearing—"Care Where it Count: Assessing VA's Capital Asset Needs." July 12, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from James M. Sullivan, Director of the Office of Asset Enterprise Management, U.S. Department of Veterans Affairs).
[74] Ibid.
[75] Ibid.
[76] CMS Alliance to Modernize Healthcare Federally Funded Research and Development Center, September 1, 2015, "Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs," https://www.va.gov/opa/choiceact/documents/assessments/Integrated_Report.pdf.
[77] Ibid.
[78] GAO–17–349, April 2017, "VA Real Property: VA Should Improve Its Efforts to Align Facilities with Veterans' Needs," https://www.gao.gov/assets/690/683938.pdf.
[79] United States Cong. House Committee on Veterans' Affairs Oversight Hearing—"Care Where it Count: Assessing VA's Capital Asset Needs." July 12, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from James M. Sullivan, Director of the Office of Asset Enterprise Management, U.S. Department of Veterans Affairs).
[80] CMS Alliance to Modernize Healthcare Federally Funded Research and Development Center, September 1, 2015, "Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs," https://www.va.gov/opa/choiceact/documents/assessments/Integrated_Report.pdf.

also found that VA's construction costs are double private industry best practice, that VA time-to-complete construction projects exceeds both public and private sector peers, and that VA's facility management costs are two to three times higher than comparable private medical facilities, on average.[81]

VA has attempted to address the Department's capital asset challenges previously. In 2003, Secretary Principi initiated the VA Capital Asset Realignment for Enhanced Services (CARES) process.[82] As part of CARES, an independent commission was formed to provide recommendations for the realignment and allocation of capital assets to meet veteran health care demand over the next 20 years.[83] The CARES Commission conducted 38 public hearings and 10 public meetings around the country, heard from 770 witnesses—including 135 members of Congress and seven governors—and received written comments from more than 212,000 people.[84] In February 2004, the CARES Commission released a report recommending substantial changes to existing VA facilities and a limited number of facility closures. Yet, thirteen years after the CARES report was released, its recommendations have yet to be fully implemented.[85] Secretary Prinicipi testified before the Committee in July 2017 that, while CARES offered "sound recommendations for realignment and allocation of the Department's capital assets to meet demand for VA's services over the next twenty years," it did not require Congress to adopt or reject the final CARES recommendations as a package and, thus, failed.[86] The bipartisan Commission on Care similarly noted that "political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs."[87] In light of this, the Commission also recommended that Congress establish a VHA facility and capital asset realignment process based on the process established by the Department of Defense Base Realignment and Closure Commission process to be implemented as soon as practicable.[88]

The Committee applauds VA's recent efforts to initiate reuse or disposal of vacant and underutilized properties across the country and encourages their continuation. However, the Committee also believes that bold steps are needed to fully address VHA's significant and increasing capital asset challenges, to ensure VHA uses taxpayer dollars wisely in caring for the nation's veterans, and—most importantly—to ensure a strong VA health care system is available to meet the needs veteran patients both today and for generations to come. Accordingly, the Committee concurs with the bipartisan Commission on Care's recommendation to establish a robust VHA capital asset realignment process freed, to the greatest extent possible, from political constraints.

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[81] Ibid.

[82] February 12, 2004, VA Office of Public and Intergovernmental Affairs, "CARES Commission Announces Recommendations," https://www.va.gov/opa/pressrel/pressrelease.cfm?id=729.

[83] Ibid.

[84] Ibid.

[85] United States Cong. House Committee on Veterans' Affairs Oversight Hearing—"Care Where it Count: Assessing VA's Capital Asset Needs." July 12, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from the Honorable Anthony J.Principi).

[86] Ibid.

[87] Commission on Care, June 30, 2016, "Commission on Care Final Report," https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

[88] Ibid.

As such, title II of the bill would require VA to establish a nine member AIR Commission. The AIR Commissioners would be appointed by the President, with the advice and consent of the Senate and in consultation with Congressional leaders and congressionally chartered, membership-based veterans service organizations (VSOs). The Commission as a whole would be required to reflect current demographics of veterans enrolled in the VA health care system and to have expertise in health care system and federal capital asset planning and management. In addition, at least three Commissioners would be required to represent the VSO community. The Commission would be tasked with considering recommendations made by VA and submitting a report to the President on VHA facility modernization and realignment. The Commission would only be able to change a recommendation made by VA for the modernization or realignment of a VHA facility if: the Commission determines that VA deviated substantially from VA's criteria in making a given recommendation and a change would be consistent with the final criteria; the Commission publishes a notice of the proposed change in the Federal Register not less than 45 days before transmitting the Commission's report including the change to the President; and the Commission conducts public hearings on the proposed change. Upon the President's approval of the Commission's report, the report would be transmitted to Congress. Congress would be required to act under expedited legislative procedures to issue a resolution of disapproval of the Commission's report and the full list of recommendations it contains. Absent such a resolution, VA would be required to take any such action as may be necessary to carry out the actions recommended by the Commission.

The Committee recognizes that the implementation of the Commission's recommended actions would be a substantial task for VA as it is likely that VA will need to carry out a level of construction, leasing, environmental compliance, and property disposition activity that exceeds typical levels. As VA's existing legal authority to initiate property actions may be inadequate to accommodate the Commission's recommendations, title II of the bill would include additional authorities to allow VA to take such action as may be necessary to modernize or realign any VHA facility and to transfer or lease properties to historic preservation organizations. To ensure that VA's maintenance needs continue to be met while the Commission's work is ongoing, title II of the bill would prohibit VA from pausing major or minor construction activities while the Commission process is ongoing.

The Committee intends for the AIR Commission process to be data-driven and to incorporate feedback from veterans, employees, stakeholders, and communities who would be most impacted by VHA modernization or realignment. As such, title II of the bill would require VA to consult with VSOs to establish criteria to use to assess and recommend the modernization or realignment of VHA facilities and to take certain factors—including local veteran and stakeholder input—into account to ensure such recommendations are robust and fair. Title II of the bill would also require VA to consult with local veterans and VSOs to conduct periodic assessments of the capacity of each Veterans Integrated Service Network (VISN) and VA medical facility to furnish hospital care or medical services

to veterans. Each assessment would be required to: (1) identify existing deficiencies in the furnishing of care and services to veterans and how such deficiencies may be filled by entering into contracts or agreements with community health care providers or other entities under other provisions of law and changing the way care and services are furnished at such VISNs or VA medical facilities (including through extending hours of operation, adding personnel, and expanding treatment space through construction, leasing, or sharing of health care facilities); (2) forecast both the short-term and long-term demand in furnishing care and services at such VISN or VA medical facility; (3) consider how demand affects the need to enter into contracts or agreements; (4) consider the commercial health care market of designated catchment areas conducted by a non-governmental entity; and (5) consider the unique ability of the Federal government to retain a presence in a rural area otherwise devoid of commercial health care providers or from which such providers are at risk of leaving.

The Committee also intends the AIR Commission process to be transparent and veteran-centric. Accordingly, title II of the bill would: require that each meeting of the Commission be open to and all proceedings, information, and deliberations of the Commission to be available for review by the public; to require the online publication within 24 hours of any information transmitted or received by VA, the Commission, or the President regarding the Commission (or related activities) to be published online within 24 hours; prohibit the restriction of lawful communication from a VA employee to the Commission; require VA to make the local capacity and commercial market assessments publically available; and require the Commission to conduct public hearings and include local veterans and VSOs as witnesses in those hearings.

The Committee is aware that the ultimate success of the Commission may be contingent upon ensuring VA has sufficient time before the Commission begins its work to gather needed data, establish appropriate criteria, and make initial recommendations regarding facility actions. Accordingly, title II of the bill would allow VA until January 31, 2022, before transmitting recommendations to the Commission for review. The Commission would then have a year to conduct their work before transmitting the Commission's report to the President on January 31, 2023. The Commission would terminate on December 31, 2023.

The Committee is aware of the sensitive political considerations inherent in the AIR Commission process and, as such, title II of the bill includes provisions stipulating expedited legislative consideration of the Commission's report by Congress. The Committee believes expedited consideration is appropriate and necessary given the Committee's full concurrence with Secretary Principi's testimony that:

> [VA] will fail to honor our nation's commitment to its veterans if VA's medical system does not evolve with the times. . . While the practice of VA medicine has evolved, VA's medical infrastructure has not kept pace. VA facilities are out of step with changes in the practice of medicine, with demographic changes in the veteran population, and with statutory changes in VA's health care benefits packages. If VA does not realign itself, and close its unneeded facilities, the current de-

cline in the veteran population will make many VA medical centers museums of the past—not the guideposts for the future they should be.[89]

However, it is important to note that the Committee in no way intends title II of the bill to supersede the prohibition on the sale of the VA Greater Los Angeles Healthcare System West LA (WLA) campus in Los Angeles, California, in current law. The 387-acre property that the WLA campus resides on was deeded to the United States in 1888 to be used as the Pacific Branch of the National Home for Disabled Volunteer Soldiers.[90] The property was maintained in accordance with this purpose until the 1970s when the WLA campus was placed there. Today, the WLA campus is one of the busiest and largest medical and research campuses in the entire VA healthcare system. The Homeless Veterans Comprehensive Service Programs Act of 1992 (Public Law 102–590, 106 STAT. 5136) authorized VA to lease property on the WLA campus. However, in 2011, the American Civil Liberties Union (ACLU) of Southern California filed a class action lawsuit on behalf of homeless veterans with disabilities alleging that VA was misusing the WLA campus and discriminating against homeless veterans, "because they cannot access the medical, mental health and other services to which they are entitled" in part due to VA's use of the WLA campus leasing authority.[91] In January 2015, VA and attorneys for the plaintiffs announced that they had reached an agreement in that lawsuit in which VA agreed to develop a master plan for the WLA campus to prioritize bridge and permanent supportive housing for homeless veterans. The West Los Angeles Leasing Act of 2016 (Public Law 114–226; 130 STAT. 926) authorized VA to carry out certain leases on the WLA campus in accordance with the master plan and prohibited the sale of any property located on the WLA campus. Similar prohibitions can be found in both the Veterans' Benefits and Services Act of 1988 (Public Law 100–322; 102 STAT. 487) and the Consolidated Appropriations Act, 2008 (Public Law 110–161; 121 STAT. 1844). Given the unique history and importance of the property the WLA campus is located on, the Committee is strongly supportive of maintaining and improving the WLA campus and increasing the services provided to veterans on and through it.

Subtitle B—Other Infrastructure Matters

Section 211. Improvement to training of construction personnel

VA's construction management capability has come under intense scrutiny for inadequacy in recent years. For example, in 2013, GAO found that were substantially increased costs and schedules were delayed for the largest VA major medical facility construction projects in Denver, Colorado; Las Vegas, Nevada; New Orleans, Louisiana; and Orlando, Florida.[92] In 2015 GAO testified

[89] United States Cong. House Committee on Veterans' Affairs Oversight Hearing—"Care Where it Count: Assessing VA's Capital Asset Needs." July 12, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from the Honorable Anthony J.Principi).

[90] VA Greater Los Angeles Campus Draft Master Plan, January 28, 2016, http://www.losangeles.va.gov/masterplan/.

[91] Valentini v. Shinseki. https://www.aclusocal.org/valentini/.

[92] GAO 13–302, GAO Report, "VA Construction: Actions Needed to Decrease Delays and Lower Costs of Major Medical Facility Projects," April 4, 2013.

before the Committee that these projects ranged from 66 percent to 427 percent over budget and 14 months to 86 months behind schedule.[93] Given these findings, Congress enacted the Department of Veterans Affairs Expiring Authorities Act of 2015 (Public Law 114–58; 129 STAT. 530), which required that all VA medical facility construction projects exceeding $100 million be managed by another federal agency. Congress also enacted the Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016 (Public Law 114–315; 130 STAT. 1536), which required that each VA employee with construction responsibilities undergoes a program of ongoing professional training and development including instruction on industry standards and acquisition best practices. However, the Committee remains concerned about the level of training that VA construction personnel receive and about VA's interpretation of current law give that it appears that VA has interpreted and implemented the law to cover training courses that are not significantly more numerous or wide ranging than the courses being offered before the law's enactment. The Committee also believes that it is necessary to broaden training in construction disciplines beyond architects, engineers, real property specialists, and other such professionals located in programmatic offices that are specifically devoted to construction. There is a much wider universe of personnel involved in construction acquisition, notably including contracting officers, contract specialists, and contracting officers' representatives. Relatedly, since the passage of the Defense Workforce Improvement Act of 1991 (Public Law 101–510; 104 STAT. 1485), the accepted way to deliver such interdisciplinary acquisition training is through formal certification programs. All civilian agencies have subsequently been mandated to adopt certification programs for the fields of contracting and program management. The Department of Defense continues to offer a wider range of certification programs to its employees, notably including certification in facilities engineering. The Committee asserts that it would be advantageous for VA to adopt a similar, formal certification program for construction and facilities management.

In accordance with this belief, section 211 of the bill would require VA to implement a training and certification program for construction and facilities management personnel. All VA employees who are members of occupational series relating to construction or facilities management or VA employees who award or administer contracts for major construction, minor construction, or non-recurring maintenance (including contract specialists or contracting officers' representatives) would be included in such a program. VA would be required to create the training and certification program within one year of enactment, to ensure a majority of covered employees are certified within two years of enactment, and to ensure that all covered employees are certified as quickly as possible thereafter. VA would be required to model the training and certification program on existing curricula and certification programs in

[93] GAO–15–332T, GAO Testimony "VA Construction: VA Actions to Address Cost Increases and Schedule Delays at Major Medical-Facility Projects," January 21, 2015; GAO–15–564T, GAO Testimony, "VA Construction: Actions to Address Cost Increases and Schedule Delays at Denver and Other VA Major Medical-Facility Projects," April 24, 2015.

title 10 U.S.C. (namely, the existing Defense Acquisition Workforce Improvement Act program).

Section 212. Review of enhanced use leases

Section 8162 of title 38 U.S.C. authorizes VA to enter into enhanced use leases (EULs) with respect to VA property. Through this authority, VA out-leases underutilized real estate to private sector entities for the purpose of developing supportive housing for homeless and at-risk veterans and their families.[94] VA asserts that EUL authority affords the Department the ability to provide veterans with an expanded range of services that would not otherwise be available on medical center campuses and is both an important component of VA's program to end homelessness among veterans and a critical tool to assist VA in the effective management of physical assets. The Committee concurs with that though also believes that oversight of VA's use of its EUL authority is critical to ensure the appropriate use of VA property. As such, section 212 would require the Office of Management and Budget to review each EUL before it goes into effect to determine whether it is in compliance with relevant statutes.

Section 213. Assessment of health care furnished by the Department to veterans who live in the Pacific territories

Veterans in 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 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 213 of the bill would require VA to report on the care provided to veterans in these areas. Such a report would be required to include whether VA believes it would be feasible and appropriate to establish a VA facility in any territory that does not already contain such a facility.

TITLE III—IMPROVEMENTS TO RECRUITMENT OF HEALTH CARE PROFESSIONALS

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, including the Education Debt Repayment Program and the Health Professions Scholarship Program (HPSP). Despite these programs, VA maintains a significant number of physician vacancies across the VA healthcare system. VA's considerable recruitment and retention issues are worsened by an aging workforce that is becoming increasingly retirement-eligible.[95]

To help alleviate the shortage of physicians, section 301 of the bill would provide scholarships to medical students in exchange for service to VA. A minimum of two to four year scholarships for med-

[94] *Enhanced Use Lease (EUL)*. Department of Veterans Affairs. https://www.va.gov/assetmanagement/. Accessed May 9, 2018.

[95] 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.)

ical 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. Increase in maximum amount of debt that may be reduced under Education Debt Reduction Program of Department of Veterans Affairs

The Education Debt Repayment Program (EDRP) was authorized by the Veterans Programs Enhancement Act of 1998 (Public Law 105–368; 112 STAT. 3315). EDRP is intended to provide veteran patients with specialized care by increasing the supply of qualified health care professionals in VA facilities and assisting VA in meeting the need for qualified health care professionals in occupations where recruitment or retention is difficult.[96] VA recently testified that EDRP is among VA's most effective recruitment and retention programs.[97] The Committee strongly supports EDRP and recognizes the value it has provided to VA facilities across the country. In an effort to strengthen the effectiveness of EDRP, section 302 of the bill would increase the amount of education debt reduction available through EDRP from $120,000 to $200,000 over five years and from $24,000 to $40,000 annually.

Section 303. Establishing the Department of Veterans Affairs specialty education loan repayment program

Given the recruitment and retention challenges that VA faces and the need for VA to hire more high quality providers to treat veteran patients, section 303 of the bill would establish a new loan repayment program for medical or osteopathic student loans for newly graduated medical students or residents with at least 2 years of training remaining and 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, the Committee believes this would make the loan repayment more economically meaningful and allow VA to fund specialty positions in shortage areas, develop a predictable future physician workforce, and ensure a cadre of physicians who are incentivized to join VA's physician workforce and treat the nation's veterans.

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[96] *Education Debt Reduction Program (EDRP).* https://www.vacareers.va.gov/assets/common/print/EDRP_VA_Careers_Page.pdf. Accessed May 8, 2018.

[97] United States Cong. House Committee on Veterans' Affairs. *"FY 2019 Department of Veterans Affairs Budget Request for the Veterans Health Administration."* March 15, 2018. 115th Cong. 2nd sess. Washington: GPO, 2018. (Testimony from Carolyn M. Clancy M.D., Executive in Charge of the Veterans Health Administration for the U.S. Department of Veterans Affairs.)

Section 304. Veterans healing veterans medical access and scholarship program

In order to assist VA in recruiting veteran physicians, section 304 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 at four historically black colleges and universities. 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 their last military discharge who are not eligible for GI Bill benefits and who meet the minimum admission requirement for medical school. The scholarship recipients would agree to successfully complete medical school, obtain a license to practice medicine, complete postgraduate 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.

Section 305. Bonuses for recruitment, relocation, and retention

Chapter 45 and Chapter 53 of title 5 U.S.C. authorizes VA to provide awards and bonuses to employees. The Choice Act limited the amount of awards and bonuses payable to VA employees to no more than $360 million from fiscal year 2014 through fiscal year 2024. The Comprehensive Addiction and Recovery Act of 2016 (Public Law 114–198; 130 STAT 695) further limited the amount of awards and bonuses payable to VA employees to $230 million for fiscal year 2017 through fiscal year 2018, $225 million for fiscal year 2019 through fiscal year 2021, and $360 million for fiscal year 2022 through fiscal year 2024. The limitations imposed on awards and bonuses to VA employees included recruitment, relocation, and retention incentive payments. This has raised concerns from VA, VSOs, and other stakeholders that such limitations could have unintended negative consequences on VA's ability to hire high-quality clinicians and support staff to effectively serve veteran patients. As such, section 305 of the bill roll back the limitation on amounts available for award and would prioritize recruitment, relocation, and retention incentives within the total limitations on awards and bonuses.

Section 306. Inclusion of Vet Center employees in education debt reduction program of Department of Veterans Affairs

As referenced in the analysis portion of section 302 of the bill above, the Committee strongly supports EDRP and believes it to be an effective tool to increase recruitment and retention of highly-qualified clinicians. Through the Readjustment Counseling Service,

VA operates 300 Vet Centers.[98] Vet Centers provide readjustment counseling services to eligible veterans, servicemembers, and their families in an effort to assist them in making a successful transition from the military to civilian life.[99] Such services include individual, group, and family counseling; bereavement counseling; military sexual trauma counseling; peer support; recreational opportunities; substance abuse assessment; and employment assessment.[100] The Committee strongly supports the Vet Center program and commends the VA clinicians working there for the services they provide to veterans and their families. In an effort to aid those clinicians in their work and to recruit more clinicians to join their ranks, section 306 of the bill would require VA to ensure that clinical staff working in Vet Centers are eligible to compete for and participate in EDRP.

TITLE IV—HEALTH CARE IN UNDERSERVED AREAS

The Department of Health and Human Services' Health Resources and Services Administration (HRSA) defines a medically underserved area as an area designated by HRSA as having too few primary care providers, a high infant mortality, a high poverty or a high elderly population.[101] The Committee acknowledges that some VA facilities may meet this criterion or may otherwise face unique challenges to providing timely, quality care for veteran patients. As such, those facilities may require a higher level of support and resources and should be identified and supported by VA leaders. Accordingly, title IV of the bill would require VA to: (1) develop criteria to designate VA medical facilities as underserved facilities; (2) consider a number of factors with respect to such facilities, including the ratio of veterans to providers; the range of specialties covered; whether the local community is medically underserved; the type, number, and age of open consults; and whether the facility is meeting VA's wait time goals; (3) perform an analysis annually (if not more often) to determine which facilities qualify as underserved; and (4) submit a plan to Congress, within one year of enactment and not less frequently than annually thereafter, to address underserved facilities. Title IV of the bill would also require VA to carry out a three-year pilot program to furnish mobile deployment teams of medical personnel to underserved facilities and to consider the medical positions of greatest need at such facilities and the size and composition of teams to be deployed. It would also require VA to establish a pilot program to establish medical residency programs at covered facilities, including VA facilities, a facility operated by an Indian tribe or tribal organization, an Indian Health Service facility, a Federally-qualified health center, or a DOD facility.

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[98] *Vet Center Program.* https://www.vetcenter.va.gov/Vet_Center_Services.asp. Accessed May 8, 2018.

[99] Ibid.

[100] Ibid.

[101] *AMUA Find.* Health Resources and Services Administration. https://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx. Accessed May 9, 2018.

TITLE V—OTHER MATTERS

Section 501. Annual report on performance awards and bonuses awarded to certain high-level employees of the Department

As referenced in the analysis portion of section 305 of the bill above, current law authorizes VA to provide performance awards and bonuses to certain employees. The Committee recognizes that this authority represents an important recruitment and retention tool and can be a powerful incentive to hard-working employees at all levels of the Department. The Committee supports a judicious use of this authority to reward top performers but desires transparency for Congress and the American people regarding the performance awards and bonuses that are paid to senior leaders across the country. As such, section 501 of the bill would require VA to submit an annual report to Congress on performance awards and bonuses paid to the Veterans Integrated Service Network Directors, VA medical center Directors, Regional Office Directors, and senior executives. Each such report would be required to include the amount of each award or bonus, the job title of each individual who received an award or bonus, and the location where each individual who received an award or bonus works.

Section 502. Role of Podiatrists in Department of Veterans Affairs

Approximately 61 percent of veterans newly separated from service in the Armed Forces have used VA health care since October 1, 2001.[102] The most common diagnosis for these veterans is for a musculoskeletal ailment.[103] Some of these musculoskeletal ailments are the result of lower extremity injuries inflicted by improvised explosive devices on the battlefield. Musculoskeletal ailments and lower extremity injuries are also an increasingly prevalent concern among previous generations of veterans who may be struggling with issues exacerbated by aging, chronic conditions like diabetes, and complications resulting from military service. A February 2017 VA white paper states that, in fiscal year 2016, approximately 1.8 million veteran users of the VA healthcare system were at risk for major foot wounds, infection, and amputations.[104] That number represents a 21 percent increase from fiscal year 2015.[105] This led VA to conclude that, "[t]here is a growing health care demand for primary and specialty podiatric services, especially among veterans suffering from polytraumatic injuries, spinal cord injury, and limb amputation."[106]

However, VA's ability to effectively and efficiently recruit and retain podiatrists to treat foot and ankle issues among veteran patients are hampered by outdated statutory requirements governing the treatment of podiatrists within the VA healthcare system. VA's qualifications for podiatrists were developed in 1976 and have not kept pace with modern podiatric education and training.[107] The American Podiatric Medical Association (APMA) testified in 2017

[102] *VA Health Care Utilization by Recent Veterans*. Public Health, Epidemiology. https://www.publichealth.va.gov/epidemiology/reports/oefoifond/health-care-utilization/. Accessed July 20, 2017.
[103] Ibid.
[104] Department of Veterans Affairs White Paper on Podiatry Pay. February 2017.
[105] Ibid.
[106] Ibid.
[107] Ibid.

that "unlike 41 years ago, the current podiatric medical school curriculum is vastly expanded in medicine, surgery and patient experiences and encounters, including whole body history and physical examinations."[108] Because VA's standards do not align with current podiatry practice, VA podiatrists experience disparities in recognition and pay when compared to their non-VA peers, which results in serious podiatry recruitment and retention issues within VA. The average compensation for a podiatrist in the private sector is $30,000 higher than the highest compensation available to a podiatrist practicing in VA.[109] As a result, VA struggles to recruit the most experienced, qualified podiatrists and to retain the podiatrists already practicing within the VA healthcare system. For example, in fiscal years 2015 and 2016, almost 62 percent of VA medical centers had to replace podiatrists, disrupting patient care and continuity.[110] What's more, 66 percent of the new podiatrists hired in 2016 had less than 10 years of experience and only 30 percent were board certified.[111] Further, when there is a podiatry vacancy within a VA medical facility, it takes an average of 14 months, for that vacancy to be filled.[112]

To address the growing need for podiatry care within the VA healthcare system, section 502 of the bill would stipulate that a VA podiatrist is eligible to be appointed to a supervisory position to the same degree that a VA physician is eligible to be appointed to such a position. To ensure appropriate supervision of specialty providers within the VA healthcare system, section 502 of the bill would also require VA to work with appropriate stakeholders to establish standards to ensure that specialists appointed to supervisory positions do not provide direct clinical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties. Further, section 502 of the bill would make Doctors of Podiatric Medicine (DPMs) equal to Doctors of Osteopathy (DOs) and Medical Doctors (MDs) in terms of pay within the VA healthcare system. The Committee believes that this will correct long-standing inequities between the treatment of podiatrists in VA medical facilities and in the private sector, significantly improve VA's ability to recruit and retain high-quality podiatrists to treat veteran patients with foot and ankle issues and result in better care and higher cost savings than would otherwise be expected.

Section 503. Definition of major medical facility project

Section 8104(a)(2) of title 38, U.S.C. requires Congressional authorization for VA major medical facility projects. A "major medical facility project" is defined as a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $10 million. That $10 million threshold was set by the Veterans Benefits, Health Care, and Information Technology

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[108] United States Cong. House Committee on Veterans' Affairs Subcommittee on Health. *"VA Specialized Services: Lower Extremity Conditions"* May 2, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from Seth Rubenstein DPM, Treasurer, Board of Trustees/Immediate Past Chairman, Legislative Committee, American Podiatric Medical Association).

[109] United States Cong. House Committee on Veterans' Affairs Subcommittee on Health. "VA Specialized Services: Lower Extremity Conditions" May 2, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from Jeffrey Robbins, DPM, Chief of Podiatry, Veterans Health Administration, U.S. Department of Veterans Affairs).

[110] Ibid.

[111] Ibid.

[112] VA White Paper on Podiatry Pay. February 2017.

Act of 2006 (Public Law 109–461, 120 STAT. 3403), which raised such threshold from $7 million to $10 million. The bipartisan Commission on Care noted that this $10 million threshold—which has not been revisited since 2006—has made it difficult for VA to modernize and renovate aging facilities in recent years.[113] The Committee concurs. Section 503 of the bill would modify the definition of a VA major medical facility project by raising the threshold for Congressional authorization from $10 million to $20 million.

Section 504. Authorization of certain major medical facility projects of Department of Veterans Affairs

As referenced in the analysis portion of section 503 of the bill above, section 8104(a)(2) of title 38, U.S.C. requires Congressional authorization for VA major medical facility projects. Section 504 of the bill would authorize a VA major medical facility project in Livermore, California, in an amount not to exceed $117.3 million.

Section 505. Department of Veterans Affairs personnel transparency

Committee oversight as well as GAO and IG reports have found inadequate staffing and gaps in hiring at VA facilities nationwide for the last several years. This can adversely impact care to veteran patients by creating or contributing to access issues and scheduling delays. In December 2016, GAO released a report, which found that VHA fell short of Federal standards for effective internal controls to support Human Resources (HR) functions, compromising VHA's ability to deliver sufficient support to effectively recruit and retain the high-quality employees VA needs to effectively serve veteran patients.[114] This finding is consistent with the Committee's findings that VA HR employees in the field and in leadership often lack information regarding key measures that could indicate weaknesses in HR practices. This is particularly concerning given that testimony before the Committee has found that VA's considerable recruitment and retention issues are worsened by an aging workforce that is becoming increasingly retirement-eligible.[115] In order to increase transparency with respect to staffing for VA facilities and aid in Congressional and stakeholder oversight of the generous hiring authorities that VA has been granted, section 505 of the bill would require VA to make information regarding vacancies, accessions and separation actions, new hires, and personnel encumbering positions publically

[113] Commission on Care, June 30, 2016, "Commission on Care Final Report," https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care__Final-Report__063016__FOR-WEB.pdf

[114] GAO–17–30, December 2016, "Management Attention is Needed to Address Systemic, Long-standing Human Capital Challenges," http://www.gao.gov/assets/690/681805.pdf

[115] United States Cong. House Committee on Veterans' Affairs Subcommittee on Health. *"Legislative Hearing on draft legislation to improve the authority of the Secretary of Veterans Affairs to hire and retain physicians and other employees of the Department of Veterans Affairs."* March 16, 2016. 114th Cong. 2nd sess. Washington: GPO, 2016 (Testimony of Max Stier, President and Chief Executive Officer, Partnership for Public Service.) available on a VA website. It would also require the IG to conduct a review of the website on a semi-annual basis and VA to report to Congress annually on the steps VA is taking to achieve full staffing capacity, including the amount of additional funds necessary to enable VA to reach full staffing capacity.

Section 506. Program on establishment of peer specialists in patient aligned care team settings within medical centers of Department of Veterans Affairs

VA operates a number of programs in which veteran patients are assisted by fellow veterans who are employed by VA (or serve as volunteers) and work alongside the veteran patient's care team to promote a successful recovery and reintegration and adherence to the veteran patient's plan of care. The Committee strongly supports peer support programs, particularly for those veteran patients who are struggling with mental health or substance abuse issues. The Committee believes that further integrating peer support into VA primary care settings could help engage more veterans into these programs and assist in reducing stigma and other barriers to care among at-risk veterans. Accordingly, section 506 of the bill would require VA to carry out a program to place at least two peer specialists within patient aligned care teams to promote the use and integration of mental health, substance use disorder, and behavioral health services in a primary care setting.

Section 507. Department of Veterans Affairs medical scribe pilot program

The use of electronic health records (EHRs) has become standard practice for the vast majority of healthcare delivery systems in United States. While evidence shows that EHRs do improve patient safety and outcomes, many clinicians find using EHRs to be burdensome and feel that taking time to enter data into a computer detracts from the quality of their interaction with patients and limits the amount of patients they are able to see daily. To address this disconnect between providers, patients, and productivity, private practices have begun employing non-clinical staff whose sole purpose is entering dictations from the physician into a patient's EHR and helping the physician to navigate the patient's existing medical record.

Medical scribes have proven to be particularly useful for increasing physician productivity and satisfaction in fast-paced clinical environments such as emergency departments (EDs) and specialty care settings.[116] Medical scribes are trained on privacy considerations and on how to swiftly and accurately navigate and enter data into a patient's medical record before being assigned to a physician. Once appropriately trained, the scribe then follows the physician during patient interactions and documents each encounter as appropriate.

Section 507 of the bill would create a two-year pilot program under which VA will increase the use of medical scribes in emergency department and specialty care settings at 10 VA medical centers. To provide transparency on staffing methodology for medical scribes in VA facilities, such pilot would require half of the scribes in such pilot to be employed by VA and half to be contract employees. VA would be required to regularly report to Congress on the effects the pilot on provider efficiency, patient satisfaction, average wait times, the number of patients seen per day and the amount

[116] Rajiv Arya MD, Danielle M. Salovich, Pamela Ohman-Strickland PhD, Mark A. Merlin DO. "Impact of Scribes on Performance Indicators in the Emergency Department" *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine*. April 23, 2010. http://onlinelibrary.wiley.com/doi/10.1111/j.1553_2712.2010.00718.x/full

of time required to train an employee to perform medical scribe functions under the pilot program. GAO would also be required to issue a report on the pilot after its conclusion.

Section 508. Loans guaranteed under home loan program of Department of Veterans Affairs

Section 3729 of title 38, U.S.C., requires individuals who utilize their VA home loan guaranty benefit to pay a funding fee. The amount of the funding fee varies based on an individual's status; the amount of down payment brought forward; and the date of the loan origination. The rates of funding fees (expressed as a percentage of the loan) have remained the same since 2004. The funding fee can be rolled into the life of the loan and is waived if the servicemember has a service-connected disability. These fees reduce the subsidy cost associated with VA's guaranty of mortgage loans, and have typically been viewed as a reasonable cost to the benefit gained by having VA guarantee a mortgage loan. Section 508 of the bill would extend the current funding fee rates for mortgages closed on or after September 30, 2027, through September 30, 2028. The Committee believes that this is a reasonable extension of the current rates.

Section 509. Extension of reduction in amount of pension furnished by Department of Veterans Affairs for certain veterans covered by Medicaid plans for services furnished by nursing facilities

Section 5503 of title 38 U.S.C. sets forth the criteria under which eligibility for income-based pension payments and aid and attendance allowances are affected by domiciliary or nursing home residence. In instances where a veteran, or surviving spouse, has neither a spouse nor a child and is receiving Medicaid-covered nursing home care, the veteran or surviving spouse is eligible to receive no more than $90 per month in VA pension or death pension payments for any period after the end of the third full calendar month following the month of admission. Under current law, this authority shall expire on September 30, 2027. Section 509 of the bill would extend such authority through September 30, 2028.

Section 510. Appropriation of amounts

To fund the Choice program, the Choice Act also created and deposited $10 billion into the Veterans Choice Fund and stipulated that Choice would sunset either when the money in the Choice fund was fully expended or three years after enactment of the Act. Since the law was enacted on August 7, 2014, three years after enactment of the Act would have been August 7, 2017. However, Congress passed an Act to amend the Veterans Access, Choice, and Accountability Act of 2014 to modify the termination date for the Veterans Choice Program, and for other purposes (Public Law 115–26; 131 STAT. 129) in April 2017 following testimony that VA expected to have money left in the Choice Fund on August 7, 2017.[117] However, in June 2017, VA testified that Choice funds would be fully obligated sooner than previously expected and, as a result, VA was

[117] United States Cong. House Committee on Veterans' Affairs Oversight Hearing—"Care Where it Count: Assessing VA's Capital Asset Needs." March 7 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from the Honorable David Shulkin M.D, Secretary of Veterans Affairs).

requesting additional funds be deposited into the Choice Fund.[118] VA also testified that, without such action, waiting times for veteran patients would increase and access to care in the community would decrease.[119] In response, Congress enacted the VA Choice and Quality Employment Act of 2017 (Public Law 115–46; 131 STAT. 958) to appropriate $2.1 billion into the Choice Fund to preserve the availability of Choice care for veterans patients through the end of calendar year 2017 and the Third Continuing Appropriations for Fiscal Year 2018, Missile Defense, Health Provisions, Other Matters, and Budgetary Effects Act (Public Law 115–96; 131 STAT. 2044) to appropriate an additional $2.1 billion into the Choice Fund to preserve the availability of Choice care for veterans patients through May 2018.

Section 510 of the law would authorize and appropriate $5.2 billion to the Choice Fund. It is the Committee's intent that this amount will be sufficient to ensure veteran access to care until one year after enactment of the bill when the Program is fully implemented.

HEARINGS

There were no full Committee or Subcommittee hearings held on H.R. 5674. The bill represents a negotiated agreement between the Committee on Veterans' Affairs of the U.S. House of Representatives and the Committee on Veterans' Affairs of the U.S. Senate and combines various elements of H.R. 4242, as amended, H.R. 4243, as amended, and S. 2193, as amended.

SUBCOMMITTEE CONSIDERATION

There was no Subcommittee consideration of H.R. 5674.

COMMITTEE CONSIDERATION

On May 8, 2018, the full Committee met in open markup session, a quorum being present, and ordered H.R. 5674 to be reported favorably to the House of Representatives by a recorded vote of 20 yeas and 2 noes. During consideration of the bill, the following amendments were considered:

An amendment offered by Representative Tim Walz of Minnesota, the Ranking Member of the full Committee, that would require discretionary budget caps to be raised in accordance with the authorization of appropriations and regulations made by or pursuant to the bill. The amendment was not agreed to by a recorded vote of 8 yeas to 13 noes.

An amendment offered by Representative Tim Walz of Minnesota, the Ranking Member of the full Committee, that would: (1) require VA to review a determination to provide care to an eligible veteran in the community six months after the date of such determination for veterans referred to the community due to a VA medical facility's failure to comply with quality standards and one year after the date of such determina-

[118] United States Cong. House Committee on Veterans' Affairs Oversight Hearing—"FY 2018 Department of Veterans Affairs Budget Request for the Veterans Health Administration." June 22, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from Poonam Alaigh M.D., Acting Under Secretary for Health, U.S. Department of Veterans Affairs).

[119] Ibid.

tion for veterans referred to the community for other reasons; and (2) cap at two the number of walk-in care visits a veteran could make in a year. The amendment was not agreed to by a recorded vote of 8 yeas to 13 noes.

An amendment offered by Representative Beto O'Rourke of Texas that would allow a recipient of EDRP funds to elect to receive payments on a monthly or annual basis. The amendment was not agreed to by voice vote.

An amendment offered and then withdrawn by Representative Julia Brownley of California that would include roads that are not accessible to the general public, traffic, or hazardous weather as "environmental factors."

An amendment offered and then withdrawn by Representative Julia Brownley of California that would require VA to provide child care assistance to eligible veterans.

An amendment offered and then withdrawn by Representative Julia Brownley of California that would make the pilot program on counseling in retreat settings for women veterans permanent.

An amendment in the nature of a substitute offered by Representative Tim Walz of Minnesota, the Ranking Member of full Committee, that would replace the bill with a combination of elements from H.R. 4242, as amended, and S. 2193, as amended. The amendment in the nature of a substitute was not agreed to by a recorded vote of 8 yeas to 14 noes.

COMMITTEE VOTES

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives four recorded votes were taken on amendments or in connection with ordering H.R. 5674 reported to the House. Their disposition was as follows:

An amendment offered by Representative Tim Walz of Minnesota, the Ranking Member of the full Committee, that would require discretionary budget caps to be raised in accordance with the authorization of appropriations and regulations made by or pursuant to the bill. The amendment was not agreed to by a recorded vote of 8 yeas to 13 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: 5/8/2018
Subject: Full Committee Markup of H.R. 299, H.R. 1972, H.R. 2147, H.R. 3642, H.R. 3832, H.R. 4245, H.R. 4334, H.R. 4451 as Amended, H.R. 4635, H.R. 4830 as Amended, H.R. 4958, H.R. 5044, H.R. 5215, H.R. 5418, H.R. 5520, and H.R. 5674

Roll Call Vote #1
Mr. Walz's Amendment #1 to H.R. 5674

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			
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			
Mr. O'Rourke, TX	X		
Miss Rice, NY	X		
Mr. Correa, CA	X		
Mr. Lamb, PA	X		
Ms. Esty, CT			
Mr. Peters, CA	X		
Total	**8**	**13**	

Mr. Chairman, the vote is __8____ Yeas and __13____ Noes ___3__ Not voting

An amendment offered by Representative Tim Walz of Minnesota, the Ranking Member of the full Committee, that would: (1) require VA to review a determination to provide care to an eligible veteran in the community six months after the date of such determination for veterans referred to the community due to a VA medical facility's failure to comply with quality standards and one year after the date of such determination for veterans referred to the community for other reasons; and (2) cap at two the number of walk-in care visits a veteran could make in a year. The amendment was not agreed to by a recorded vote of 8 yeas to 13 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: 5/8/2018
Subject: Full Committee Markup of H.R. 299, H.R. 1972, H.R. 2147, H.R. 3642, H.R. 3832, H.R. 4245, H.R. 4334, H.R. 4451 as Amended, H.R. 4635, H.R. 4830 as Amended, H.R. 4958, H.R. 5044, H.R. 5215, H.R. 5418, H.R. 5520, and H.R. 5674

Roll Call Vote #2
Mr. Walz's Amendment #3 to H.R. 5674

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			
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			
Mr. O'Rourke, TX	X		
Miss Rice, NY	X		
Mr. Correa, CA	X		
Mr. Lamb, PA	X		
Ms. Esty, CT			
Mr. Peters, CA	X		
Total	**8**	**13**	

Mr. Chairman, the vote is __8____ Yeas and __13____ Noes ___3__ Not voting

An amendment in the nature of a substitute offered by Representative Tim Walz of Minnesota, the Ranking Member of full Committee, that would replace the bill with a combination of elements from H.R. 4242, as amended, and S. 2193, as amended. The amendment in the nature of a substitute was not agreed to by a recorded vote of 8 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: 5/8/2018
Subject: Full Committee Markup of H.R. 299, H.R. 1972, H.R. 2147, H.R. 3642, H.R. 3832, H.R. 4245, H.R. 4334, H.R. 4451 as Amended, H.R. 4635, H.R. 4830 as Amended, H.R. 4958, H.R. 5044, H.R. 5215, H.R. 5418, H.R. 5520, and H.R. 5674

Roll Call Vote #3
Mr. Walz's Amendment in the Nature of a Substitute H.R. 5674

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			
Mr. O'Rourke, TX	X		
Miss Rice, NY	X		
Mr. Correa, CA	X		
Mr. Lamb, PA	X		
Ms. Esty, CT			
Mr. Peters, CA	X		
Total	**8**	**14**	

Mr. Chairman, the vote is __8____ Yeas and __14____ Noes ___2__ Not voting

A motion by Representative Gus Bilirakis of Florida, the Vice Chairman of the full Committee, to report H.R. 5674 favorably to the House of Representatives was adopted by a recorded vote of 20 yeas and 2 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: 5/8/2018
Subject: Full Committee Markup of H.R. 299, H.R. 1972, H.R. 2147, H.R. 3642, H.R. 3832, H.R. 4245, H.R. 4334, H.R. 4451 as Amended, H.R. 4635, H.R. 4830 as Amended, H.R. 4958, H.R. 5044, H.R. 5215, H.R. 5418, H.R. 5520, and H.R. 5674

Roll Call Vote #4
Report H.R. 5674 Favorably Out of Committee

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			
Mr. O'Rourke, TX	X		
Miss Rice, NY	X		
Mr. Correa, CA	X		
Mr. Lamb, PA	X		
Ms. Esty, CT			
Mr. Peters, CA	X		
Total	**20**	**2**	

Mr. Chairman, the vote is __20____ Yeas and __2____ Noes ___2__ Not voting

COMMITTEE CORRESPONDENCE

PETE SESSIONS, TEXAS
CHAIRMAN

TOM COLE, OKLAHOMA
ROB WOODALL, GEORGIA
MICHAEL C. BURGESS, TEXAS
DOUG COLLINS, GEORGIA
BRADLEY BYRNE, ALABAMA
DAN NEWHOUSE, WASHINGTON
KEN BUCK, COLORADO
LIZ CHENEY, WYOMING

STEPHEN M. COTE, STAFF DIRECTOR
(202) 225-9191
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Committee on Rules
U.S. House of Representatives
H-312 The Capitol
Washington, DC 20515-6269

ONE HUNDRED FIFTEENTH CONGRESS

JAMES P. McGOVERN, MASSACHUSETTS
RANKING MINORITY MEMBER

ALCEE L. HASTINGS, FLORIDA
JARED POLIS, COLORADO
NORMA J. TORRES, CALIFORNIA

DON SISSON, MINORITY STAFF DIRECTOR

MINORITY OFFICE
H-152, THE CAPITOL
(202) 225-9091

May 10, 2018

The Honorable Phil Roe
Chairman
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Roe:

On May 8, 2018, the Committee on Veterans' Affairs ordered reported H.R. 5674, the VA MISSION Act of 2018. As you know, the Committee on Rules was granted an additional referral upon the bill's introduction pursuant to the Committee's jurisdiction under rule X of the Rules of the House of Representatives over rules and joint rules of the House.

Because of your willingness to consult with my committee and make necessary changes to the legislation regarding this matter, I will waive consideration of the bill by the Rules Committee. By agreeing to waive its consideration of the bill, the Rules Committee does not waive its jurisdiction over H.R. 5674. In addition, the Committee on Rules reserves its authority to seek conferees on any provisions of the bill that are within its jurisdiction during any House-Senate conference that may be convened on this legislation. I ask your commitment to support any request by the Committee on Rules for conferees on H.R. 5674 or related legislation.

I also request that you include this letter and your response as part of your committee's report on the bill and in the Congressional Record during consideration of the legislation on the House floor. Thank you for your attention to these matters.

Sincerely,

Pete Sessions
Chairman, House Committee on Rules

REPUBLICANS
DAVID P. ROE, TENNESSEE, CHAIRMAN
GUS M. BILIRAKIS, FLORIDA
MIKE COFFMAN, COLORADO
BRAD WENSTRUP, OHIO
AMATA RADEWAGEN, AMERICAN SAMOA
MIKE BOST, ILLINOIS
BRUCE POLIQUIN, MAINE
NEAL DUNN, FLORIDA
JODEY ARRINGTON, TEXAS
JOHN RUTHERFORD, FLORIDA
CLAY HIGGINS, LOUISIANA
JACK BERGMAN, MICHIGAN
JIM BANKS, INDIANA
JENNIFFER GONZÁLEZ-COLÓN, PUERTO RICO

JON TOWERS, STAFF DIRECTOR

U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED FIFTEENTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
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DEMOCRATS
TIM WALZ, MINNESOTA, RANKING
MARK TAKANO, CALIFORNIA
JULIA BROWNLEY, CALIFORNIA
ANN KUSTER, NEW HAMPSHIRE
BETO O'ROURKE, TEXAS
KATHLEEN RICE, NEW YORK
J. LUIS CORREA, CALIFORNIA
KILILI SABLAN, NORTHERN MARIANA ISLANDS
ELIZABETH ESTY, CONNECTICUT
SCOTT PETERS, CALIFORNIA

RAY KELLEY
DEMOCRATIC STAFF DIRECTOR

May 10, 2018

The Honorable Pete Sessions
Chairman
Committee on Rules
H-314, the Capitol
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter regarding the Rules Committee's jurisdictional interest in H.R. 5674, the VA MISSION Act of 2018, and your willingness to forego consideration of H.R. 5674 by your committee.

I agree that the Committee on Rules has a valid jurisdictional interest in certain provisions of H.R. 5674, and that the Committee's jurisdiction will not be adversely affected by your decision to forego consideration of H.R. 5674. As you have requested, I will address the necessary changes to the legislation and I will support your request for an appropriate appointment of outside conferees from your Committee in the event of a House-Senate conference on this or similar legislation should such a conference be convened.

Finally, I will include a copy of your letter and this response in the Committee Report and in the *Congressional Record* during the floor consideration of this bill.

Thank you again for your cooperation.

Sincerely,

David P. Roe

David P. Roe M.D.
Chairman

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 strengthen and improve the VA healthcare system's ability to provide timely, quality care to the nation's veterans and their caregivers.

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 has requested but not received from the Director of the Congressional Budget Office an estimate of new budget authority, entitlement authority, or tax expenditures or revenues.

EARMARKS AND TAX AND TARIFF BENEFITS

H.R. 5674 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 has requested but not received from the Director of the Congressional Budget Office an estimate of new budget authority, entitlement authority, or tax expenditures or revenues. The Committee believes, according to a preliminary score from the Congressional Budget Office, that enactment of H.R. 5674 would result in approximately $48 billion in discretionary costs over 5 years and approximately $5.2 billion in mandatory costs for the Choice fund.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the Committee has requested but not received from the Director of the Congressional Budget Office an estimate of the costs of the reported bill.

FEDERAL MANDATES STATEMENT

The Committee has requested but not received from the Director of the Congressional Budget Office an estimate of new budget authority, entitlement authority, or tax expenditures or revenues. The Committee intends to adopt as its own estimate of Federal Mandates regarding H.R. 5674 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. 5674.

STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to Article I, section 8 of the United States Constitution, H.R. 5674 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. 5674 does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

STATEMENT ON DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee finds that no provision of H.R. 5674 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. 5674 contains directed rulemaking provisions that would require the Secretary to prescribe regulations.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title; Table of contents

Section 1(a) of the bill would provide a short title of H.R. 5674, the "VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018" or "VA MISSION Act of 2018."

Section 1(b) of the bill would provide the table of contents:

TITLE I—CARING FOR OUR VETERANS

Sec. 100. Short title; references to title 38, United States Code.

Subtitle A—Developing an Integrated High-Performing Network

CHAPTER 1—ESTABLISHING COMMUNITY CARE PROGRAMS

Sec. 101. Establishment of Veterans Community Care Program.
Sec. 102. Authorization of agreements between Department of Veterans Affairs and non-Department providers.
Sec. 103. Conforming amendments for State veterans homes.
Sec. 104. Access standards and standards for quality.
Sec. 105. Access to walk-in care.

Sec. 106. Strategy regarding the Department of Veterans Affairs High-Performing Integrated Health Care Network.
Sec. 107. Applicability of Directive of Office of Federal Contract Compliance Programs.
Sec. 108. Prevention of certain health care providers from providing non-Department health care services to veterans.
Sec. 109. Remediation of medical service lines.

CHAPTER 2—PAYING PROVIDERS AND IMPROVING COLLECTIONS

Sec. 111. Prompt payment to providers.
Sec. 112. Authority to pay for authorized care not subject to an agreement.
Sec. 113. Improvement of authority to recover the cost of services furnished for non-service-connected disabilities.
Sec. 114. Processing of claims for reimbursement through electronic interface.

CHAPTER 3—EDUCATION AND TRAINING PROGRAMS

Sec. 121. Education program on health care options.
Sec. 122. Training program for administration of non-Department of Veterans Affairs health care.
Sec. 131. Establishment of processes to ensure safe opioid prescribing practices by non-Department of Veterans Affairs health care providers.
Sec. 132. Improving information sharing with community providers.
Sec. 133. Competency standards for non-Department of Veterans Affairs health care providers.
Sec. 134. Department of Veterans Affairs participation in national network of State-based prescription drug monitoring programs.

CHAPTER 5—OTHER NON–DEPARTMENT HEALTH CARE MATTERS

Sec. 141. Plans for Use of Supplemental Appropriations Required.
Sec. 142. Veterans Choice Fund flexibility.
Sec. 143. Sunset of Veterans Choice Program.
Sec. 144. Conforming amendments.

Subtitle B—Improving Department of Veterans Affairs Health Care Delivery

Sec. 151. Licensure of health care professionals of the Department of Veterans Affairs providing treatment via telemedicine.
Sec. 152. Authority for Department of Veterans Affairs Center for Innovation for Care and Payment.
Sec. 153. Authorization to provide for operations on live donors for purposes of conducting transplant procedures for veterans.

Subtitle C—Family Caregivers

Sec. 161. Expansion of family caregiver program of Department of Veterans Affairs.
Sec. 162. Implementation of information technology system of Department of Veterans Affairs to assess and improve the family caregiver program.

Sec. 163. Modifications to annual evaluation report on caregiver program of Department of Veterans Affairs.

TITLE II—VA ASSET AND INFRASTRUCTURE REVIEW

Subtitle A—Asset and Infrastructure Review

Sec. 201. Short title.
Sec. 202. The Commission.
Sec. 203. Procedure for making recommendations.
Sec. 204. Actions regarding infrastructure and facilities of the Veterans Health Administration.
Sec. 205. Implementation.
Sec. 206. Department of Veterans Affairs Asset and Infrastructure Review Account.
Sec. 207. Congressional consideration of Commission report.
Sec. 208. Other matters.
Sec. 209. Definitions.

Subtitle B—Other Infrastructure Matters

Sec. 211. Improvement to training of construction personnel.
Sec. 212. Review of enhanced use leases.
Sec. 213. Assessment of health care furnished by the Department to veterans who live in the Pacific territories.

TITLE III—IMPROVEMENTS TO RECRUITMENT OF HEALTH CARE PROFESSIONALS

Sec. 301. Designated scholarships for physicians and dentists under Department of Veterans Affairs Health Professional Scholarship Program.
Sec. 302. Increase in maximum amount of debt that may be reduced under Education Debt Reduction Program of Department of Veterans Affairs.
Sec. 303. Establishing the Department of Veterans Affairs Specialty Education Loan Repayment Program.
Sec. 304. Veterans healing veterans medical access and scholarship program.
Sec. 305. Bonuses for recruitment, relocation, and retention.
Sec. 306. Inclusion of Vet Center employees in education debt reduction program of Department of Veterans Affairs.

TITLE IV—HEALTH CARE IN UNDERSERVED AREAS

Sec. 401. Development of criteria for designation of certain medical facilities of the Department of Veterans Affairs as underserved facilities and plan to address problem of underserved facilities.
Sec. 402. Pilot program to furnish mobile deployment teams to underserved facilities.
Sec. 403. Pilot program on graduate medical education and residency.

TITLE V—OTHER MATTERS

Sec. 501. Annual report on performance awards and bonuses awarded to certain high-level employees of the department.
Sec. 502. Role of podiatrists in Department of Veterans Affairs.

Sec. 503. Definition of major medical Sec. 1. Short title; table of contents.
Sec. 504. Authorization of certain major medical facility projects of the Department of Veterans Affairs.
Sec. 505. Department of Veterans Affairs personnel transparency.
Sec. 506. Program on establishment of peer specialists in patient aligned care team settings within medical centers of Department of Veterans Affairs.
Sec. 507. Department of Veterans Affairs medical scribe pilot program.
Sec. 508. Loans guaranteed under home loan program of Department of Veterans Affairs.
Sec. 509. Extension of reduction in amount of pension furnished by Department of Veterans Affairs for certain veterans covered by Medicaid plans for services furnished by nursing facilities.
Sec. 510. Appropriation of amounts.
Sec. 511. Technical correction.

TITLE I—CARING FOR OUR VETERANS

Section 100. Short title; Reference to Title 38, United States Code

Section 100(a) of this bill would provide a short title to be cited as the "Caring for our Veterans Act of 2018."

Section 100(b) of the bill would specify that any title that is amended or repeal that is expressed in terms of an amendment, is in reference to a section or provision in Title 38, U.S.C, unless otherwise expressed.

Subtitle A—Developing an Integrated High-Performing Network

Chapter 1—Establishing Community Care Programs

Section 101. Establishment of veterans community care program

Section 101(a) of this bill would amend section 1703 of title 38 U.S.C. to read as follows: "1703. Veterans Community Care Program."

The amended section 1703(a) would establish a program to furnish hospital care, medical services, and extend care services to covered veterans through health care providers specified in subsection (c) of the amended section 1703. VA would be required to coordinate the furnishing of hospital care, medical services, and extended care services to covered veterans, including coordination of, at a minimum, the following: ensuring the scheduling of medical appointments in a timely manner and the establishment of a mechanism to receive medical records from non-Department providers; ensuring continuity of care and services; ensuring coordination among regional networks if the covered veteran accesses care and services in a different network than the regional network in which a covered veteran resides; and ensuring that covered veterans do not experience a lapse in care resulting from errors or delays by VA or its contractors or an unusual or excessive burden in accessing hospital care, medical services, or extended care services. The amended section 1703 would also establish that a covered veteran is only authorized to receive care or services under this section upon the authorization of such care or services by VA.

The amended section 1703(b) would define the term "covered veteran" as any veteran who is enrolled under section 1705 of this title or, if not enrolled, is otherwise entitled to hospital care, medical services, or extended care services.

The amended section 1703(c) would define "health care providers" as providers participating in the Medicare program, the Department of Defense, Indian Health Service, any Federally-qualified health center, or any other provider that meets criteria established by the Secretary.

The amended section 1703(d) would establish the conditions under which care is required to be furnished through non-VA providers. Subject to the availability of appropriations, hospital care, medical services, and extended care services shall be provided to a covered veteran through health care providers specified in subsection (c) if: VA does not offer the care or services the veteran requires; VA does not operate a full service medical facility in the State in which the covered veteran resides; the covered veteran was an eligible veteran under the Veterans Access, Choice, and Accountability Act of 2014 as of the day before the date of enactment of this bill who continues to reside in a location that would qualify the veteran for eligibility under such section and either resides in one of the five States with the lowest population density as determined by data from the 2010 decennial census or does not reside in such a State but received care or services under this title in the year preceding the enactment of this bill and is seeking care or services within two years of the date of the enactment of this bill; the covered veteran has contacted VA to request care or services and the Department is not able to furnish such care and service in a manner that complies with designated access standards developed by VA under section 1703B of this title; or the covered veteran and the covered veteran's referring clinician agree that furnishing care and services through a non-Department entity or provider would be in the best medical interest of the covered veteran based on criteria created by VA. Such criteria shall include consideration of the following: the distance between the covered veteran and the facility that provides the care or services the veteran requires; the nature of the care or services required; the frequency that the care or services needs to be furnished; the timeliness of available appointments for the care or services the veteran needs; and whether the covered veteran faces an unusual or excessive burden to access care or services, and should include the following considerations: whether the covered veteran faces an excessive driving distance, geographical challenge, or environmental factor that impedes the access of the covered veteran; whether the care or service sought by the veteran is provided by a VA medical facility that is reasonably accessible to a covered veteran; whether a medical condition of the covered veteran affects the ability of said veteran to travel; whether there is a compelling reason as determined by VA that the veteran needs to receive care or service from a medical facility other than a VA medical facility; and such other consideration as VA considers appropriate. The decision to receive hospital care, medical services, or extended care services under such subparagraphs from a non-department health care provider shall be at the election of the veteran.

The amended section 1703(e) would establish conditions under which care is authorized to be furnished through non-Department providers. VA shall measure timeliness of a VA medical service line in comparison with the same medical service lines at different VA facilities and measure quality at a VA medical service line of a facility by comparing it with two or more distinct and appropriate non-Department service lines. VA may not concurrently furnish care or services through non-department providers with respect to more than three medical service lines at any one VA facility and may not concurrently furnish care or services through non-department providers under this authority with respect to more than 36 medical service lines nationally. VA may limit the types of care veterans receive in terms of the length of time such care and services will be available, the location at which such care and services will be available, and the clinical care and services that will be available. Care authorized under this subsection with respect to a medical service line shall cease when the remediation described in section 1706A with respect to such medical service line is complete. VA shall ensure continuity and coordination of care for any veteran who elects to receive care or services under this subsection from a non-department health care provider through the completion of an episode of care. VA would be required to publish in the Federal Register, and shall take all reasonable steps to provide direct notice to covered veterans affected, at least once a year starting the time period during which such care and services will be available, the location or locations where such care and services will be available, and the clinical services available at each location in accordance with regulations that VA shall proscribe. The veteran shall elect whether to receive the care or service.

The amended section 1703(f) would require the review of decisions made under subsection (d) or (e) to be subject to VA's clinical appeals process and may not be appealed to the Board of Veterans' Appeals.

The amended section 1703(g) would authorize VA to develop a tiered provider network based on criteria established by VA but prohibit VA from prioritizing providers in a tier over providers in any other tier in a manner that limits the choice of a veteran in selecting a health care provider.

The amended section 1703(h) would require VA to enter into consolidated, competitively bid contracts to establish networks of health care providers to provide sufficient access to care. VA must ensure that covered veterans are able to make their own appointments using advanced technology, to the extent practicable, and require VA, to the extent practicable, to schedule appointments for care and service. VA may terminate a contract with an entity at such time and upon such notice to the entity as VA may specify for purposes of this section, if VA notifies the appropriate committees of Congress that, at a minimum the entity: failed to comply substantially with the provisions of the contract or this section and the regulations prescribed under this section; failed to comply with the access standards or the standards for quality established by VA; is excluded from participating in a Federal health care program; is identified as an excluded source on the list maintained in the System for Award Management, or any successor system; or has been convicted of felony or other serious offense under Federal

or state law and the continued participation of the entity would be detrimental to the best interests of veterans or the Department. It is reasonable to terminate the contract based on the health care needs of veterans or to terminate the contract based on coverage provided by contract or sharing agreements entered into under authorities other than this section. Whenever an entity is failing to meet contractual obligations, VA shall submit to the House and Senate Committees on Veterans' Affairs a report on such failings. The report shall include: an explanation of the reasons for providing such notice; a description of the effect of such failure, including with respect to cost, schedule, and requirements; a description of the actions taken by VA to mitigate such failure; a description of the actions taken by the contractor to address such failure; and a description of any effect on the community provider market for veterans in the affected area. VA would be required to instruct each entity awarded a contract to recognize and accept, on an interim basis, the credentials and qualifications of health care providers who are authorized to furnish care to veterans under a community care program of the Department in effect as of the day before the date of enactment of the Caring for our Veterans Act of 2018, including under the Patient-Centered Community Care Program and the Veterans Choice Program. The interim acceptance period shall be determined by VA based on the following criteria: when the current certification agreement for a health care provider expires and whether the Department has enacted certification and eligibility criteria and regulatory procedures by which non-department providers will be authorized under this section. VA would be required to create a system or systems for monitoring and assessing the quality of care provided to veterans through a network under this subsection.

The amended section 1703(i) would establish payment rates for care and services. Except as provided in paragraph (2), and to the extent practicable, the rate paid for care and services under any provision in this title may not exceed the rate paid by the United States to a provider of services or a supplier under the Medicare program under title XI or title XVIII of the Social Security Act, including but not limited to section 1834 of such Act, for the same care or services. A higher rate than the rate established in paragraph (1) may be negotiated with respect to furnishing care to a veteran who resides in a highly rural area. A "highly rural area" is defined as an area located in a county that has fewer than seven individuals residing in that county per square mile. With respect to furnishing care or services under this section in Alaska, the Alaska Fee Schedule of the Department shall be followed, except for when another payment agreement, including a contract or provider agreement, is in effect. With respect to care or services under this section in a state with an All-Payer Model Agreement under section 1814(b)(3) of the Social Security Act, the Medicare payment rates under paragraph (2)(A) shall be calculated based on the payment rates under such agreement. VA may incorporate, to the extent practicable, the use of value-based reimbursement models to promote the provision of high-quality care, and with respect to care for which there is not a rate paid under Medicare, the rate paid for such care shall be determined by VA.

The amended section 1703(j) would establish the standards for the treatment of other health plan contracts. In any case where a veteran is furnishing care under this section for a non-service connected disability, as described in subsection (a)(2) of section 1729 of this title, VA shall recover or collect reasonable charges for such care from a health plan contract described in section 1729.

The amended section 1703(k) would establish the standard for payment made by the veteran. A covered veteran shall not pay a greater amount for receiving care or services under this section than the amount the veteran would pay for receiving the same or comparable care at a medical facility of the Department or health care provider of the Department.

The amended section 1703(l) would require the Secretary to determine whether to authorize an organ or bone marrow transplant for a covered veteran at a non-Department facility when such transplant is required and, in the opinion of the primary care provider, the covered veteran has a medically compelling reason to travel outside the region of the Organ Procurement and Transplantation Network.

The amended section 1703(m) would establish the system to monitor the care provided. Not later than 540 days after the date of enactment, and annually thereafter, VA shall submit to the appropriate committees of Congress a review of the types and frequency of care furnished trough non-Department providers. The review submitted shall include an assessment of the following: the top 25 percent of types of care and services most frequently provided due to the Department not offering such care and services; the frequency such care and services were sought by covered veterans; an analysis of the reasons VA was unable to provide such care; any steps the Department took to provide such care and services at a medical facility of the Department; and the cost of such care and services. In monitoring the care furnished under this section, VA would be required to do the following: with respect to the care furnished through provider networks VA shall compile data on the types of care furnished through such network and how many patient used each type of care and service; identify gaps in care furnished through such networks; identify how such gaps may be fixed through new contracts with such networks or changes in the manner in which care is provided through such networks; assess the total amount spent by VA to furnish care through such network; assess the timelines of the Department in referring care and services to such networks; and assess the timelines of such networks in accepting referrals and scheduling and completing appointments. VA shall report the number of medical service lines not to be providing care or services that comply with the standards for quality that VA established. Additionally, VA would assess the use of academic affiliates and centers of excellence of the Department to furnish care and services to veterans under this section. Lastly, VA would assess the care and services furnished to veterans under this section by medical facilities operated by Federal agencies other than the Department.

The amended section 1703(n) would establish a prohibition on certain limitations. VA shall not limit the types of care or services veterans may receive under this section if it is in the best medical interest of the veteran as determined by the veteran and the vet-

eran's health care provider. Additionally, no provision in this section may be construed to alter or modify any other provision of law establishing specific eligibility criteria for certain care services.

The amended section 1703(o) would define the term "appropriate committees of Congress" to mean the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate and the House of Representatives and the term "medical service line" to mean a clinic within a VA medical center.

Section 101(b) of this bill would establish an effective date. Section 1703 of title 38 U.S.C., as amended by subsection (a), shall take effect on the later of the date that is 30 days after the date on which VA submits the report required under section 101(q)(2) of the Veterans Access, Choice, and Accountability Act of 2014, or the date on which VA promulgates regulations pursuant to subsection (c).

Section 101(c) of this bill would require VA to promulgate regulations to carry out section 1703 of title 38 U.S.C. Before promulgating the regulations required, VA shall provide to the appropriate committees of Congress periodic updates to confirm the progress of VA toward developing such regulations. The first update shall occur no later than 120 days from the date of the enactment of this Act.

Section 101(d) of this bill would require VA, notwithstanding section 1703 of title 38 U.S.C., as amended by subsection (a), to continue all contracts, memorandums of understanding, memorandums of agreements, and other arrangements that were in effect on the day before the date of the enactment of this Act between VA and the Department of American Indian and Alaska Native health care systems as established under the terms of VA and the Department of American Indian and Alaska Native Health Service Memorandum of Understanding, signed October 1, 2010, the National Reimbursement Agreement, signed December 5, 2012, arrangements under section 405 of the Indian Health Care Improvement Act, and agreements entered into under sections 102 and 103 of the Veterans Access, Choice, and Accountability Act of 2014. In addition, the above shall not be construed to prohibit VA and the parties to the contracts, memorandums of understanding, memorandums or agreements, and other arrangements described from making lawful changes.

Sec. 102. Authorization of agreements between Department of Veterans Affairs and non-Department providers

Section 102(a) of this bill would amend subchapter I of chapter 17 by inserting after section 1703 the following new section: § 1703A. Agreements with eligible entities or providers; certification processes"

The new section 1703A(a) would stipulate that when care or service is required by a veteran who is entitled to such care or service under this chapter is not feasibly available to the veteran from a facility of the Department or through a contract or sharing agreement entered into pursuant to another provision of law, VA may furnish such care or services to such veteran through an agreement under this section with an eligible entity or provider to provide such care or services. An agreement entered into under this section to provide care and service shall be known as a "Vet-

erans Care Agreement." Care or services provided to a veteran from a facility of VA or through a contract or sharing agreement may be considered not feasibly available when VA determines the veteran's medical condition, the travel involved, the nature of the care or services required, or a combination of these factors make the use of a VA facility or sharing agreement impracticable or inadvisable. The Secretary or any official authorized by the Secretary may enter into a Veterans Care Agreement. Each agreement of material size, as determined by VA, shall be reviewed by VA to determine whether it is feasible and advisable to provide such care or service within a VA facility or by sharing agreement, and if so, act to do so. VA shall review each Veterans Care Agreement of material size that has been in effect for at least six months within the first two years of its taking effect, and not less frequently than once every four years thereafter. If a Veterans Care Agreement has not been in effect for at least six months by the date of the required review, the agreement shall be reviewed during the next cycle of required reviews. In fiscal year 2019 and in each fiscal year thereafter, in addition to the standards of material size established by VA, any agreement for the purchase of extended care services that exceeds $5,000,000 annually shall be considered of material size. From time to time, VA may publish a notice in the Federal Register to adjust the dollar amount specified above to account for changes in the cost of health care based upon market surveys and other available data.

The new section 1703A(b) would define eligible entities and providers as: any provider of services that has enrolled and enter into provider agreement under section 1866(a) of the Social Security Act and any physician or supplier who has enrolled and entered into a participation agreement under section 1842(h) of such act; any provider participating under a State plan under title XIX of such act; 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); a center for independent living (as defined in section 702 of the Rehabilitation Act); or any entity or provider not described above that VA determines to be eligible pursuant to the certification process described above.

The new section 1703A(c) would require VA to establish a process for certification of eligible providers or recertification of current providers. The process shall, at a minimum, establish deadlines for actions on applications for certification; create standards for approval or denial of certification, duration of certification, revocation of certification, and recertification; require the denial of certification if the provider is excluded from participating in a Federal health care program under section 1128 or section 1128A of the Social Security Act; establish procedures for screening eligible providers according to the risk of fraud, waste, and abuse that are similar to the standards under section 1866 of Social Security Act and title 48, Code of Federal Regulations, or successor program; and apply the restrictions and penalties set forth in chapter 21 of title 41 and treat this section as a procurement program only for the purposes of applying such provisions.

The new section 1703A(d) would establish the rates paid by VA to health care providers under a Veterans Care agreement at the rates paid by the U.S. under section 1703(i) of this title.

The new section 1703A(e) would establish the terms of Veterans Care Agreements. VA may define the requirements for providers and entities entering into agreements under this section based upon such factors as the number of patients receiving care, the number of employees employed by said entity, the amount paid by VA to the provider or entity, or other factors as determined by VA. To furnish care under this section, an eligible entity or provider shall agree: to accept payment at the rates established in regulations prescribed under this section; that payment by VA under this section on behalf of a veteran to a provider of services or care shall, unless rejected and refunded by the provider within 30 days of receipt, constitute payment in full and extinguish any liability on the part of the veteran for the treatment or care provided, and no provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate this requirement; to provide only the care and services authorized by VA under this section and to obtain prior written consent from VA for any care outside the scope of such authorization; to bill VA in accordance with the regulations under this section; to not seek to recover or collect from a health plan contract or third party for any care or service that is furnished or paid for by VA; to provide medical records to VA in the time frame and format specified by VA; and to meet such other terms and conditions, including quality of care assurance standards as specified in regulation.

The new section 1703A(f) would establish the discontinuation or nonrenewal of a Veterans Care Agreement. An eligible entity or provider may discontinue a Veterans Care Agreement upon notice to VA as may be provided in regulations prescribed under this section. VA may discontinue a Veterans Care Agreement upon such reasonable notice to the eligible entity or provider as may be specified in regulations under this section. VA may terminate the contract if an official designated by VA: has determined that the provider failed to comply substantially with the provisions of the agreement or with provision of this section; has determined the provider is excluded from participation in a Federal health care program under the Social Security Act or is identified on the System for Award Management Exclusions list as provided in part 9 of title 48, Code of Federal Regulations, and part 180 of title 2 of such Code, or successor regulations; has ascertained that the eligible entity or provider has been convicted of a felony or other serious offense under Federal or State law and determines the provider's continued participation would be detrimental the best interest of veterans or VA; or has determined that it is reasonable to terminate the agreement based on health care needs of a veteran.

The new section 1703A(g) would require VA to establish a system(s) for monitoring the quality of care provided to veterans through Veterans Care Agreements and for assessing the quality of care furnished by providers before the renewal of their agreement.

The new section 1703A(h) would require VA to create procedures for providers to present all disputes arising under or related to Veterans Care Agreements. Such procedures constitute the providers exhaustive and exclusive administrative remedies. Providers must first exhaust such administrative procedures before seeking any judicial review under section 1346 of title 28. Any disputes under this section must pertain to either the scope of authorization under

the agreement or claims for payment subject to the agreement and are not claims that would otherwise require application of sections 7101 through 7109 of title 41 U.S.C.

The new section 1703A(i) would establish the applicability of other provisions of law under this section. A Veterans Care Agreement may be authorized by VA and such action shall not be treated as: an award for the purposes of such laws that would otherwise require the use of competitive procedures for the furnishing of care and services; or a Federal contract for the acquisition of goods or services for purposes of any provision of Federal law governing Federal contracts for the acquisition of goods or services except section 4706(d) of title 41 U.S.C. Unless otherwise specified in this section, any provider that enters into an agreement is not subject to, in the carrying out of the agreement, any law to which providers of services under the Medicare program are not subject. An eligible provider is subject to: all laws regarding integrity, ethics, or fraud, or that subject a person to civil or criminal penalties; and all laws that protect against employment discrimination or that otherwise ensure equal employment opportunities. A provider under this section shall not be treated as a Federal contractor or subcontractor for purposes of chapter 67 of title 41, U.S.C.

The new section 1703A(j) would establish that care furnished to a veteran under a Veterans Care Agreement shall be subject to the same terms and provisions as they would be if receiving care in VA.

The new section 1703A(k) would require VA to promulgate regulations to carry out this section.

Section 102(b) of this bill provides for a clerical amendment of the table of sections.

Sec. 103. Conforming amendments for State Veterans Homes

Section 103(a) of this bill would amend section 1745(a) of title 38, U.S.C. to authorize VA to enter into Veteran Care Agreements with State Veterans Homes and eliminate competitive contracting actions and other requirements associated with federal contracts. State Veterans Homes, while not considered federal contactors for the purposes of this section, would still be required to follow federal laws related to fraud, waste, and abuse as well as employment law.

Section 103(b) of this bill would establish the effective date as on or after the effective date of regulations issued by VA.

Sec. 104. Access standards and standards for quality

Section 104(a) of this bill would further amend Subchapter I of chapter 17 by inserting after section 1703A the following new sections: "§ 1703B. Access standards" and "§ 1703C. Standards for quality."

The new section 1703B(a) would require VA to establish access standards for furnishing care and services to covered veterans and shall define such categories to cover all care and services within the medical benefits package.

The new section 1703B(b) would ensure that the access standards provide to covered veterans, VA employees, and health care providers in the establish network, relevant comparative information that is clear, useful, and timely so that covered veterans can make informed decisions regarding their care.

The new section 1703B(c) would require VA to consult with all pertinent Federal entities, private sector entities, and other nongovernmental entities to create the access standards.

The new section 1703B(d) would require VA to submit to the appropriate committees of Congress a report detailing the access standards not later than 270 days after enactment. Before submitting the report, VA shall provide periodic updates to confirm progress toward developing the access standards. The first update shall occur no later than 120 days after enactment. Following the creation of access standards, VA shall submit to the appropriate committees of Congress a report detailing implementation of and compliance with the access standards. This report shall be submitted no later than 540 days after implementation of the access standards.

The new section 1703B(e) would establish that every three years after implementation, and no less frequently than once every three years thereafter, VA must review the access standards and submit a report to Congress on the findings and any necessary modifications.

The new section 1703B(f) would require VA to ensure that health care providers in the network are able to comply with the access standards.

The new section 1703B(g) would have VA publish in the Federal Register and on its website the access standards.

The new section 1703B(h) would allow for covered veterans to contact VA at any time to request a determination of their eligibility to receive care and services from a non-Department entity or provider as it pertains to the access standards. VA shall establish a process to review any requests from covered veterans to determine clinical necessity for requested care and if VA is able to provide such care in a manner that complies with the designated access standards.

The new section 1703B(i) would define terms: "appropriate committees of Congress" and "covered veteran."

The new section 1703C(a) would require VA to establish standards for quality regarding care and services furnished by VA and non-VA providers. In establishing standards for quality, VA shall consider existing health quality measures in public and private health care systems and shall consider data such as: veteran satisfaction with care and service quality at VA medical facilities within the past two years; the timeliness of care; the effectiveness of care; the safety, including complications, readmissions, and deaths; and efficiency of care. VA shall consult with all pertinent Federal entities, entities in the private sector, and other nongovernmental entities in establishing standards of quality. VA shall submit to the appropriate committees of Congress a report detailing the standards for quality not later than 270 days after enactment. Before submitting the report, VA shall provide periodic updates to confirm progress toward developing the standards for quality. The first update shall occur no later than 120 days after enactment.

The new section 1703C(b) would require VA to publish data on these quality measures on the Hospital Compare website through the Centers for Medicare and Medicaid to give veterans the information necessary to compare performance measures between VA and community health care providers not later than one year after

implementation of the standards. VA shall consider and solicit public comment on potential changes not later than two years after implementation of the standards.

The new section 1703C(c) would define the terms: "appropriate committees of Congress" and "covered veteran."

Section 104(b) of this bill provides for a clerical amendment of the table of sections.

Sec. 105. Access to Walk-In Care.

Section 105 of this bill would amend Subchapter I of chapter 17 by inserting after section 1725 the following new section: "§ 1725A. Access to walk-in care."

The new section 1725A(a) would require VA to develop procedures to ensure eligible veterans can access walk-in care from non-Department providers.

The new section 1725(b) defines an eligible veteran under this section as one who is enrolled in the VA health system and has received care within the last two years.

The new section 1725(c) defines qualifying non-department entities or providers as a non-department provider or entity with an agreement or contract with the VA to furnish services provided under this section.

The new section 1725(d) authorizes VA to utilize Federally Qualified Health Centers (FQHC), when practicable.

The new section 1725(e) requires VA to ensure continuity of care for veterans who receive walk-in care, including the sharing of medical records.

The new section 1725(f) requires VA to establish a copayment structure for eligible veterans. For the first two visits in a calendar year, a veteran who would not be required to pay a copay if not otherwise required to pay such a copay under this title. Similarly, for the first two visits in a calendar year, a veteran who would be required to pay a copay if otherwise required to pay such a copay under this title. The Secretary shall prescribe by rule any adjusted copayment requirements for visits furnished after the first two episodes of care.

The new section 1725(g) requires VA to promulgate regulations no later than one year after enactment to carry out this section.

The new section 1725(h) defines "walk-in care" as non-emergent care provided by a qualifying non-Department entity or provider that furnishes episodic care and not longitudinal management of conditions.

Section 105(b) of this bill establishes an effective date upon the implementation of final regulations.

Section 105(c) of this bill provides for a clerical amendment of the table of sections.

Sec. 106. Strategy regarding the Department of Veterans Affairs high-performing integrated health care network

Section 106(a) of this bill would amend Subchapter II of chapter 73 by inserting after section 7330B the following new section: "§ 7330C. Quadrennial Veterans Health Administration Review."

The new section 7330C(a) would require VA to conduct quadrennial market area assessments, including: demand for VA healthcare; an inventory of VA's capacity to provide healthcare; an

assessment of community contract capacity; an assessment obtained from other Federal direct delivery systems of their capacity to provide health care to veterans; an assessment of the health care capacity of non-contracted providers where there is insufficient network supply; an assessment of the health care capacity of academic affiliates and other VA collaborations as it relates to providing health care to veterans; an assessment of the effects on VA health care capacity by the access and quality standards established under this bill; and the number of appointments for health care services, disaggregated by VA medical facilities and non-Department health care providers. VA shall submit to the appropriate committees of Congress the market area assessments and shall ensure that the Department budget for any fiscal year reflects the findings of the most recent market assessments.

The new section 7330C(b) of the bill would require VA to submit one year after the date of enactment and not less frequently than once every four years thereafter to the appropriate committees a strategic plan that specifies a four-year forecast of demand for care from the Department, capacity provided by each medical center of the Department, and capacity provided through community care providers. In developing the strategic plan, the Secretary shall assess access and quality standards, assess market assessments, assess the needs of the Department to provide for service connected conditions, consult with key stakeholders, identify emerging issues, trends and opportunities, develop recommendations, consider surveys, examine existing programs and policies, assess remediation of medical service lines, and consider other matters as appropriate.

The new section 7330C(c) outlines responsibilities of VA for overseeing transformation and organizational changes across the Department, developing capital infrastructure planning and procurement, and developing a multi-year budget process.

The new section 7330C(d) defines "Appropriate Committees of Jurisdiction."

Section 106(b) of this bill provides for a clerical amendment of the table of sections.

Sec. 107. Applicability of directive of Office of Federal Contract Compliance programs

Section 107(a) of this bill would require the same affirmative action moratorium on Veterans Care Agreement contractors and subcontractors as is applied to TRICARE contractors and subcontractors in Directive 2014–01 of the Office of Federal Contract Compliance Programs of the Department of Labor.

Section 107(b) of this bill would direct the above moratorium to not be altered or rescinded until May 19, 2019.

Section 107(c) of this bill defines the term "TRICARE program."

Sec. 108. Prevention of certain health care providers from providing non-Department health care services to veterans

Section 108(a) of this bill would allow VA to deny or revoke the eligibility of a provider to provide non-Department care if VA deems that provider was removed from employment with the Department due to conduct relating to the delivery of safe and appropriate care or violated the requirements of a medical license that resulted in the loss of such license.

Section 108(b) of this bill would allow VA permissive action to deny, revoke, or suspend the eligibility of a health care provider to provide non-Department care on and after the date that is one year after enactment.

Section 108(c) of this bill would require VA to suspend the eligibility of a non-VA provider if the provider is suspended from serving as a VA provider.

Section 108(d) of this bill would require the Comptroller General of the United States to submit to Congress a report on the implementation of this section, including: the aggregate number of health care providers denied or suspended; an evaluation of any impact on access to care for patients or staffing shortages; an explanation of the coordination of VA with medical licensing boards of States and the efforts of VA to address any concerns from these boards; and any recommendations the Comptroller General finds appropriate.

Section 108(e) of this bill would define the term: "non-Department health care services."

Sec. 109. Remediation of medical services lines

Section 109(a) of this bill would amend subchapter I of chapter 17 by inserting after section 1706 the following new section: "§ 1706A. Remediation of medical service lines."

The new section 1706A(a) would require VA to submit to Congress a plan to remediate medical service lines not later than 30 days after determining that the service line does not comply with standards for quality. The specific actions shall include, but are not limited to: increasing personnel or temporary personnel assistance, including mobile deployment teams; utilizing special hiring incentives, including the Education Debt Reduction Program (EDRP) and recruitment, relocation, and retention incentives; utilizing direct hiring authority; providing improved training opportunities for staff; acquiring improved equipment; making structural modifications to the facility used by the medical service line; and such other actions as VA considers appropriate.

The new section 1706A(b) would require each report to include the individuals at the Central Office of the Veterans Health Administration, the facility used by the medical service line, and the central office of relevant Veterans Integrated Service Network who are responsible for overseeing the progress of the service line.

The new section 1706A(c) would require VA to submit interim reports to Congress on the remediation actions and costs taken for each medical service line submitted for assessment. This analysis shall be published on the VA's website.

The new section 1706A(d) would require VA to submit annual reports to Congress on the remediation actions and costs taken for each medical service line submitted for assessment. This analysis shall be published on the VA's website.

Section 109(b) of this bill provides for a clerical amendment of the table of sections.

Chapter 2—Paying Providers and Improving Collections

Sec. 111. Prompt payment to providers

Section 111(a) of this bill would amend subchapter I of chapter 17 by inserting after section 1703C, the following new section: "§ 1703D. Prompt payment standards."

The new section 1703D(a) would establish a prompt payment process that requires VA to pay for, or deny payment for, services within 30 calendar days of receipt of a clean electronic claim or within 45 calendar days of receipt of a clean paper claim. In the case of a denial, VA would have to notify the provider of the reason for denying the claim and what, if any, additional information would be required to process the claim. Upon the receipt of the additional information, VA would have to pay, deny, or otherwise adjudicate the claim within 30 calendar days. These requirements would only apply to payments made on an invoice basis and would not apply to capitation or other forms of periodic payments to entities or providers.

The new section 1703D(b) would establish that Non-VA entities or providers would be required to submit a claim to VA within 180 days of providing care or services.

The new section 1703D(c) would establish the application of title 31 to fraudulent claims. The Secretary shall prescribe regulations barring a health care entity or provide from furnishing care or services if it is determined that such entity or provider submitted fraudulent claims.

The new section 1703D(d) would establish that any claim that has not been denied, made pending, or paid within the specified time periods would be considered overdue and subject to interest payment penalties. VA to report annually on the number of and the amount paid in overdue claims.

The new section 1703D(e) would authorize VA to deduct the amount of any overpayment from payments due to an entity or provider under certain conditions.

The new section 1703D(f) would require VA to provide to all health care entities and providers in the program a list of information and documentation that is required to establish a clean claim under this section.

The new section 1703D(g) would allow VA to have claims processing performed by either a contracted third-party administrator or other entity to conduct these administrative functions. This section would require an independent review of claims that includes the capacity of VA to process such claims in a timely manner and a cost benefit analysis comparing the capacity of VA to a third-party entity capable of processing such claims.

The new section 1703D(h) would require VA to submit to the appropriate committees of Congress a report on the feasibility and advisability of adopting a funding mechanism similar to what is utilized by other Federal agencies.

The new section 1703D(i) would define the terms: "appropriate committees of Congress", "clean electronic claim", "clean paper claim", "fraudulent claims", and "health care entity or provider."

Section 111(b) of this bill provides for a clerical amendment of the table of sections

Sec. 112. Authority to pay for authorized care not subject to an agreement.

Section 112(a) of this bill would amend subchapter IV of chapter 81 by adding the following new section: "§ 8159. Authority to pay for services authorized but not subject to an agreement."

The new section 8159(a) would authorize VA to pay for services not subject to a contract or agreement.

The new section 8159(b) would require VA to take reasonable efforts to enter into a contract or agreement with a provider to ensure that future care and services authorized by VA are subject to the contract.

Section 112(b) of this bill provides for a clerical amendment of the table of sections.

Sec. 113. Improvement of authority to recover the cost of services furnished for non-service-connected disabilities

Section 113(a) of this bill would allow for VA to collect from a third-party for care provided to non-veterans by amending section 1729.

Section 113(b) of this bill would authorize VA to seek collections when VA pays for care rather than furnishing it. This section also removes duplicative language.

Section 113(c) of this bill would amend the statute on eligible individuals.

Sec. 114. Processing of claims for reimbursement through electronic interface

Section 114 of this bill would allow VA to enter into an agreement with a third-party entity to electronically process health care claims from community providers.

Chapter 3—Education and Training Programs

Sec. 121. Education program on health care options

Section 121(a) of this bill would require VA to develop and administer an education program that teaches veterans about their health care options.

Section 121(b) of this bill would establish the elements of the program. It shall teach veterans about: eligibility criteria for care from VA; priority groups for enrollment; the copayments and other financial obligations, if any apply; how to utilize the access standards and standards for quality; teach veterans about the interaction between health insurance and VA; and provide information on what to do when filing a complaint about health care received.

Section 121(c) of this bill would require VA to ensure that such programs are accessible to all veterans, regardless of internet access or disabilities.

Section 121(d) of this bill would require VA to develop a method to evaluate the effectiveness of the education program and once a year, submit a report to Congress on the evaluations of the education program.

Section 121(e) of this bill would define the terms: "Medicaid", "Medicare", and "TRICARE program."

Sec. 122. Training program for administration of non-Department of Veterans Affairs health care

Section 122(a) of this bill would require VA to develop and implement a training program to train employees and contractors of VA on how to administer non-VA health care programs, particularly the management of prescription opioids.

Section 122(b) of this bill would require VA to develop a method to evaluate the effectiveness of the training program and shall submit to Congress an annual report on the findings of the evaluation.

Sec. 123. Continuing medical education for non-Department medical professionals

Section 123(a) of this bill would establish a program to provide continuing medical education material to non-VA medical professionals at no cost to them.

Section 123(b) of this bill would establish that the material provided to non-VA professionals be the same material provided to VA professionals.

Section 123(c) of this bill would require VA to administer the program, determine the curriculum of the program, ensure the accreditation of the program in as many States as possible, ensure the consistence of the program with rules and regulations of medical licensing agency in each State, that the program is no cost to the participant, and that VA monitor, evaluate, and report to Congress on the utilization and effectiveness once a year.

Section 123(d) of this bill would define "non-Department medical professional."

Chapter 4—Other Matters Relating to Non-Department of Veterans Affairs Providers

Sec. 131. Establishment of processes to ensure safe opioid prescribing practices by non-Department of Veterans Affairs health care providers

Section 131(a) of this bill would require VA to 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 VA.

Section 131(b) of this bill would require VA to implement a process to ensure that, if a veteran is provided care by a covered provider under the laws administered by VA, the provider submit medical history of the veteran to VA.

Section 131(c) of this bill would require all covered providers to submit medical record of any care furnished, including prescriptions of opioids, to VA for each veteran seen. Upon receiving these records, VA is responsible for entering the prescriptions into the electronic health record of the veteran, and VA is responsible for monitoring the prescription as outlined in the Opioid Safety Initiative. VA must submit an annual report to Congress evaluating the compliance of cover providers with the requirements of this section.

Section 131(d) of this bill would require VA to take appropriate action with a covered provider determined to not be adhering to or complying with the Opioid Safety Initiative. VA may refuse authorization of care by such provider and direct their removal from the network.

Section 131(e) of this bill would define "covered health care provider."

Sec. 132. Improving information sharing with community providers

Section 132 of this bill would amend section 7332(b)(2) to clarify that VA could share medical record information with non-Department entities for the purpose of providing health care to patients or performing other health care related activities and remove certain restrictions on VA's ability to recover funds from third parties for the cost of non-service-connected care.

Sec. 133. Competency standards for non-Department of Veterans Affairs health care providers

Section 133(a) of this bill would require VA to establish standards and requirements for the provision of care by non-VA health care providers in clinical areas for which VA has special expertise, including post-traumatic stress disorder, military sexual trauma-related conditions, and traumatic brain injuries.

Section 133(b) of this bill would, to the extent possible, require covered health care providers who are in a clinical area of expertise for VA to fulfill training requirements determined by VA, before furnishing care.

Section 133(c) of this bill would establish an effective date at one year after the date of enactment.

Sec. 134. Department of Veterans Affairs participation in national network of State-based prescription drug monitoring program

Section 134(a) of this bill would amend chapter 17 by inserting after section 1730A the following new section: "§ 1730B. Access to State prescription drug monitoring programs."

The new section 1730B(a) would allow any licensed health care provider or delegate to be considered an authorized recipient or user of data from the national network of State-based prescription drug monitoring programs. Under this authority, licensed health care providers or delegates would be required to query the network in accordance with applicable VA regulations and policies and no State would be authorized to restrict the access of licensed health care providers or delegates from accessing that State's prescription drug monitoring programs.

The new section 1730B(b) would define "covered patients."

The new section 1730B(c) would define terms: "controlled substance", "delegate", "licensed health care provider", "national network of State-based prescription monitoring programs", and "State".

Section 134(b) of this bill provides for a clerical amendment of the table of sections.

Chapter 5—Other Non-Department Health Care Matters

Sec. 141. Plans for use of supplemental appropriations required

Section 141 of this bill would require VA to submit to Congress a justification for any new supplemental appropriations request submitted outside of the standard budget process no later than 45 days before the date on which a budgetary issue would start affecting a program or service. It would also require a detailed strategic

plan on how VA intends to use the requested appropriation and for how long the requested funds are expected to meet the need.

Sec. 142. Veterans Choice fund flexibility

Section 142 of this bill would amend section 802 of the Choice Act to authorize VA, beginning March 1, 2019, to use the remaining Veterans Choice Fund to pay for any health care services under Chapter 17 of Title 38 at non-Department facilities or through non-Department providers furnishing care in VA facilities.

Sec. 143. Sunset of Veterans Choice Program

Section 143 of this bill would provide a sunset date for the Veterans Choice Program one year after the date of enactment of this Act.

Sec. 144. Conforming amendments

Section 144 of this bill would repeal and replace existing authorities to account for changes made by section 101 of the bill to consolidate and create the Veterans Community Care program.

Subtitle B—Improving Department of Veterans Affairs Health Care Delivery

Sec. 151. Licensure of health care professionals of the Department of Veterans Affairs providing treatment via telemedicine

Section 151(a) of this bill would amend Chapter 17 by inserting after section 1730B, as added by section 134, the following new section: "§ 1730C. Licensure of health care professionals providing treatment via telemedicine."

The new section 1730C(a) would allow covered health care professionals to practice at any location in any State if using telemedicine under this chapter.

The new section 1730C(b) would define a "covered health care professional."

The new section 1730C(c) would enforce that subsection (a) of this section shall apply to a covered health care professional regardless of whether they are located in a Federally owned facility during the treatment.

The new section 1730C(d) would establish that this provision shall supersede any provisions of State law if those provisions are inconsistent with this section.

The new section 1730C(e) would establish that nothing may be construed to remove, limit, or otherwise affect any obligation of a covered health care professional under the Controlled Substance Act.

The new section 1730C(f) would define "State."

Section 151(b) of this bill provides for a clerical amendment of the table of sections.

Section 151(c) of this bill would require VA to submit a report to Congress on the effectiveness of telemedicine within one year of enactment, providing data on provider and patient satisfaction, the effect of telemedicine on patient wait-times, health care utilization, and other measures.

Sec. 152. Authority for Department of Veterans Affairs Center for Innovation for Care and Payment

Section 152(a) of this bill would amend subchapter I of chapter 17 by inserting after section 1703D, as added by section 11, the following new section: "§ 1703E. Center for Innovation for Care and Payment."

The new section 1703E(a) would authorize VA 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. VA would be required to test models where VA determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. VA would be required to focus on models expected to reduce program costs while preserving or enhancing the quality of or access to care VA provides. VA would be authorized to consider a number of different factors in selecting models to test. The models tested under this program could not be designed in such a way as to allow the United States to recover or collect reasonable charges from a Federal health care program (including Medicare, Medicaid, and TRICARE) for care or services furnished by VA to veterans.

The new section 1703E(b) would authorize the pilot programs to last no longer than five years.

The new section 1703E(c) would require VA ensure that each pilot program occurs in an area or areas appropriate for the intended purpose of the program. To the extent possible, the programs shall be located in geographically diverse areas.

The new section 1703E(d) would establish that the funding for the pilot programs shall come from appropriations provided in advance for VHA and information technology systems.

The new section 1703E(e) would require VA to publish information and take all reasonable action to give notice to veterans eligible to participate in the pilot programs.

The new section 1703E(f) would authorize VA 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. VA would only be allowed to act upon any such waiver after Congress enacts a joint resolution approving the action.

The new section 1703E(g) would limit VA to carrying out no more than ten pilot programs concurrently and would prohibit VA from spending more than $50 million per fiscal year on the programs. This limit may be increased only if VA receives written consent from the Chairmen of the Committees on Veterans' Affairs in the House and the Senate, respectively.

The new section 1703E(h) would require VA to conduct an evaluation of each model tested, which shall include an analysis of the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined by VA and the changes in spending by reason of that model. VA shall make the results of each evaluation public in the Federal Registry.

The new section 1703E(i) would establish that VA shall obtain advice from the Under Secretary for Health and the Special Medical Advisory Group to develop and implement any of the pilot pro-

grams, as well as consult relevant Federal agencies and interested parties.

The new section 1703E(j) would authorize VA to expand, through rulemaking, the duration and scope of successful pilot programs to the extent VA determines that such expansion is expected to reduce spending without reducing the quality of or access to care or improve the quality of or access to care without increasing spending; VA would also have to determine that such expansion would not deny or limit the coverage or provision of benefits for applicable individuals.

Section 152(b) of this bill provides for a conforming amendment of the table of sections.

Sec. 153. Authorization to provide for operations on live donors for purposes of conducting transplant procedures for veterans

Section 153(a) of this bill would amend subchapter VIII of chapter 17 by adding the following new section: "§ 1788. Transplant procedures with live donors and related services."

The new section 1788(a) would authorize VA to provide for an operation on a live donor, regardless of the donor's eligibility for VA health care, if the procedure is for an eligible veteran.

The new section 1788(b) would require VA to provide any care or services before and after conducting the transplant procedure.

The new section 1788(c) would allow VA to, in carrying out this section, provide the care and services from subsection (a) and (b) of this section in a non-VA facility, provided VA has an agreement with the facility.

Section 153(b) of this bill provides for a clerical amendment of the table of sections.

Subtitle C—Family Caregivers

Sec. 161. Expansion of Family Caregiver Program of Department of Veterans Affairs

Section 161(a) of this bill would amend Subparagraph (B) of subsection (a)(2) of section 1720G to expand eligibility for VA's Program of Comprehensive Assistance for Family Caregivers to veterans with a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service on or before May 7, 1975. After the date that is two years after the date on which the certification is submitted, eligibility would be expanded to also include veterans with a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service after May 7, 1975, and before September 11, 2001. Not later than 30 days after the date on which VA submits to Congress the certification of this title, VA shall publish the date specified in such subsection in the Federal Register. The stipend calculation is also modified, and VA shall take into account: the assessment by the family caregiver of the needs of the veteran; the extent to which the veteran can function safely and independently; and the amount of time required for the family caregiver to provide assistance to the veteran. VA shall provide instruction, preparation, and training, as well as technical support, to each family caregiver who is approved as a provider of personal care for an eligible veteran. VA shall periodically evaluate the needs of the eligible veteran to de-

termine if additional instruction, training, or technical support is needed. VA may enter into agreements with Federal agencies, States, and private entities to provide assistance to family caregivers, and VA may provider fair compensation to these entities for assistance rendered.

Section 161(b) of this bill would modify the definition of "personal care services" under Subsection (d)(4).

Sec. 162. Implementation of information technology system of Department of Veterans Affairs to assess and improve the Family Caregiver Program

Section 162(a) of this bill would require VA to implement an information technology system that fully supports the Family Caregiver Program and allows for data assessment and comprehensive monitoring by not later than October 1, 2018.

Section 162(b) of this bill would require VA to use data from the system to conduct an assessment of key aspects of the program and how they are carried out. The assessment shall occur no later than 180 days after implementation of the system.

Section 162(c) of this bill would establish that VA shall use the system to monitor and assess the workload of the Program and the use of support services by the caregivers. Based on the monitoring and assessment, VA shall identify and implement modifications to ensure the program is functioning as intended.

Section 162(d) of this bill would require VA to submit a report to Congress and the Comptroller General of the United States not later than 90 days after the date of enactment of this bill. The Comptroller General shall review the report and notify Congress on the progress and assessment of the system.

Section 162(e) of this bill would define the terms: "active military, naval, or air service" and "Program."

Sec. 163. Modifications to annual evaluation report on Caregiver Program of Department of Veterans Affairs

Section 163(a) of this bill would amend subparagraph (A)(iv) of section 101(c)(2) of the Caregivers and Veterans Omnibus Health Services Act by inserting "including a description of any barriers to accessing and receiving care and services und such programs."

Section 163(b) of this bill would amend Subparagraph (b) of such section by inserting a requirement for an evaluation of the sufficiency and consistency of caregiver training.

TITLE II—VA ASSET AND INFRASTRUCTURE REVIEW

Subtitle A—Asset and Infrastructure Review

Section 201. Short title

Section 201 of this bill would establish the short title of the subtitle as the "VA Asset and Infrastructure Review Act of 2018."

Section 202. The Commission

Section 202(a) of this bill would establish an independent "Asset and Infrastructure Review Commission."

Section 202(b) of this bill would require the Commission to carry out the duties described in this title.

Section 202(c) of this bill would require the President, with the advice and consent of the Senate, to appoint nine AIR Commissioners and to transmit nominations to the Senate by May 31, 2021. Additionally, it would require the President to consult with the Speaker and minority leader of the House of Representatives and the majority and minority leader of the Senate in selecting individuals for Commission nomination and congressionally chartered, membership-based veterans service organizations (VSOs) specifically concerning the appointment of three members. The President would be required to nominate one person to serve as the Chair of the Commission and one person to serve as the Vice Chair of the Commission, and in nominating individuals for appointment to the Commission, to ensure: that veterans (reflecting current demographics of veterans enrolled in the VA health care system) are adequately represented in the membership of the Commission; that at least one member of the Commission has experience with a private integrated health care system that has annual gross revenue of more than $50 million; that at least one member has experience as a senior manager for a Federally-qualified health center, the Department of Defense, or the Indian Health Service; that at least one member has experience with capital asset management for the Federal government and is familiar with trades related to building and real property (including construction, engineering, architecture, leasing, and strategic partnerships); and, that at least three members represent congressionally-chartered, membership-based VSOs.

Section 202(d) of this bill would require the Commission to meet only during calendar years 2022 and 2023, and requires that each meeting of the Commission be open and all proceedings, information, and deliberations of the Commission to be available for review by the public.

Section 202(e) of this bill would require a vacancy in the Commission to be filled in the same manner as the original appointment, but the individual appointed to fill the vacancy to serve only for the unexpired portion of the term for which the individual's predecessor was appointed.

Section 202(f) of this bill would require Commissioners to serve without pay, requires each member of the Commission who is an officer/employee of the United States to only receive compensation for their services as an officer/employee of the U.S, and allows Commissioners to receive travel expenses, including per diem.

Section 202(g) of this bill would require the Commission to appoint a staff director who has not served as a VA employee during the one-year period preceding the date of appointment and who is not otherwise barred or prohibited from serving as a Director under Federal ethics law and regulations by reason of post-employment conflict of interest and requires the Director to be paid at the rate of basic pay payable for level IV of the Executive Schedule.

Section 202(h) of this bill would require the Director, with the approval of the Commission, to appoint and fix the pay of additional personnel, to make such appointments without regard to the provisions of title 5 U.S.C. governing appointments in the competitive service, and any personnel so appointed to be paid without regard to provisions relating to the classification and General Schedule pay rates except that an individual so appointed may not re-

ceive pay in excess of the annual rate of basic pay payable for GS–15. This bill would allow not more than two-thirds of the personnel employed by or detailed to the Commission to be on detail from VA and not more half of the professional analysts to be detailed from VA. This section also prohibits a person from being detailed to the Commission from VA if, within six months before the detail is set to begin, the person participated personally or substantially in any matter concerning the preparation of recommendations regarding Veterans Health Administration (VHA) facilities. Additionally, it would allow any Federal department or agency to detail personnel to the Commission upon request. Lastly, this bill would allow the Commission to secure necessary information from Federal agencies and Federal agencies to furnish such information upon request.

Section 202(i) of this bill would allow the Commission to procure, by contract to the extent funds are available, the temporary or intermittent services or experts of consultants and to lease real property and acquire personal property either of its own accord or in consultation with the General Services Administration (GSA).

Section 202(j) of this bill would terminate the Commission on December 31, 2023.

Section 202(k) of this bill would prohibit the restriction of lawful communication from a VA employee to the Commission.

Section 203. Procedure for making recommendations

Section 203(a) of this bill would require VA, not later than February 1, 2021, and after consulting with VSOs, to publish in the Federal Register and transmit to the Committees on Veterans' Affairs of the House of Representatives and the Senate the criteria proposed by VA to be used in assessment and making recommendations regarding the modernization or realignment of VHA facilities and require such criteria to include the veteran's preference regarding access to VA health care. VA would be required to hold a 90-day public comment period for VA's proposed criteria, and, not later than May 31, 2021, to publish in the Federal Register and transmit to HVAC/SVAC, the final criteria to be used in making recommendations regarding the modernization or realignment of VHA facilities.

Section 203(b) of this bill would require VA, not later than January 31, 2022, and after consulting with VSOs, to publish in the Federal Register and transmit to Committees on Veterans' Affairs of the House of Representatives and the Senate a report detailing recommendations regarding the modernization or realignment of VHA facilities. VA would be required to consider the following factors in making recommendations regarding the modernization or realignment of VHA facilities: the degree to which health care delivery or other site for providing services to veterans reflect VA's metrics regarding market area health system planning; the provision of effective and efficient access to high-quality health care and services to veterans; the extent to which real property that no longer meets the needs of the Federal Government could be reconfigured, repurposed, consolidated, realigned, exchanged, outleased, repurposed, replaced, sold, or disposed; VHA's need to acquire infrastructure or facilities that will be used for the provision of health care and service to veterans; the extent to which operation and maintenance costs are reduced through consolidating, collo-

cating, and reconfiguring space and through realizing other operational efficiencies; the extent and timing of potential costs and savings, including the number of years such costs and savings will be incurred, beginning with the date of completion of the proposed recommendation; the extent to which the real property aligns with VA's mission; the extent to which any action would impact other VA missions including education, research, or emergency preparedness; local stakeholder inputs and any factors identified through public field hearings; capacity and commercial market assessments; and, any other factors VA determines appropriate. VA would be required to assess the capacity of each Veterans Integrated Service Network (VISN) and VA medical facility to furnish hospital care or medical services to veterans and require each assessment to: identify existing deficiencies in the furnishing of care and services to veterans and how such deficiencies may be filled by entering into contracts or agreements with community health care providers or other entities under other provisions of law and changing the way care and services are furnished at such VISNs or VA medical facilities (including through extending hours of operation, adding personnel, and expanding treatment space through construction, leasing, or sharing of health care facilities); forecast, based on future projections and historical trends, both the short-term and long-term demand in furnishing care and services at such VISN or VA medical facility; consider how demand affects the need to enter into contracts or agreements; consider the commercial health care market of designated catchment areas conducted by a non-governmental entity; and, consider the unique ability of the Federal government to retain a presence in a rural area otherwise devoid of commercial health care providers or from which such providers are at risk of leaving. VA would be required to consult with VSOs and veterans served by each VISN and medical facility affected by the assessments. VA would be required to submit the local capacity and commercial market assessments to Committees on Veterans' Affairs of the House of Representatives and the Senate with the recommendations regarding the modernization or realignment of VHA facilities and to make the assessments publicly available. VA would be required to include with the recommendations regarding the modernization or realignment of VHA facilities a summary of the selection process that resulted in the recommendation for each VHA facility and a justification for each recommendation and to transmit the summaries and justifications not later than 7 days after the date of transmittal to HVAC/SVAC. VA shall consider all facilities equally without regard to whether the facility has been previously considered or proposed for reuse, modernization, or realignment. VA shall make all information used by VA to prepare a recommendation available to Congress, the Commission and the Comptroller General. Each VA Under Secretary, VISN director, VA medical center director, VA program office director, and each person who is in a position of duties which includes personal and substantial involvement in the preparation and submission of information and recommendations concerning the modernization or realignment of VHA facilities would certify that information submitted to VA or to the Commission concerning the modernization or realignment of VHA facilities is accurate and complete to the best of that person's knowledge and belief. The Commission is re-

quired to conduct public hearings on VA's recommendations regarding the modernization or realignment of VHA facilities, to include required public hearings in regions affected by a VA recommendation for the closure of a facility and, to the greatest extent practicable, public hearings in regions affected by a recommendation for other (non-closure) action by VA. Each Commission public hearing shall include, at a minimum, a local veteran who is enrolled in the VA healthcare system and identified by a local VSO and a local elected official. The Commission shall, not later than January 31, 2023, to transmit to the President a report and analysis of the recommendations made by VA together with the Commission's recommendations for the modernization or realignment of VHA facilities. The Commission is authorized to change a recommendation made by VA for the modernization or realignment of a VHA facility only if the Commission: determines that VA deviated substantially from VA's final criteria in making such recommendation; determines that the change is consistent with the final criteria; publishes a notice of the proposed change in the Federal Register not less than 45 days before transmitting the Commission's recommendations to the President; and, conducts public hearings on the proposed change. The Commission must explain and justify any recommendation made by the Commission that is different from the recommendations made by VA in the Commission's report that is transmitted to the President and to transmit the copy of such report to Committees on Veterans' Affairs of the House of Representatives and the Senate on the same day that it is transmitted to the President. The Commission, after transmitting its report to the President, shall promptly provide information used by the Commission in making its recommendations to any Member of Congress upon request.

Section 203(d) of this bill would require the President, not later than February 15, 2023, to transmit to the Commission and to Congress a report containing the President's approval or disapproval of the Commission's recommendations. If the President approves of the Commission's recommendations, the President is required to transmit a copy of the Commission's recommendations to the Congress together with a certification of approval. If the President disapproves of the Commission's recommendations in whole or in part, the President is required to transmit to the Commission and the Congress the reasons for that disapproval and require the Commission, not later than March 15, 2023, to transmit a report containing the Commission's findings and conclusions based on the review and analysis of the reasons for disapproval and a list of recommendations that the commission determines are appropriate to the President. If the President approves of the Commission's resubmitted recommendations, the President is required to transmit a copy of the recommendations to Congress together with a certification of such approval. This bill would require the process for modernization or realignment of VHA facilities to be terminated, if the President does not transmit a certification of approval to Congress, by March 30, 2023.

Section 204. Actions regarding infrastructure and facilities of the Veterans Health Administration

Section 204(a) of this bill would require VA, in the absence of a resolution of Congressional disapproval having been enacted within 45 days of Presidential transmission of the report to Congress or the adjournment of the 117th Congress, to begin implementing the recommendations made in the report under Section 103(d) within 3 years the President having transmitted the report to Congress.

Section 204(b) of this bill would allow VA not to carry out any modernization or realignment recommendations by the Commission in a report transmitted from the President if a joint resolution is enacted disapproving such recommendations of the Commission before the earlier of: the end of the 45-day period beginning on the date on which the President transmits such report; or the adjournment of Congress sine die for the session during which a report is transmitted. Implementation includes the planning of modernizations or realignments. Days on which either House is not in session because of adjournment of more than three days shall be excluded from the computation of the period.

Section 205. Implementation

Section 205(a) of this bill would allow VA to take such actions as necessary to implement the modernization or realignment of any VHA facility, perform environmental mitigation, abatement or restoration of facilities being closed or realigned to include compliance with historical preservation requirements, provide outplacement assistance to employees of the Department, reimburse Federal agencies for services, and enter into Enhanced Use Lease contracts.

Section 205(b) of this bill would outline how VA may dispose or transfer surplus properties slated for disposal or realignment under this Act, including consultation with state and local governments for proper disposal of real property and roads. VA may transfer title to a redevelopment authority for a facility for the purposes of a federal lease for a term not to exceed 50 years. Such lease may not require rental payments by the government. If the lease involves a substantial portion of the facility, the department or agency may obtain facility services from the redevelopment authority as a provision of the lease. Such services shall not include municipal services, firefighting or security guard functions. Provisions of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 apply. Nothing in this title shall limit or otherwise affect application of McKinney-Vento Homeless Assistance Act provisions.

Section 205(c) of this bill would exempt the actions of the President, Commission, and the VA, except during the process of disposal and relocation, from the National Environmental Policy Act of 1969. The Secretary shall not have to consider the need for closing, realigning, transferring function, or alternative facilities in carrying out the this subtitle.

Section 205(d) of this bill would exempt VA from any legal prohibition of closing or realigning VHA facilities included in any appropriation or authorization Act.

Section 205(e) of this bill would provide the authority for VA to transfer a deed of a VHA facility to a party who agrees to perform the environmental compliance activities that are required under

Federal and State laws. Such transfer may occur if VA certifies to Congress that all costs to be paid by the Department are equal to or greater than market value or if such cost are lower than the recipient of the transfer agrees to pay the difference, and authorizes VA to pay the recipient an amount equal to the lesser of the two such amounts. VA would be required to disclose information regarding environmental restoration, waste management, and environmental compliance activities before entering into a deed transfer.

Section 206. Department of Veterans Affairs Asset and Infrastructure Review Account

Section 206(a) of this bill would establish a single account in the ledgers of the US Treasury with which VA shall administer as a single account. The account shall be known as "Department of Veterans Affairs Asset and Infrastructure Review Account."

Section 206(b) of this bill would allow for the credit to the account any funds authorized and appropriated and any proceeds from a lease, transfer, or disposal of property.

Section 206(c) of this bill would allow VA to use the account for the purposes of carrying out this subtitle, to cover property management and disposal costs, to cover costs of supervision, inspection, overhead, engineering, and design, or for any other purposes in support of the Department's mission and operations.

Section 206(d) of this bill would require VA to establish a consolidated budget display detailing the amount and nature of the credits to and expenditures from, separately details environmental remediation costs, specifies and details any transfers, and details any intra-budget activity transfers with the account that does or will exceed one million dollars during a fiscal year. This information shall be submitted to Congress as part of the Presidential budget submission.

Section 206(e) of this bill would require that upon closure of the account any unobligated funds, upon submission of an accounting report to the appropriate committees of Congress, shall be transferred from the Treasury to VA. No later than 60 days after the closure of the Account, VA shall submit a report to the appropriate committees of Congress detailing all the funds credited to and expended from the Account and any remaining funds.

Section 207. Congressional consideration of Commission report

Section 207(a) of this bill would describe the term "joint resolution" as a resolution introduced within the 45-day period beginning on the date on which the President transmits the report to congress which does not include a preamble and contains specific language as to the resolving clause and title.

Section 207(b) of this bill would outline the means by which the House of Representatives shall consider such resolution to include reporting and discharge, proceeding to consideration, and consideration.

Section 207(c) of this bill outlines the means by which the Senate shall consider such resolution to include referral, reporting and discharge, and floor consideration to include consideration, vote on passage, and ruling of the chair on procedure.

Section 207(d) of this bill would prohibit any amendment to a joint resolution of disapproval.

Section 207(e) of the bill would define the coordination between either House upon receipt of companion measures.

Section 207(f) of the bill would state that this section is applicable only with respect to the procedure followed in that House in the case of a joint resolution and supersedes other rules only to the extent that it is inconsistent with such rules, with the recognition of the constitutional right of either House to change the rules.

Section 208. Other matters

Section 208(a) of the bill would require the online publication of all communications, within 24 hours, between VA, the Commission and the President with regards to this title.

Section 208(b) of this bill would prohibit the VA from pausing or stopping any scheduled construction, leasing, long-term planning project activities, or budgetary processes with regards to the construction during the activities of the Commission, President, or Congress in carrying out this title.

Section 208(c) of this bill authorizes the Secretary to recommend, via budget submissions, any recommendations for future commissions or other capital realignment and management processes.

Section 209. Definitions

Section 209 of this bill would define the terms: "Account", "Commission", "date of approval", "VHA facility", "infrastructure", "modernization", "realignment", "Secretary", "redevelopment authority", and "redevelopment plan."

Subtitle B—Other Infrastructure Matters

Section 211. Improvement to training of construction personnel

Section 211 of this bill would amend subsection (g) of section 8103 of title 38, U.S.C., requiring VA to implement a training and certification program for construction and facilities management personnel. VA would be required to create the training and certification program within one year of enactment, to ensure a majority of covered employees are certified within two years of enactment, and to ensure that all covered employees are certified as quickly as possible thereafter. VA would be required to model the training and certification program on existing curricula and certification programs in title 10 U.S.C. (namely, the existing Defense Acquisition Workforce Improvement Act program). VA would be authorized to provide the training in-person, online, provided by another Federal department or agency, or a combination of the above. VA would be authorized to offer one or more than one level of certification and to enter into a contract with an appropriate entity to provide the training curriculum and certification. All VA employees who are members of occupational series relating to construction or facilities management or VA employees who award or administer contracts for major construction, minor construction, or non-recurring maintenance (including contract specialists or contracting officers' representatives) would be included.

Sec. 212. Review of enhanced use lease

Section 212 of this bill would amend section 8162(b)(6) to require the Office of Management and Budget review each enhanced use lease before the lease goes into effect.

Section 213. Assessment of health care furnished by the Department to Veterans who live in the Pacific territories

Section 213(a) of this bill would require VA to submit to the House and Senate Committees on Veterans' Affairs a report regarding the health care furnished by VA to veterans who live in the Pacific territories.

Section 213(b) of this bill would establish that the report shall assess the ability of the Department to provide hospital care, medical, mental health, and geriatric services, as well as assess the feasibility of establishing a medical facility in any territory that does not contain such a facility.

Section 213(c) of this bill would define the term: "Pacific territories" as American Samoa, Guam, and the Northern Mariana Islands.

TITLE III—IMPROVEMENTS TO RECRUITMENT OF HEALTH CARE PROFESSIONALS

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 requiring VA 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 VA determines that staffing shortage of dentists and physicians is lower than 500. VA would award scholarships in an amount equal to not less than 10 percent of the staffing shortage. VA's agreement to provide a 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. VA may give preference to applicants who are veterans. On an annual basis, VA will provide to appropriate educational institutions information material about the availability of scholarships.

Section 301(b) of this bill 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 of Section 7619 of title 38, U.S.C. from December 21, 2019, to December 31, 2033.

Sec. 302. Increase in maximum amount of debt that may be reduced under Education Debt Reduction Program of Department of Veterans Affairs

Section 302(a) of this bill would amend Section 7683(d)(1) of Title 38, U.S.C., to increase the amount of debt which may be reimbursed under VA's Education Debt Reduction Program (EDRP) to $200,000 total over five years for the Specialty Education Loan Reduction Program, and $40,000 annually.

Section 302(b) of this bill requires VA to conduct and submit to Congress a study on the demand for VA's EDRP, to include: (1) the total number of vacancies within VHA whose applicants are eligible for EDRP, (2) the types of medical professionals in greatest demand in the US, and (3) projections of the numbers and types of medical professions that meet the needs of veterans.

Sec. 303. Establishing the Department of Veterans Affairs specialty education loan repayment program

Section 303(a) of this bill 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."

The new section, "§ 7691. Establishment" would establish a loan repayment program to incentivize individuals employed in the Veterans Health Administration to pursue education and training in medical specialties for which VA determines there is a shortage.

The new section, "§ 7692. Purpose" would outline the purpose of the Specialty Education Loan Repayment Program.

The new section, "§ 7693. Eligibility; preferences; covered costs" would outline eligibility for the participation in the Specialty Education Loan Repayment Program, give preference to veterans in this program, and outline which expenses are allowed to be covered under this section.

The new section, "§ 7694. Specialty education loan repayment" would outline the manner in which the Specialty Education Loan Repayment Program are to be made.

The new section, "§ 7695. Choice of location" would allow each participant who completes their residency to select their location of employment from a list of medical facilities of the VHA.

The new section, "§ 7696. Term of Obligation" would outline the terms of the service obligation for the Specialty Education Loan Repayment Program and would state 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, VA, 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. A formula is established by which VA may seek monetary collections from an employee who violates the terms of obligated service under this section.

The new section, "§ 7697. Relationship to Educational Assistance Program" would allow 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.

Section 303(b) of this bill would provide conforming and technical corrections.

Section 303(c) of this bill would require VA to consider the needs of VHA and anticipate the needs during the next two to six years.

Section 303(d) of this bill would require VA to determine whether a facility of the Department is underserved.

Section 303(e) of this bill would require VA to offer participation to the applicant not later than 28 days after the applicant matches with a residency in a medical specialty and such match is published.

Sec. 304. Veterans Healing Veterans Medical Access and Scholarship Program

Section 304(a) of this bill would establish that VA shall carry out a pilot program under which VA 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 304(b) of this bill would establish the eligibility requirements for the Veterans Healing Veterans Medical Access and Scholarship Program.

Section 304(c) of this bill would require 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 tuition for four years; books, fees, and technical equipment; fees associated with the National Residency Match Program; two away rotations performed during the fourth year at a VA medical facility; and 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 304(d) of this bill would outline the terms of the agreement for eligible veterans who accept funding for medical education under this section. Additionally, this section 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 304(e) of this bill would allow covered schools to accept more than two eligible veterans for the entering class of 2019.

Section 304(f) of this bill would require that no later than December 31, 2020, and annually thereafter for three years, VA shall submit to Congress a full report on the pilot program.

Section 304(g) of this bill would define "covered medical schools" as Teague-Cranston medical schools and the medical schools of Historically Black Colleges and Universities.

Sec. 305. Bonuses for recruitment, relocation, and retention

Section 302 of this bill amends Section 705(a) of PL113–146 to increase the amount authorized for the provision of bonuses to improve recruitment, relocation, and retention of employees. The section sets the limitations on bonus awards from $230,000,000 to $250,000,000 for fiscal years 2019 through 2022, and from $225,000,000 to $290,000,000 for fiscal years 2022 through 2024, with a minimum of $20,000,000 for recruitment, relocation, and retention bonuses for both time periods

Sec. 306. Inclusion of Vet Center employees in Education Debt Reduction Program of Department of Veterans Affairs

Section 306(a) of this bill extends eligibility for VA's Education Debt Reduction Program (EDRP) to clinical staff working at Vet Centers.

Section 306(b) of this bill directs VA to submit to Congress a report on the number of participants in the EDRP who work at Vet Centers.

Section 306(c) of this bill defines the term, "Vet Center."

TITLE IV—HEALTH CARE IN UNDERSERVED AREAS

Sec. 401. Development of criteria for designation of certain medical facilities of the Department of Veterans Affairs as underserved facilities and plan to address problem of underserved facilities

Section 401(a) of this bill would establish that VA shall, not later than 180 days after enactment, develop criteria to designate medical facilities as underserved.

Section 401(b) of this bill would require the developed criteria to consider: the ratio of veterans to health care providers of VA, including a separate ratio for general practitioners and specialist; the range of clinical specialties covered by such providers; whether the local community is underserved; the type, number, and age of open consults; whether the facility is meeting the wait-time goals of VA; and such other criteria developed by VA.

Section 401(c) of this bill would require Veterans Integrated Service Networks, not less than annually, perform an analysis to determine which facilities qualify as underserved.

Section 401(d) of this bill would establish that not later than one year after enactment and annually thereafter, VA shall submit to congress a plan to address the problem of underserved facilities.

Sec. 402. Pilot program to furnish mobile deployment teams to underserved facilities

Section 402(a) of this bill would require VA to carry out a pilot program to furnish mobile deployment teams to underserved facilities.

Section 402(b) of this bill would establish that VA shall consider the medical positions of greatest need at the underserved facilities, the size and composition of the team deployed, and other elements established by VA for oversight of the program.

Section 402(c) of this bill would require that VA use the results from the annual analysis from the above section 401(c) of this bill to send mobile deployment teams to the underserved areas with the most needed medical personnel.

Section 402(d) of this bill would require VA to report, not later than one year after the date of enactment, to Congress on the implementation of the program. Not later than the termination date of the pilot program, VA shall also submit a final report on the feasibility of extending and expanding the pilot program and making the pilot program permanent.

Section 402(e) of this bill would establish the duration of the pilot at three years after the date of enactment.

Section 402(f) of this bill would define the term "underserved facility."

Sec. 403. Pilot program on graduate medical education and residency

Section 403(a) of this bill would establish a pilot program to create medical residency positions authorized under section 301(b)(2) of the Veterans Access, Choice, and Accountability Act at covered facilities, including: VA facilities, a facility operated by an Indian Tribe or tribal organization, an Indian Health Service facility, a Federally-qualified health center, a DOD facility, or any other health care facility considered appropriate. To carry out the pilot program, VA may enter into agreements with entities that operate covered facilities. When establishing the parameters for location, affiliate sponsor, and duration, VA shall consider: the ratio of veterans to providers, including separate ratio for general practitioners and specialists; the range of clinical specialties of providers in the area; whether the specialty of a provider is included in the most recent staffing shortage assessment; whether the local community designated by VA as underserved; whether HHS has designated the region as a health professional shortage area; whether the facility is located in a rural or remote area; and other criteria determined to be important to VA. VA may pay stipends and provide benefits for residents regardless of whether they have been assigned to a VA facility.

Section 403(b) of this bill would establish that VA shall reimburse a covered facility for cost of: curriculum development; recruitment and retention of faculty; accreditation of the program by the Accreditation Council for Graduate Medical Education; faculty salaries attributable to duties under an agreement under this section; and expenses relating to educating a resident under this program.

Section 403(c) of this bill would require VA to report not less frequently than annually until the termination of the project on the implementation of the pilot program.

Section 403(d) of this bill would establish the termination date of the program of August 7, 2024.

TITLE V—OTHER MATTERS

Sec. 501. Annual report on performance awards and bonuses awarded to certain high-level employees of the department

Section 501(a) of this bill would amend Chapter 7 of title 38, U.S.C. by adding the following new section "§ 726. Annual report on performance awards and bonuses awarded to certain high-level employees."

The new section 726(a) would require VA to submit a report no later than 100 days after the end of each fiscal year to the appropriate committees of Congress. The report shall contain a description of all performance awards or bonuses awarded to each of the following: Regional Office Director of the VA; Director of a Medical Center of the VA; Director of a Veterans Integrated Service Network; and Senior executive of VA.

The new section 726(b) would establish that each report included the following: the amount rewarded; the job title of the individual awarded the bonus; and the location where the individual works.

The new section 726(c) would establish definitions.

Section 501(b) of this bill provides for a clerical amendment of the table of sections.

Sec. 502. Role of podiatrists in Department of Veterans Affairs

Section 502(a) of this bill would amend Subchapter I of chapter 74 by adding the following new section "§ 7413. Treatment of podiatrists; clinical oversight standards."

The new section 7413(a) would establish that, except as provided under subsection (b), a podiatric doctor appointed under section 7401(1) of this title is eligible for any supervisory position in the Veterans Health Administration to the same decree as any other physician.

The new section 7413(b) would require VA to create standards to ensure that specialists appointed to supervisory positions do not provide direct clinical oversight for purposes of peer review or practical evaluation for providers.

Section 502(a) of this bill provides for a clerical amendment of the table of sections.

Section 502(b) of this bill would amend section 7404(b) of such title to ensure that Doctors of Podiatric Medicine, Doctors of Osteopathy, and VA Medical Doctors are equal in terms of pay within the VA healthcare system. The effective date of no later than 30 days after enactment of this bill.

Sec. 503. Definition of major medical facility project

Section 503(a) of this bill would amend section 8101(3) by striking "Secretary" and all that follows through "nursing home" and inserting "Secretary, or as otherwise authorized by law, for the provision of health-care services (including hospital, outpatient clinic, nursing home)."

Section 503(b) of this bill would amend 8104(a) to modify the definition of a VA major medical facility project from a $10 million to $20 million project cost, excluding the construction, alteration, or acquisition of shared medical facility or acquisitions by exchange, non-recurring maintenance, and shared facilities, which VA's estimated costs do not exceed $20 million.

Sec. 504. Authorization of certain major medical facility projects of the Department of Veterans Affairs

Section 504(a) of this bill would authorize VA to carry out construction on the major medical facility projects in Livermore, California. The project includes: the new East Bay Community Based Outpatient Clinic and all associated site work; construction of the central Valley Engineering and Logistics support facility; and enhancing flood plain mitigation at the Central Valley and East Bay Community Based Outpatient Clinics. The construction shall not exceed $117.3 million.

Section 504(b) of this bill would authorize appropriations for construction at $117.3 million.

Section 504(c) of this bill would require VA to submit a report to the House and Senate Veterans Affairs Committees no later than 90 days after enactment of this bill. The report shall include the following: a line item accounting of expenditures relating to construction management carried out by VA for the project; the future amounts that are budgeted to be obligated for construction management; a justification for the expenditures above; and any agreement entered into by VA regarding a non-VA Federal entity providing management services relating to this project.

Sec. 505. Department of Veterans Affairs personnel transparency

Section 505(a) of this bill would require VA to make publicly available on their website the following information no later than 90 days after the enactment of this bill. VA will post by medical facility: the number of personnel encumbering positions; the number of accessions and separation actions processed during the quarter preceding the date of the publication of this information; the number of vacancies, by occupation; and the percentage of new hires for VA who were hired within the time-to-hire target of the Office of Personnel Management. VA may withhold from publication information relating to law enforcement, information security, or other positions VA has determined to be sensitive. VA shall update the information on a quarterly basis, and any VA position filled by a contractor may not be published. The VA Office of the Inspector General shall conduct a review of the website semi-annually.

Section 505(b) of this bill would require VA to submit to Congress an annual report on the steps VA is taking to achieve full staffing capacity. The report shall include the amount of additional funds necessary to enable VA to reach full staffing capacity.

Section 506. Program on establishment of peer specialists in patient aligned care team settings within medical centers of Department of Veterans Affairs

Section 506(a) of this bill would require VA to carry out a program to place at least two peer specialists in patient aligned care teams at VA medical centers.

Section 506(b) of this bill would establish the timeframe for creating the program as follows: not later than May 31, 2019, there shall be at least two peer specialists at 15 medical centers and not later than May 31, 2020, at 30 medical centers.

Section 506(c) of this bill would require VA to select medical centers for the program as follows: not fewer than five shall be medical centers designated as polytrauma centers by VA, and not fewer than ten shall be medical centers not designated as polytrauma centers. Additionally, VA shall consider the feasibility of selecting medical centers in the following areas: rural areas and underserved areas; areas not close to active military bases, and areas representing different geographic locations.

Section 506(d) of this bill would require VA to ensure that: the needs of female veterans are specifically considered and addressed and female peer specialists are made available to female veterans.

Section 506(e) of this bill would require VA to consider ways in which peer specialists can conduct outreach to health care providers serving veterans.

Section 506(f) of this bill would require VA to submit to Congress a report not later than 180 days after enactment, and every 180 days thereafter, on the effectiveness of the program. Not later than 180 days after VA has determined the program has been carried out at the last facility.

Sec. 507. Department of Veterans Affairs medical scribe pilot program

Section 507(a) of this bill would require VA to carry out a pilot program to increase the use of medical scribes at VA medical centers.

Section 507(b) of this bill would require the pilot program be carried out at ten VA medical centers with at least four being in rural areas, at least four being in urban areas, and at least two being in areas with a need for increased access or efficiency, as determined by VA.

Section 507(c) of this bill would require VA to hire 20 medical scribes as VA employees and seek to enter into contracts with appropriate entities to employ 20 medical scribes. It would also require VA to assign four medical scribes to each of the identified medical centers with two scribes assigned to each of two physicians, thirty percent of the scribes assigned to an emergency care settings, and seventy percent of the scribes assigned in specialty care settings in specialties with the longest wait times or lowest efficiency ratings, as determined by VA.

Section 507(d) of this bill would require VA to submit a report to the Committees on Veterans' Affairs of the Senate and the House of Representatives on the pilot program by not later than 180 days after the date of the commencement of the pilot and every 180 days thereafter for the duration of the pilot. Each such report would be required to include a separate analysis with respect to medical scribes employed by VA and those performing VA functions under contract regarding provider efficiency, patient satisfaction, average wait times, the number of patients seen per day by each physician or practitioner as well as metrics and data for analyzing the effectiveness of the pilot including an evaluation of each of the above elements at VA medical centers who employed scribes for an appropriate period preceding the hiring of such scribes. GAO is required to submit a report to Congress no more than 90 days after the termination of the pilot and such report is required to include a comparison of the pilot program with similar programs carried out in the private sector.

Section 507(e) of this bill would define the term: "medical scribe" as a licensed individual hired to enter information into the electronic health record or chart at the direction of a physician or licensed independent practitioner whose responsibilities include assisting the physician or practitioner in navigating the electronic health record, responding to various messages as direct by the physician or practitioner, and entering information into the electronic health record as directed by the physician or practitioner; and "urban" and "rural" as having the meanings given such terms under the rural-urban commuting codes developed by the Secretary of Agriculture and the Secretary of Health and Human Services.

Section 507(f) of this bill would stipulate that the pilot program is to be carried out using amounts otherwise authorized to be appropriated for VA and that no additional amounts are authorized to be appropriated to carry out the requirements of Section 507 of the bill.

Sec. 508. Extension of requirement to collect fees for housing loans guaranteed by Secretary of Veterans Affairs

Section 508 of this bill would amend Section 3729(b)(2) of title 38, U.S.C., by striking "2027" and inserting "2028."

Sec. 509. Extension of reduction in amount of pension furnished by Department of Veteran Affairs for certain veterans covered by Medicaid plans for services furnished by nursing facilities

Section 509 of this bill would amend Section 5503(d)(7) of title 38, U.S.C., by striking "September 30, 2027," and inserting "September 30, 2028."

Sec. 510. Appropriations of amounts

Section 510 of this bill would authorize and appropriate $5.2 billion to the Veterans Choice Fund.

Sec. 511. Technical correction

Section 511 of this bill would redesignate section 1712I of title 38 U.S.C. as section 1720I of title 38 U.S.C.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

TITLE 38, UNITED STATES CODE

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PART I—GENERAL PROVISIONS

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CHAPTER 7—EMPLOYEES

SUBCHAPTER I —GENERAL EMPLOYEE MATTERS

Sec.
701. Placement of employees in military installations.

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726. Annual report on performance awards and bonuses awarded to certain high-level employees.

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SUBCHAPTER I—GENERAL EMPLOYEE MATTERS

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§ 726. Annual report on performance awards and bonuses awarded to certain high-level employees

(a) IN GENERAL.—Not later than 100 days after the end of each fiscal year, the Secretary shall submit to the appropriate committees of Congress a report that contains, for the most recent fiscal year ending before the submittal of the report, a description of all performance awards or bonuses awarded to each of the following:

(1) Regional Office Director of the Department.

(2) Director of a Medical Center of the Department.

(3) Director of a Veterans Integrated Service Network.

(4) Senior executive of the Department.

(b) ELEMENTS.—Each report submitted under subsection (a) shall include the following with respect to each performance award or bonus awarded to an individual described in such subsection:

(1) The amount of each award or bonus.

(2) The job title of the individual awarded the award or bonus.

(3) The location where the individual awarded the award or bonus works.

(c) DEFINITIONS.—In this section:

(1) The term "appropriate committees of Congress" means the Committees on Veterans' Affairs and Appropriations of the Senate and House of Representatives.

(2) The term "senior executive" means—

(A) a career appointee; or

(B) an individual—

(i) in an administrative or executive position; and

(ii) appointed under section 7306(a) or section 7401(1) of this title.

(3) The term "career appointee" has the meaning given that term in section 3132(a) of title 5, 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.

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

1703. Veterans Community Care Program.

1703A. Agreements with eligible entities or providers; certification processes.

1703B. Access standards.

1703C. Standards for quality.

1703D. Prompt payment standard.

1703E. Center for Innovation for Care and Payment.

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1706A. Remediation of medical service lines.

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

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§ 1725A. Access to walk-in care.

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1730B. Access to State prescription drug monitoring programs.
1730C. Licensure of health care professionals providing treatment via telemedicine.

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SUBCHAPTER VIII—HEALTH CARE OF PERSONS OTHER THAN VETERANS

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1788. Transplant procedures with live donors and related services.

SUBCHAPTER I—GENERAL

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[§ 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 Department 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.**]**

§ 1703. Veterans Community Care Program

(a) IN GENERAL.—(1) There is established a program to furnish hospital care, medical services, and extended care services to covered veterans through health care providers specified in subsection (c).

(2) The Secretary shall coordinate the furnishing of hospital care, medical services, and extended care services under this section to covered veterans, including coordination of, at a minimum, the following:

(A) Ensuring the scheduling of medical appointments in a timely manner and the establishment of a mechanism to receive medical records from non-Department providers.

(B) Ensuring continuity of care and services.

(C) Ensuring coordination among regional networks if the covered veteran accesses care and services in a different network than the regional network in which the covered veteran resides.

(D) Ensuring that covered veterans do not experience a lapse in care resulting from errors or delays by the Department or its contractors or an unusual or excessive burden in accessing hospital care, medical services, or extended care services.

(3) A covered veteran may only receive care or services under this section upon the authorization of such care or services by the Secretary.

(b) COVERED VETERANS.—For purposes of this section, a covered veteran is any veteran who—

(1) is enrolled in the system of annual patient enrollment established and operated under section 1705 of this title; or

(2) is not enrolled in such system but is otherwise entitled to hospital care, medical services, or extended care services under subsection (c)(2) of such section.

(c) HEALTH CARE PROVIDERS SPECIFIED.—Health care providers specified in this subsection are the following:

(1) 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 a program.

(2) The Department of Defense.

(3) The Indian Health Service.

(4) 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))).

(5) Any health care provider not otherwise covered under any of paragraphs (1) through (4) that meets criteria established by the Secretary for purposes of this section.

(d) CONDITIONS UNDER WHICH CARE IS REQUIRED TO BE FURNISHED THROUGH NON-DEPARTMENT PROVIDERS.—(1) The Secretary shall, subject to the availability of appropriations, furnish hospital

care, medical services, and extended care services to a covered veteran through health care providers specified in subsection (c) if—

(A) the Department does not offer the care or services the veteran requires;

(B) the Department does not operate a full-service medical facility in the State in which the covered veteran resides;

(C)(i) the covered veteran was an eligible veteran under section 101(b)(2)(B) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note) as of the day before the date of the enactment of the Caring for Our Veterans Act of 2018;

(ii) continues to reside in a location that would qualify the veteran for eligibility under such section; and

(iii) either—

(I) resides in one of the five States with the lowest population density as determined by data from the 2010 decennial census; or

(II) resides in a State not described in subclause (I) and—

(aa) received care or services under this title in the year preceding the enactment of the Caring for Our Veterans Act of 2018; and

(bb) is seeking care or services within two years of the date of the enactment of the Caring for Our Veterans Act of 2018;

(D) the covered veteran has contacted the Department to request care or services and the Department is not able to furnish such care or services in a manner that complies with designated access standards developed by the Secretary under section 1703B of this title; or

(E) the covered veteran and the covered veteran's referring clinician agree that furnishing care and services through a non-Department entity or provider would be in the best medical interest of the covered veteran based upon criteria developed by the Secretary.

(2) The Secretary shall ensure that the criteria developed under paragraph (1)(E) include consideration of the following:

(A) The distance between the covered veteran and the facility that provides the hospital care, medical services, or extended care services the veteran needs.

(B) The nature of the hospital care, medical services, or extended care services required.

(C) The frequency that the hospital care, medical services, or extended care services needs to be furnished.

(D) The timeliness of available appointments for the hospital care, medical services, or extended care services the veteran needs.

(E) Whether the covered veteran faces an unusual or excessive burden to access hospital care, medical services, or extended care services from the Department medical facility where a covered veteran seeks hospital care, medical services, or extended care services, which shall include consideration of the following:

(i) Whether the covered veteran faces an excessive driving distance, geographical challenge, or environmental factor that impedes the access of the covered veteran.

(ii) Whether the hospital care, medical services, or extended care services sought by the veteran is provided by a medical facility of the Department that is reasonably accessible to a covered veteran.

(iii) Whether a medical condition of the covered veteran affects the ability of the covered veteran to travel.

(iv) Whether there is compelling reason, as determined by the Secretary, that the veteran needs to receive hospital care, medical services, or extended care services from a medical facility other than a medical facility of the Department.

(v) Such other considerations as the Secretary considers appropriate.

(3) If the Secretary has determined that the Department does not offer the care or services the covered veteran requires under subparagraph (A) of paragraph (1), that the Department does not operate a full-service medical facility in the State in which the covered veteran resides under subparagraph (B) of such paragraph, that the covered veteran is described under subparagraph (C) of such paragraph, or that the Department is not able to furnish care or services in a manner that complies with designated access standards developed by the Secretary under section 1703B of this title under subparagraph (D) of such paragraph, the decision to receive hospital care, medical services, or extended care services under such subparagraphs from a health care provider specified in subsection (c) shall be at the election of the veteran.

(e) CONDITIONS UNDER WHICH CARE IS AUTHORIZED TO BE FURNISHED THROUGH NON-DEPARTMENT PROVIDERS.—(1)(A) The Secretary may furnish hospital care, medical services, or extended care services through a health care provider specified in subsection (c) to a covered veteran served by a medical service line of the Department that the Secretary has determined is not providing care that complies with the standards for quality the Secretary shall establish under section 1703C.

(B) In carrying out subparagraph (A), the Secretary shall—

(i) measure timeliness of the medical service line at a facility of the Department when compared with the same medical service line at different Department facilities; and

(ii) measure quality at a medical service line of a facility of the Department by comparing it with two or more distinct and appropriate quality measures at non-Department medical service lines.

(C)(i) The Secretary may not concurrently furnish hospital care, medical services, or extended care services under subparagraph (A) with respect to more than three medical service lines described in such subparagraph at any one health care facility of the Department.

(ii) The Secretary may not concurrently furnish hospital care, medical services, or extended care services under subparagraph (A) with respect to more than 36 medical service lines nationally described in such subparagraph.

(2) The Secretary may limit the types of hospital care, medical services, or extended care services covered veterans may receive under paragraph (1) in terms of the length of time such care and services will be available, the location at which such care and serv-

ices will be available, and the clinical care and services that will be available.

(3)(A) Except as provided for in subparagraph (B), the hospital care, medical services, and extended care services authorized under paragraph (1) with respect to a medical service line shall cease when the remediation described in section 1706A with respect to such medical service line is complete.

(B) The Secretary shall ensure continuity and coordination of care for any veteran who elects to receive care or services under paragraph (1) from a health care provider specified in subsection (c) through the completion of an episode of care.

(4) The Secretary shall publish in the Federal Register, and shall take all reasonable steps to provide direct notice to covered veterans affected under this subsection, at least once each year stating the time period during which such care and services will be available, the location or locations where such care and services will be available, and the clinical services available at each location under this subsection in accordance with regulations the Secretary shall prescribe.

(5) When the Secretary exercises the authority under paragraph (1), the decision to receive care or services under such paragraph from a health care provider specified in subsection (c) shall be at the election of the covered veteran.

(f) REVIEW OF DECISIONS.—The review of any decision under subsection (d) or (e) shall be subject to the Department's clinical appeals process, and such decisions may not be appealed to the Board of Veterans' Appeals.

(g) TIERED NETWORK.—(1) To promote the provision of high-quality and high-value hospital care, medical services, and extended care services under this section, the Secretary may develop a tiered provider network of eligible providers based on criteria established by the Secretary for purposes of this section.

(2) In developing a tiered provider network of eligible providers under paragraph (1), the Secretary shall not prioritize providers in a tier over providers in any other tier in a manner that limits the choice of a covered veteran in selecting a health care provider specified in subsection (c) for receipt of hospital care, medical services, or extended care services under this section.

(h) CONTRACTS TO ESTABLISH NETWORKS OF HEALTH CARE PROVIDERS.—(1) The Secretary shall enter into consolidated, competitively bid contracts to establish networks of health care providers specified in paragraphs (1) and (5) of subsection (c) for purposes of providing sufficient access to hospital care, medical services, or extended care services under this section.

(2)(A) The Secretary shall, to the extent practicable, ensure that covered veterans are able to make their own appointments using advanced technology.

(B) To the extent practicable, the Secretary shall be responsible for the scheduling of appointments for hospital care, medical services, and extended care services under this section.

(3)(A) The Secretary may terminate a contract with an entity entered into under paragraph (1) at such time and upon such notice to the entity as the Secretary may specify for purposes of this section, if the Secretary notifies the appropriate committees of Congress that, at a minimum—

(i) the entity—

(I) failed to comply substantially with the provisions of the contract or with the provisions of this section and the regulations prescribed under this section;

(II) failed to comply with the access standards or the standards for quality established by the Secretary;

(III) is 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);

(IV) is identified as an excluded source on the list maintained in the System for Award Management, or any successor system; or

(V) has been convicted of a felony or other serious offense under Federal or State law and the continued participation of the entity would be detrimental to the best interests of veterans or the Department;

(ii) it is reasonable to terminate the contract based on the health care needs of veterans; or

(iii) it is reasonable to terminate the contract based on coverage provided by contracts or sharing agreements entered into under authorities other than this section.

(B) Nothing in subparagraph (A) may be construed to restrict the authority of the Secretary to terminate a contract entered into under paragraph (1) under any other provision of law.

(4) Whenever the Secretary provides notice to an entity that the entity is failing to meet contractual obligations entered into under paragraph (1), 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 such failure. Such report shall include the following:

(A) An explanation of the reasons for providing such notice.

(B) A description of the effect of such failure, including with respect to cost, schedule, and requirements.

(C) A description of the actions taken by the Secretary to mitigate such failure.

(D) A description of the actions taken by the contractor to address such failure.

(E) A description of any effect on the community provider market for veterans in the affected area.

(5)(A) The Secretary shall instruct each entity awarded a contract under paragraph (1) to recognize and accept, on an interim basis, the credentials and qualifications of health care providers who are authorized to furnish hospital care and medical services to veterans under a community care program of the Department in effect as of the day before the date of the enactment of the Caring for Our Veterans Act of 2018, including under the Patient-Centered Community Care Program and the Veterans Choice Program under section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note), as qualified providers under the program established under this section.

(B) The interim acceptance period under subparagraph (A) shall be determined by the Secretary based on the following criteria:

(i) With respect to a health care provider, when the current certification agreement for the health care provider expires.

(ii) Whether the Department has enacted certification and eligibility criteria and regulatory procedures by which non-Department providers will be authorized under this section.

(6) The Secretary shall establish a system or systems for monitoring the quality of care provided to covered veterans through a network under this subsection and for assessing the quality of hospital care, medical services, and extended care services furnished through such network before the renewal of the contract for such network.

(i) PAYMENT RATES FOR CARE AND SERVICES.—(1) Except as provided in paragraph (2), and to the extent practicable, the rate paid for hospital care, medical services, or extended care services under any provision in this title may not exceed the rate 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 XI or title XVIII of the Social Security Act (42 U.S.C. 1301 et seq.), including section 1834 of such Act (42 U.S.C. 1395m), for the same care or services.

(2)(A) A higher rate than the rate paid by the United States as described in paragraph (1) may be negotiated with respect to the furnishing of care or services to a covered veteran who resides in a highly rural area.

(B) In this paragraph, 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.

(3) With respect to furnishing care or services under this section in Alaska, the Alaska Fee Schedule of the Department of Veterans Affairs shall be followed, except for when another payment agreement, including a contract or provider agreement, is in effect.

(4) With respect to furnishing hospital care, medical services, or extended care services under this section in a State with an All-Payer Model Agreement under section 1814(b)(3) of the Social Security Act (42 U.S.C. 1395f(b)(3)) that became effective on or after January 1, 2014, the Medicare payment rates under paragraph (2)(A) shall be calculated based on the payment rates under such agreement.

(5) Notwithstanding paragraph (1), the Secretary may incorporate, to the extent practicable, the use of value-based reimbursement models to promote the provision of high-quality care.

(6) With respect to hospital care, medical services, or extended care services for which there is not a rate paid under the Medicare program as described in paragraph (1), the rate paid for such care or services shall be determined by the Secretary.

(j) TREATMENT OF OTHER HEALTH PLAN CONTRACTS.—In any case in which a covered veteran is furnished hospital care, medical services, or extended care 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 1729 in accordance with such section.

(k) PAYMENT BY VETERAN.—A covered veteran shall not pay a greater amount for receiving care or services under this section than

the amount the veteran would pay for receiving the same or comparable care or services at a medical facility of the Department or from a health care provider of the Department.

(l) TRANSPLANT AUTHORITY FOR IMPROVED ACCESS.—(1) In the case of a covered veteran described in paragraph (2), the Secretary shall determine whether to authorize an organ or bone marrow transplant for that covered veteran at a non-Department facility.

(2) A covered veteran described in this paragraph—

(A) requires an organ or bone marrow transplant; and

(B) 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.

(m) MONITORING OF CARE PROVIDED.—(1)(A) Not later than 540 days after the date of the enactment of the Caring for Our Veterans Act of 2018, and not less frequently than annually thereafter, the Secretary shall submit to appropriate committees of Congress a review of the types and frequency of care sought under subsection (d).

(B) The review submitted under subparagraph (A) shall include an assessment of the following:

(i) The top 25 percent of types of care and services most frequently provided under subsection (d) due to the Department not offering such care and services.

(ii) The frequency such care and services were sought by covered veterans under this section.

(iii) An analysis of the reasons the Department was unable to provide such care and services.

(iv) Any steps the Department took to provide such care and services at a medical facility of the Department.

(v) The cost of such care and services.

(2) In monitoring the hospital care, medical services, and extended care services furnished under this section, the Secretary shall do the following:

(A) With respect to hospital care, medical services, and extended care services furnished through provider networks established under subsection (i)—

(i) compile data on the types of hospital care, medical services, and extended care services furnished through such networks and how many patients used each type of care and service;

(ii) identify gaps in hospital care, medical services, or extended care services furnished through such networks;

(iii) identify how such gaps may be fixed through new contracts within such networks or changes in the manner in which hospital care, medical services, or extended care services are furnished through such networks;

(iv) assess the total amounts spent by the Department on hospital care, medical services, and extended care services furnished through such networks;

(v) assess the timeliness of the Department in referring hospital care, medical services, and extended care services to such networks; and

(vi) assess the timeliness of such networks in—

(I) accepting referrals; and

(II) scheduling and completing appointments.

(B) Report the number of medical service lines the Secretary has determined under subsection (e)(1) not to be providing hospital care, medical services, or extended care services that comply with the standards for quality established by the Secretary.

(C) Assess the use of academic affiliates and centers of excellence of the Department to furnish hospital care, medical services, and extended care services to covered veterans under this section.

(D) Assess the hospital care, medical services, and extended care services furnished to covered veterans under this section by medical facilities operated by Federal agencies other than the Department.

(3) Not later than 540 days after the date of the enactment of the Caring for Our Veterans Act of 2018 and not less frequently than once each year thereafter, 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 information gathered under paragraph (2).

(n) PROHIBITION ON CERTAIN LIMITATIONS.—(1) The Secretary shall not limit the types of hospital care, medical services, or extended care services covered veterans may receive under this section if it is in the best medical interest of the veteran to receive such hospital care, medical services, or extended care services, as determined by the veteran and the veteran's health care provider.

(2) No provision in this section may be construed to alter or modify any other provision of law establishing specific eligibility criteria for certain hospital care, medical services, or extended care services.

(o) DEFINITIONS.—In this section:

(1) The term "appropriate committees of Congress" means—

(A) the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate; and

(B) the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives.

(2) The term "medical service line" means a clinic within a Department medical center.

§ 1703A. Agreements with eligible entities or providers; certification processes

(a) AGREEMENTS AUTHORIZED.—(1)(A) When hospital care, a medical service, or an extended care service required by a veteran who is entitled to such care or service under this chapter is not feasibly available to the veteran from a facility of the Department or through a contract or sharing agreement entered into pursuant to another provision of law, the Secretary may furnish such care or service to such veteran through an agreement under this section with an eligible entity or provider to provide such hospital care, medical service, or extended care service.

(B) An agreement entered into under this section to provide hospital care, a medical service, or an extended care service shall be known as a "Veterans Care Agreement".

(C) For purposes of subparagraph (A), hospital care, a medical service, or an extended care service may be considered not feasibly available to a veteran from a facility of the Department or through

a contract or sharing agreement described in such subparagraph when the Secretary determines the veteran's medical condition, the travel involved, the nature of the care or services required, or a combination of these factors make the use of a facility of the Department or a contract or sharing agreement described in such subparagraph impracticable or inadvisable.

(D) A Veterans Care Agreement may be entered into by the Secretary or any Department official authorized by the Secretary.

(2)(A) Subject to subparagraph (B), the Secretary shall review each Veterans Care Agreement of material size, as determined by the Secretary or set forth in paragraph (3), for hospital care, a medical service, or an extended care service to determine whether it is feasible and advisable to provide such care or service within a facility of the Department or by contract or sharing agreement entered into pursuant to another provision of law and, if so, take action to do so.

(B)(i) The Secretary shall review each Veterans Care Agreement of material size that has been in effect for at least six months within the first two years of its taking effect, and not less frequently than once every four years thereafter.

(ii) If a Veterans Care Agreement has not been in effect for at least six months by the date of the review required by subparagraph (A), the agreement shall be reviewed during the next cycle required by subparagraph (A), and such review shall serve as its review within the first two years of its taking effect for purposes of clause (i).

(3)(A) In fiscal year 2019 and in each fiscal year thereafter, in addition to such other Veterans Care Agreements as the Secretary may determine are of material size, a Veterans Care Agreement for the purchase of extended care services that exceeds $5,000,000 annually shall be considered of material size.

(B) From time to time, the Secretary may publish a notice in the Federal Register to adjust the dollar amount specified in subparagraph (A) to account for changes in the cost of health care based upon recognized health care market surveys and other available data.

(b) ELIGIBLE ENTITIES AND PROVIDERS.—For purposes of this section, an eligible entity or provider is—

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

(2) any provider participating under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.);

(3) 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));

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

(5) any entity or provider not described in paragraph (1) or (2) of this subsection that the Secretary determines to be eligible pursuant to the certification process described in subsection (c).

(c) ELIGIBLE ENTITY OR PROVIDER CERTIFICATION PROCESS.—The Secretary shall establish by regulation a process for the certification of eligible entities or providers or recertification of eligible entities

or providers under this section. Such a process shall, at a minimum—

(1) establish deadlines for actions on applications for certification;

(2) set forth standards for an approval or denial of certification, duration of certification, revocation of an eligible entity or provider's certification, and recertification of eligible entities or providers;

(3) require the denial of certification if the Secretary determines the eligible entity or provider is excluded from participation in a Federal health care program under section 1128 or section 1128A of the Social Security Act (42 U.S.C. 1320a–7 or 1320a–7a) or is currently identified as an excluded source on the System for Award Management Exclusions list described in part 9 of title 48, Code of Federal Regulations, and part 180 of title 2 of such Code, or successor regulations;

(4) establish procedures for screening eligible entities or providers according to the risk of fraud, waste, and abuse that are similar to the standards under section 1866(j)(2)(B) of the Social Security Act (42 U.S.C. 1395cc(j)(2)(B)) and section 9.104 of title 48, Code of Federal Regulations, or successor regulations; and

(5) incorporate and apply the restrictions and penalties set forth in chapter 21 of title 41 and treat this section as a procurement program only for purposes of applying such provisions.

(d) RATES.—To the extent practicable, the rates paid by the Secretary for hospital care, medical services, and extended care services provided under a Veterans Care Agreement shall be in accordance with the rates paid by the United States under section 1703(i) of this title.

(e) TERMS OF VETERANS CARE AGREEMENTS.—(1) Pursuant to regulations promulgated under subsection (k), the Secretary may define the requirements for providers and entities entering into agreements under this section based upon such factors as the number of patients receiving care or services, the number of employees employed by the entity or provider furnishing such care or services, the amount paid by the Secretary to the provider or entity, or other factors as determined by the Secretary.

(2) To furnish hospital care, medical services, or extended care services under this section, an eligible entity or provider shall agree—

(A) to accept payment at the rates established in regulations prescribed under this section;

(B) that payment by the Secretary under this section on behalf of a veteran to a provider of services or care shall, unless rejected and refunded by the provider within 30 days of receipt, constitute payment in full and extinguish any liability on the part of the veteran for the treatment or care provided, and no provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate this requirement;

(C) to provide only the care and services authorized by the Department under this section and to obtain the prior written consent of the Department to furnish care or services outside the scope of such authorization;

(D) to bill the Department in accordance with the methodology outlined in regulations prescribed under this section;

(E) to not seek to recover or collect from a health plan contract or third party, as those terms are defined in section 1729 of this title, for any care or service that is furnished or paid for by the Department;

(F) to provide medical records to the Department in the time frame and format specified by the Department; and

(G) to meet such other terms and conditions, including quality of care assurance standards, as the Secretary may specify in regulation.

(f) DISCONTINUATION OR NONRENEWAL OF A VETERANS CARE AGREEMENT.—(1) An eligible entity or provider may discontinue a Veterans Care Agreement at such time and upon such notice to the Secretary as may be provided in regulations prescribed under this section.

(2) The Secretary may discontinue a Veterans Care Agreement with an eligible entity or provider at such time and upon such reasonable notice to the eligible entity or provider as may be specified in regulations prescribed under this section, if an official designated by the Secretary—

(A) has determined that the eligible entity or provider failed to comply substantially with the provisions of the Veterans Care Agreement, or with the provisions of this section or regulations prescribed under this section;

(B) has determined the eligible entity or provider is excluded from participation in a Federal health care program under section 1128 or section 1128A of the Social Security Act (42 U.S.C. 1320a–7 or 1320a–7a) or is identified on the System for Award Management Exclusions list as provided in part 9 of title 48, Code of Federal Regulations, and part 180 of title 2 of such Code, or successor regulations;

(C) has ascertained that the eligible entity or provider has been convicted of a felony or other serious offense under Federal or State law and determines the eligible entity or provider's continued participation would be detrimental to the best interests of veterans or the Department; or

(D) has determined that it is reasonable to terminate the agreement based on the health care needs of a veteran.

(g) QUALITY OF CARE.—The Secretary shall establish a system or systems for monitoring the quality of care provided to veterans through Veterans Care Agreements and for assessing the quality of hospital care, medical services, and extended care services furnished by eligible entities and providers before the renewal of Veterans Care Agreements.

(h) DISPUTES.—(1) The Secretary shall promulgate administrative procedures for eligible entities and providers to present all disputes arising under or related to Veterans Care Agreements.

(2) Such procedures constitute the eligible entities' and providers' exhaustive and exclusive administrative remedies.

(3) Eligible entities or providers must first exhaust such administrative procedures before seeking any judicial review under section 1346 of title 28 (known as the "Tucker Act").

(4) Disputes under this section must pertain to either the scope of authorization under the Veterans Care Agreement or claims for pay-

ment subject to the Veterans Care Agreement and are not claims for the purposes of such laws that would otherwise require application of sections 7101 through 7109 of title 41, United States Code.

(i) APPLICABILITY OF OTHER PROVISIONS OF LAW.—(1) A Veterans Care Agreement may be authorized by the Secretary or any Department official authorized by the Secretary, and such action shall not be treated as—

(A) an award for the purposes of such laws that would otherwise require the use of competitive procedures for the furnishing of care and services; or

(B) a Federal contract for the acquisition of goods or services for purposes of any provision of Federal law governing Federal contracts for the acquisition of goods or services except section 4706(d) of title 41.

(2)(A) Except as provided in the agreement itself, in subparagraph (B), and unless otherwise provided in this section or regulations prescribed pursuant to this section, an eligible entity or provider 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 under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) are not subject.

(B) An eligible entity or provider that enters into an agreement under this section is subject to—

(i) all laws regarding integrity, ethics, or fraud, or that subject a person to civil or criminal penalties; and

(ii) all laws that protect against employment discrimination or that otherwise ensure equal employment opportunities.

(3) Notwithstanding paragraph (2)(B)(i), an eligible entity or provider that enters into an agreement under this section shall not be treated as a Federal contractor or subcontractor for purposes of chapter 67 of title 41 (commonly known as the "McNamara-O'Hara Service Contract Act of 1965").

(j) PARITY OF TREATMENT.—Eligibility for hospital care, medical services, and extended care services furnished to any veteran pursuant to a Veterans Care Agreement shall be subject to the same terms as though provided in a facility of the Department, and provisions of this chapter applicable to veterans receiving such care and services in a facility of the Department shall apply to veterans treated under this section.

(k) RULEMAKING.—The Secretary shall promulgate regulations to carry out this section.

§ 1703B. Access standards

(a)(1) The Secretary shall establish access standards for furnishing hospital care, medical services, or extended care services to covered veterans for the purposes of section 1703(d).

(2) The Secretary shall ensure that the access standards established under paragraph (1) define such categories of care to cover all care and services within the medical benefits package of the Department of Veterans Affairs.

(b) The Secretary shall ensure that the access standards provide covered veterans, employees of the Department, and health care providers in the network established under section 1703(h) with relevant comparative information that is clear, useful, and timely, so

that covered veterans can make informed decisions regarding their health care.

(c) The Secretary shall consult with all pertinent Federal entities (including the Department of Defense, the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services), entities in the private sector, and other nongovernmental entities in establishing access standards.

(d)(1) Not later than 270 days after the date of the enactment of the Caring for Our Veterans Act of 2018, the Secretary shall submit to the appropriate committees of Congress a report detailing the access standards.

(2)(A) Before submitting the report required under paragraph (1), the Secretary shall provide periodic updates to the appropriate committees of Congress to confirm the Department's progress towards developing the access standards required by this section.

(B) The first update under subparagraph (A) shall occur no later than 120 days from the date of the enactment of the Caring for Our Veterans Act of 2018.

(3) Not later than 540 days after the date on which the Secretary implements the access standards established under subsection (a), the Secretary shall submit to the appropriate committees of Congress a report detailing the implementation of and compliance with such access standards by Department and non-Department entities or providers.

(e) Not later than three years after the date on which the Secretary establishes access standards under subsection (a) and not less frequently than once every three years thereafter, the Secretary shall—

(1) conduct a review of such standards; and

(2) submit to the appropriate committees of Congress a report on the findings and any modification to the access standards with respect to the review conducted under paragraph (1).

(f) The Secretary shall ensure health care providers specified under section 1703(c) are able to comply with the applicable access standards established by the Secretary.

(g) The Secretary shall publish in the Federal Register and on an internet website of the Department the designated access standards established under this section for purposes of section 1703(d)(1)(D).

(h)(1) Consistent with paragraphs (1)(D) and (3) of section 1703(d), covered veterans may contact the Department at any time to request a determination regarding whether they are eligible to receive care and services from a non-Department entity or provider based on the Department being unable to furnish such care and services in a manner that complies with the designated access standards established under this section.

(2) The Secretary shall establish a process to review such requests from covered veterans to determine whether—

(A) the requested care is clinically necessary; and

(B) the Department is able to provide such care in a manner that complies with designated access standards established under this section.

(3) The Secretary shall promptly respond to any such request by a covered veteran.

(i)(1) The term "appropriate committees of Congress" means—

(A) the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate; and

(B) the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives.

(2) The term "covered veterans" refers to veterans described in section 1703(b) of this title.

§ 1703C. Standards for quality

(a) IN GENERAL.—(1) The Secretary shall establish standards for quality regarding hospital care, medical services, and extended care services furnished by the Department pursuant to this title, including through non-Department health care providers pursuant to section 1703 of this title.

(2) In establishing standards for quality under paragraph (1), the Secretary shall consider existing health quality measures that are applied to public and privately sponsored health care systems with the purpose of providing covered veterans relevant comparative information to make informed decisions regarding their health care.

(3) The Secretary shall collect and consider data for purposes of establishing the standards under paragraph (1). Such data collection shall include—

(A) after consultation with veterans service organizations and other key stakeholders on survey development or modification of an existing survey, a survey of veterans who have used hospital care, medical services, or extended care services furnished by the Veterans Health Administration during the most recent two-year period to assess the satisfaction of the veterans with service and quality of care; and

(B) datasets that include, at a minimum, elements relating to the following:

(i) Timely care.

(ii) Effective care.

(iii) Safety, including, at a minimum, complications, readmissions, and deaths.

(iv) Efficiency.

(4) The Secretary shall consult with all pertinent Federal entities (including the Department of Defense, the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services), entities in the private sector, and other nongovernmental entities in establishing standards for quality.

(5)(A) Not later than 270 days after the date of the enactment of the Caring for Our Veterans Act of 2018, the Secretary shall submit to the appropriate committees of Congress a report detailing the standards for quality.

(B)(i) Before submitting the report required under subparagraph (A), the Secretary shall provide periodic updates to the appropriate committees of Congress to confirm the Department's progress towards developing the standards for quality required by this section.

(ii) The first update under clause (i) shall occur no later than 120 days from the date of the enactment of the Caring for Our Veterans Act of 2018.

(b) PUBLICATION AND CONSIDERATION OF PUBLIC COMMENTS.—(1) Not later than one year after the date on which the Secretary establishes standards for quality under subsection (a), the Secretary shall publish the quality rating of medical facilities of the Department in

the publicly available Hospital Compare website through the Centers for Medicare & Medicaid Services for the purpose of providing veterans with information that allows them to compare performance measure information among Department and non-Department health care providers.

(2) Not later than two years after the date on which the Secretary establishes standards for quality under subsection (a), the Secretary shall consider and solicit public comment on potential changes to the measures used in such standards to ensure that they include the most up-to-date and applicable industry measures for veterans.

(c)(1) The term "appropriate committees of Congress" means—

(A) the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate; and

(B) the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives.

(2) The term "covered veterans" refers to veterans described in section 1703(b) of this title.

§ 1703D. Prompt payment standard

(a) IN GENERAL.—(1) Notwithstanding any other provision of this title or of any other provision of law, the Secretary shall pay for hospital care, medical services, or extended care services furnished by health care entities or providers under this chapter within 45 calendar days upon receipt of a clean paper claim or 30 calendar days upon receipt of a clean electronic claim.

(2) If a claim is denied, the Secretary shall, within 45 calendar days of denial for a paper claim and 30 calendar days of denial for an electronic claim, notify the health care entity or provider of the reason for denying the claim and what, if any, additional information is required to process the claim.

(3) Upon the receipt of the additional information, the Secretary shall ensure that the claim is paid, denied, or otherwise adjudicated within 30 calendar days from the receipt of the requested information.

(4) This section shall only apply to payments made on an invoice basis and shall not apply to capitation or other forms of periodic payment to entities or providers.

(b) SUBMITTAL OF CLAIMS BY HEALTH CARE ENTITIES AND PROVIDERS.—A health care entity or provider that furnishes hospital care, a medical service, or an extended care service under this chapter shall submit to the Secretary a claim for payment for furnishing the hospital care, medical service, or extended care service not later than 180 days after the date on which the entity or provider furnished the hospital care, medical service, or extended care service.

(c) FRAUDULENT CLAIMS.—(1) Sections 3729 through 3733 of title 31 shall apply to fraudulent claims for payment submitted to the Secretary by a health care entity or provider under this chapter.

(2) Pursuant to regulations prescribed by the Secretary, the Secretary shall bar a health care entity or provider from furnishing hospital care, medical services, and extended care services under this chapter when the Secretary determines the entity or provider has submitted to the Secretary fraudulent health care claims for payment by the Secretary.

(d) OVERDUE CLAIMS.—(1) Any claim that has not been denied with notice, made pending with notice, or paid to the health care

entity or provider by the Secretary shall be overdue if the notice or payment is not received by the entity provider within the time periods specified in subsection (a).

(2)(A) If a claim is overdue under this subsection, the Secretary may, under the requirements established by subsection (a) and consistent with the provisions of chapter 39 of title 31 (commonly referred to as the "Prompt Payment Act"), require that interest be paid on clean claims.

(B) Interest paid under subparagraph (A) shall be computed at the rate of interest established by the Secretary of the Treasury under section 3902 of title 31 and published in the Federal Register.

(3) Not less frequently than annually, the Secretary shall submit to Congress a report on payment of overdue claims under this subsection, disaggregated by paper and electronic claims, that includes the following:

(A) The amount paid in overdue claims described in this subsection, disaggregated by the amount of the overdue claim and the amount of interest paid on such overdue claim.

(B) The number of such overdue claims and the average number of days late each claim was paid, disaggregated by facility of the Department and Veterans Integrated Service Network region.

(e) OVERPAYMENT.—(1) The Secretary shall deduct the amount of any overpayment from payments due a health care entity or provider under this chapter.

(2) Deductions may not be made under this subsection unless the Secretary has made reasonable efforts to notify a health care entity or provider of the right to dispute the existence or amount of such indebtedness and the right to request a compromise of such indebtedness.

(3) The Secretary shall make a determination with respect to any such dispute or request prior to deducting any overpayment unless the time required to make such a determination before making any deductions would jeopardize the Secretary's ability to recover the full amount of such indebtedness.

(f) INFORMATION AND DOCUMENTATION REQUIRED.—(1) The Secretary shall provide to all health care entities and providers participating in a program to furnish hospital care, medical services, or extended care services under this chapter a list of information and documentation that is required to establish a clean claim under this section.

(2) The Secretary shall consult with entities in the health care industry, in the public and private sector, to determine the information and documentation to include in the list under paragraph (1).

(3) If the Secretary modifies the information and documentation included in the list under paragraph (1), the Secretary shall notify all health care entities and providers described in paragraph (1) not later than 30 days before such modifications take effect.

(g) PROCESSING OF CLAIMS.—(1) In processing a claim for compensation for hospital care, medical services, or extended care services furnished by a non-Department health care entity or provider under this chapter, the Secretary may act through—

(A) a non-Department entity that is under contract or agreement for the program established under section 1703(a) of this title; or

(B) a non-Department entity that specializes in such processing for other Federal agency health care systems.

(2) The Secretary shall seek to contract with a third party to conduct a review of claims described in paragraph (3) that includes—

(A) a feasibility assessment to determine the capacity of the Department to process such claims in a timely manner; and

(B) a cost benefit analysis comparing the capacity of the Department to a third party entity capable of processing such claims.

(3) The review required under paragraph (2) shall apply to claims for hospital care, medical services, or extended care services furnished under section 1703 of this Act, as amended by the Caring for Our Veterans Act of 2018, that are processed by the Department.

(h) REPORT ON ENCOUNTER DATA SYSTEM.—(1) Not later than 90 days after the date of the enactment of the Caring for Our Veterans Act of 2018, the Secretary shall submit to the appropriate committees of Congress a report on the feasibility and advisability of adopting a funding mechanism similar to what is utilized by other Federal agencies to allow a contracted entity to act as a fiscal intermediary for the Federal Government to distribute, or pass through, Federal Government funds for certain non-underwritten hospital care, medical services, or extended care services.

(2) The Secretary may coordinate with the Department of Defense, the Department of Health and Human Services, and the Department of the Treasury in developing the report required by paragraph (1).

(i) DEFINITIONS.—In this section:

(1) The term "appropriate committees of Congress" means—

(A) the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate; and

(B) the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives.

(2) The term "clean electronic claim" means the transmission of data for purposes of payment of covered health care expenses that is submitted to the Secretary which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the entity or provider that furnished the care or service, submitted in such format as prescribed by the Secretary in regulations for the purpose of paying claims for care or services.

(3) The term "clean paper claim" means a paper claim for payment of covered health care expenses that is submitted to the Secretary which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the entity or provider that furnished the care or service, submitted in such format as prescribed by the Secretary in regulations for the purpose of paying claims for care or services.

(4) The term "fraudulent claims" means the knowing misrepresentation of a material fact or facts by a health care entity or provider made to induce the Secretary to pay a claim that was not legally payable to that provider.

(5) The term "health care entity or provider" includes any non-Department health care entity or provider, but does not include any Federal health care entity or provider.

§ 1703E. 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 addresses 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 (including family members and other caregivers of such individual) at the center of the care team 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. To the extent practicable, the Secretary shall ensure that the pilot programs are located in geographically diverse areas of the United States.

(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 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, a report 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 Secretary may not carry out more than 10 pilot programs concurrently.

(2)(A) Subject to subparagraph (B), the Secretary may not expend more than $50,000,000 in any fiscal year from amounts under subsection (d).

(B) The Secretary may expend more than the amount in subparagraph (A) if—

(i) the Secretary determines that the additional expenditure is necessary to carry out pilot programs under this section;

(ii) the Secretary submits to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report setting forth the amount of the additional expenditure and a justification for the additional expenditure; and

(iii) the Chairmen of the Committees on Veterans' Affairs of the Senate and the House of Representatives transmit to the Secretary a letter approving of the additional expenditure.

(3) 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 Caring for Our Veterans Act of 2018.

(4) 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.

(5)(A) If the Secretary determines that a 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) 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 a pilot program under subparagraph (A)(ii), for purposes of subparagraphs (F) and (G) of subsection (f)(2), 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 ADVICE.—(1) The Secretary shall obtain advice from 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.

* * * * * * *

§ 1706A. Remediation of medical service lines

(a) IN GENERAL.—Not later than 30 days after determining under section 1703(e)(1) that a medical service line of the Department is providing hospital care, medical services, or extended care services

that does not comply with the standards for quality established by the Secretary, the Secretary shall submit to Congress an assessment of the factors that led the Secretary to make such determination and a plan with specific actions, and the time to complete them, to be taken to comply with such standards for quality, including the following:

(1) Increasing personnel or temporary personnel assistance, including mobile deployment teams.

(2) Special hiring incentives, including the Education Debt Reduction Program under subchapter VII of chapter 76 of this title and recruitment, relocation, and retention incentives.

(3) Utilizing direct hiring authority.

(4) Providing improved training opportunities for staff.

(5) Acquiring improved equipment.

(6) Making structural modifications to the facility used by the medical service line.

(7) Such other actions as the Secretary considers appropriate.

(b) RESPONSIBLE PARTIES.—In each assessment submitted under subsection (a) with respect to a medical service line, the Secretary shall identify the individuals at the Central Office of the Veterans Health Administration, the facility used by the medical service line, and the central office of the relevant Veterans Integrated Service Network who are responsible for overseeing the progress of that medical service line in complying with the standards for quality established by the Secretary.

(c) INTERIM REPORTS.—Not later than 180 days after submitting an assessment under subsection (a) with respect to a medical service line, the Secretary shall submit to Congress a report on the progress of that medical service line in complying with the standards for quality established by the Secretary and any other measures the Secretary will take to assist the medical service line in complying with such standards for quality.

(d) ANNUAL REPORTS.—Not less frequently than once each year, the Secretary shall—

(1) submit to Congress an analysis of the remediation actions and costs of such actions taken with respect to each medical service line with respect to which the Secretary submitted an assessment and plan under paragraph (1) in the preceding year, including an update on the progress of each such medical service line in complying with the standards for quality and timeliness established by the Secretary and any other actions the Secretary is undertaking to assist the medical service line in complying with standards for quality as established by the Secretary; and

(2) publish such analysis on the internet website of the Department.

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

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§ 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 services, 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] *or entered an agreement* 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] 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 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 causalities 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 *or agreements* with private facilities that is available to the Secretary ⟦(under sections 1703(a)(2) and 1710(a)(1)(B) of this title)⟧ 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 contract 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.

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§ 1720G. Assistance and support services for caregivers

(a) PROGRAM OF COMPREHENSIVE ASSISTANCE FOR FAMILY CAREGIVERS.—(1)(A) The Secretary shall establish a program of comprehensive assistance for family caregivers of eligible veterans.

(B) The Secretary shall only provide support under the program required by subparagraph (A) to a family caregiver of an eligible veteran if the Secretary determines it is in the best interest of the eligible veteran to do so.

(2) For purposes of this subsection, an eligible veteran is any individual who—

(A) is a veteran or member of the Armed Forces undergoing medical discharge from the Armed Forces;

[(B) has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001; and**]**

(B) for assistance provided under this subsection—

(i) before the date on which the Secretary submits to Congress a certification that the Department has fully implemented the information technology system required by section 162(a) of the Caring for Our Veterans Act of 2018, has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001;

(ii) during the two-year period beginning on the date on which the Secretary submitted to Congress the certification described in clause (i), has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service—

(I) on or before May 7, 1975; or

(II) on or after September 11, 2001; or

(iii) after the date that is two years after the date on which the Secretary submits to Congress the certification described in clause (i), has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service; and

(C) is in need of personal care services because of—

(i) an inability to perform one or more activities of daily living;

(ii) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury**[**; or**]***;*

(iii) a need for regular or extensive instruction or supervision without which the ability of the veteran to function in daily life would be seriously impaired; or

[(iii)**]** *(iv)* such other matters as the Secretary considers appropriate.

(3)(A) As part of the program required by paragraph (1), the Secretary shall provide to family caregivers of eligible veterans the following assistance:

(i) To each family caregiver who is approved as a provider of personal care services for an eligible veteran under paragraph (6)—

(I) such instruction, preparation, and training as the Secretary considers appropriate for the family caregiver to provide personal care services to the eligible veteran;

(II) ongoing technical support consisting of information and assistance to address, in a timely manner, the routine, emergency, and specialized caregiving needs of the family caregiver in providing personal care services to the eligible veteran;

(III) counseling; and

(IV) lodging and subsistence under section 111(e) of this title.

(ii) To each family caregiver who is designated as the primary provider of personal care services for an eligible veteran under paragraph (7)—

(I) the assistance described in clause (i);

(II) such mental health services as the Secretary determines appropriate;

(III) respite care of not less than 30 days annually, including 24-hour per day care of the veteran commensurate with the care provided by the family caregiver to permit extended respite;

(IV) medical care under section 1781 of this title**[**; and**]***;*

(V) a monthly personal caregiver stipend**[**.**]***; and*

(VI) through the use of contracts with, or the provision of grants to, public or private entities—

(aa) financial planning services relating to the needs of injured veterans and their caregivers; and

(bb) legal services, including legal advice and consultation, relating to the needs of injured veterans and their caregivers.

(B) Respite care provided under subparagraph (A)(ii)(III) shall be medically and age-appropriate and include in-home care.

(C)(i) The amount of the monthly personal caregiver stipend provided under subparagraph (A)(ii)(V) shall be determined in accordance with a schedule established by the Secretary that specifies stipends based upon the amount and degree of personal care services provided.

(ii) The Secretary shall ensure, to the extent practicable, that the schedule required by clause (i) specifies that the amount of the monthly personal caregiver stipend provided to a primary provider of personal care services for the provision of personal care services to an eligible veteran is not less than the monthly amount a commercial home health care entity would pay an individual in the geographic area of the eligible veteran to provide equivalent personal care services to the eligible veteran.

(iii) In determining the amount and degree of personal care services provided under clause (i) with respect to an eligible veteran whose need for personal care services is based in whole or in part on a need for supervision or protection under paragraph (2)(C)(ii) or regular instruction or supervision under paragraph (2)(C)(iii), the Secretary shall take into account the following:

(I) The assessment by the family caregiver of the needs and limitations of the veteran.

(II) The extent to which the veteran can function safely and independently in the absence of such supervision, protection, or instruction.

(III) The amount of time required for the family caregiver to provide such supervision, protection, or instruction to the veteran.

[(iii)**]** *(iv)* If personal care services are not available from a commercial home health entity in the geographic area of an eligible veteran, the amount of the monthly personal caregiver stipend payable under the schedule required by clause (i) with respect to the eligible veteran shall be determined by taking into consideration the costs of commercial providers of personal care services in providing personal care services in geographic areas other than the geographic area of the eligible veteran with similar costs of living.

(D) In providing instruction, preparation, and training under subparagraph (A)(i)(I) and technical support under subparagraph (A)(i)(II) to each family caregiver who is approved as a provider of personal care services for an eligible veteran under paragraph (6), the Secretary shall periodically evaluate the needs of the eligible veteran and the skills of the family caregiver of such veteran to determine if additional instruction, preparation, training, or technical support under those subparagraphs is necessary.

(4) An eligible veteran and a family member of the eligible veteran seeking to participate in the program required by paragraph (1) shall jointly submit to the Secretary an application therefor in such form and in such manner as the Secretary considers appropriate.

(5) For each application submitted jointly by an eligible veteran and family member, the Secretary shall evaluate *(in collaboration with the primary care team for the eligible veteran to the maximum extent practicable)*—

(A) the eligible veteran—

(i) to identify the personal care services required by the eligible veteran; and

(ii) to determine whether such requirements could be significantly or substantially satisfied through the provision of personal care services from a family member; and

(B) the family member to determine the amount of instruction, preparation, and training, if any, the family member requires to provide the personal care services required by the eligible veteran—

(i) as a provider of personal care services for the eligible veteran; and

(ii) as the primary provider of personal care services for the eligible veteran.

(6)(A) The Secretary shall provide each family member of an eligible veteran who makes a joint application under paragraph (4) the instruction, preparation, and training determined to be required by such family member under paragraph (5)(B).

(B) Upon the successful completion by a family member of an eligible veteran of instruction, preparation, and training under subparagraph (A), the Secretary shall approve the family member as a provider of personal care services for the eligible veteran.

(C) The Secretary shall, subject to regulations the Secretary shall prescribe, provide for necessary travel, lodging, and per diem expenses incurred by a family member of an eligible veteran in undergoing instruction, preparation, and training under subparagraph (A).

(D) If the participation of a family member of an eligible veteran in instruction, preparation, and training under subparagraph (A) would interfere with the provision of personal care services to the eligible veteran, the Secretary shall, subject to regulations as the Secretary shall prescribe and in consultation with the veteran, provide respite care to the eligible veteran during the provision of such instruction, preparation, and training to the family member so that the family member can participate in such instruction, preparation, and training without interfering with the provision of such services to the eligible veteran.

(7)(A) For each eligible veteran with at least one family member who is described by subparagraph (B), the Secretary shall designate one family member of such eligible veteran as the primary provider of personal care services for such eligible veteran.

(B) A primary provider of personal care services designated for an eligible veteran under subparagraph (A) shall be selected from among family members of the eligible veteran who—

(i) are approved under paragraph (6) as a provider of personal care services for the eligible veteran;

(ii) elect to provide the personal care services to the eligible veteran that the Secretary determines the eligible veteran requires under paragraph (5)(A)(i);

(iii) have the consent of the eligible veteran to be the primary provider of personal care services for the eligible veteran; and

(iv) are considered by the Secretary as competent to be the primary provider of personal care services for the eligible veteran.

(C) An eligible veteran receiving personal care services from a family member designated as the primary provider of personal care services for the eligible veteran under subparagraph (A) may, in accordance with procedures the Secretary shall establish for such purposes, revoke consent with respect to such family member under subparagraph (B)(iii).

(D) If a family member designated as the primary provider of personal care services for an eligible veteran under subparagraph (A) subsequently fails to meet any requirement set forth in subparagraph (B), the Secretary—

(i) shall immediately revoke the family member's designation under subparagraph (A); and

(ii) may designate, in consultation with the eligible veteran, a new primary provider of personal care services for the eligible veteran under such subparagraph.

(E) The Secretary shall take such actions as may be necessary to ensure that the revocation of a designation under subparagraph (A) with respect to an eligible veteran does not interfere with the provision of personal care services required by the eligible veteran.

(8) If an eligible veteran lacks the capacity to make a decision under this subsection, the Secretary may, in accordance with regulations and policies of the Department regarding appointment of guardians or the use of powers of attorney, appoint a surrogate for the eligible veteran who may make decisions and take action under this subsection on behalf of the eligible veteran.

(9)(A) The Secretary shall monitor the well-being of each eligible veteran receiving personal care services under the program required by paragraph (1).

(B) The Secretary shall document each finding the Secretary considers pertinent to the appropriate delivery of personal care services to an eligible veteran under the program.

(C) The Secretary shall establish procedures to ensure appropriate follow-up regarding findings described in subparagraph (B). Such procedures may include the following:

(i) Visiting an eligible veteran in the eligible veteran's home to review directly the quality of personal care services provided to the eligible veteran.

(ii) Taking such corrective action with respect to the findings of any review of the quality of personal care services provided an eligible veteran as the Secretary considers appropriate, which may include—

(I) providing additional training to a family caregiver; and

(II) suspending or revoking the approval of a family caregiver under paragraph (6) or the designation of a family caregiver under paragraph (7).

(10) The Secretary shall carry out outreach to inform eligible veterans and family members of eligible veterans of the program required by paragraph (1) and the benefits of participating in the program.

(11)(A) In providing assistance under this subsection to family caregivers of eligible veterans, the Secretary may enter into contracts, provider agreements, and memoranda of understanding with Federal agencies, States, and private, nonprofit, and other entities to provide such assistance to such family caregivers.

(B) The Secretary may provide assistance under this paragraph only if such assistance is reasonably accessible to the family caregiver and is substantially equivalent or better in quality to similar services provided by the Department.

(C) The Secretary may provide fair compensation to Federal agencies, States, and other entities that provide assistance under this paragraph.

(b) PROGRAM OF GENERAL CAREGIVER SUPPORT SERVICES.—(1) The Secretary shall establish a program of support services for caregivers of covered veterans who are enrolled in the health care system established under section 1705(a) of this title (including caregivers who do not reside with such veterans).

(2) For purposes of this subsection, a covered veteran is any individual who needs personal care services because of—

(A) an inability to perform one or more activities of daily living;

(B) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury; or

(C) such other matters as the Secretary shall specify.

(3)(A) The support services furnished to caregivers of covered veterans under the program required by paragraph (1) shall include the following:

(i) Services regarding the administering of personal care services, which, subject to subparagraph (B), shall include—

(I) educational sessions made available both in person and on an Internet website;

(II) use of telehealth and other available technologies; and

(III) teaching techniques, strategies, and skills for caring for a disabled veteran;

(ii) Counseling and other services under section 1782 of this title.

(iii) Respite care under section 1720B of this title that is medically and age appropriate for the veteran (including 24-hour per day in-home care).

(iv) Information concerning the supportive services available to caregivers under this subsection and other public, private, and nonprofit agencies that offer support to caregivers.

(B) If the Secretary certifies to the Committees on Veterans' Affairs of the Senate and the House of Representatives that funding available for a fiscal year is insufficient to fund the provision of services specified in one or more subclauses of subparagraph (A)(i), the Secretary shall not be required under subparagraph (A) to provide the services so specified in the certification during the period beginning on the date that is 180 days after the date the certification is received by the Committees and ending on the last day of the fiscal year.

(4) In providing information under paragraph (3)(A)(iv), the Secretary shall collaborate with the Assistant Secretary for Aging of the Department of Health and Human Services in order to provide caregivers access to aging and disability resource centers under the Administration on Aging of the Department of Health and Human Services.

(5) In carrying out the program required by paragraph (1), the Secretary shall conduct outreach to inform covered veterans and caregivers of covered veterans about the program. The outreach shall include an emphasis on covered veterans and caregivers of covered veterans living in rural areas.

(c) CONSTRUCTION.—(1) A decision by the Secretary under this section affecting the furnishing of assistance or support shall be considered a medical determination.

(2) Nothing in this section shall be construed to create—

(A) an employment relationship between the Secretary and an individual in receipt of assistance or support under this section; or

(B) any entitlement to any assistance or support provided under this section.

(d) DEFINITIONS.—In this section:

(1) The term "caregiver", with respect to an eligible veteran under subsection (a) or a covered veteran under subsection (b), means an individual who provides personal care services to the veteran.

(2) The term "family caregiver", with respect to an eligible veteran under subsection (a), means a family member who is a caregiver of the veteran.

(3) The term "family member", with respect to an eligible veteran under subsection (a), means an individual who—

(A) is a member of the family of the veteran, 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 but is not a member of the family of the veteran.

(4) The term "personal care services", with respect to an eligible veteran under subsection (a) or a covered veteran under subsection (b), means services that provide the veteran the following:

(A) Assistance with one or more [independent] activities of daily living.

(B) Supervision or protection based on symptoms or residuals of neurological or other impairment or injury.

(C) Regular or extensive instruction or supervision without which the ability of the veteran to function in daily life would be seriously impaired.

[(B)] *(D)* Any other non-institutional extended care (as such term is used in section 1701(6)(E) of this title).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out the programs required by subsections (a) and (b)—

(1) $60,000,000 for fiscal year 2010;

(2) $1,542,000,000 for the period of fiscal years 2011 through 2015;

(3) $625,000,000 for fiscal year 2016;

(4) $734,628,000 for fiscal year 2017; and

(5) $839,828,000 for each of fiscal years 2018 and 2019.

* * * * * * *

§ [1712I] *1720I*. Mental and behavioral health care for certain former members of the Armed Forces

(a) IN GENERAL The Secretary shall furnish to former members of the Armed Forces described in subsection (b)—

(1) an initial mental health assessment; and

(2) the mental healthcare or behavioral healthcare services authorized under this chapter that are required to treat the mental or behavioral health care needs of the former service members, including risk of suicide or harming others.

(b) ELIGIBLE INDIVIDUALS A former member of the Armed Forces described in this subsection is an individual who—

(1) is a former member of the Armed Forces, including the reserve components;

(2) while serving in the active military, naval, or air service, was discharged or released therefrom under a condition that is not honorable but not—

(A) a dishonorable discharge; or

(B) a discharge by court-martial;

(3) is not otherwise eligible to enroll in the health care system established by section 1705 of this title; and

(4)(A)(i) served in the Armed Forces for a period of more than 100 cumulative days; and

(ii) was deployed in a theater of combat operations, in support of a contingency operation, or in an area at a time during which hostilities are occurring in that area during such service,

including by controlling an unmanned aerial vehicle from a location other than such theater or area; or

(B) while serving in the Armed Forces, was the victim of a physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment (as defined in section 1720D(f) of this title).

(c) NON-DEPARTMENT CARE(1) In furnishing mental or behavioral health care services to an individual under this section, the Secretary may provide such mental or behavioral health care services at a non- Department facility if—

(A) in the judgment of a mental health professional employed by the Department, the receipt of mental or behavioral health care services by that individual in facilities of the Department would be clinically inadvisable; or

(B) facilities of the Department are not capable of furnishing such mental or behavioral health care services to that individual economically because of geographical inaccessibility.

(2) The Secretary shall carry out paragraph (1) pursuant to section 1703 of this title or any other provision of law authorizing the Secretary to enter into contracts or agreements to furnish hospital care and medical services to veterans at non-Department facilities.

(d) SETTING AND REFERRALS In furnishing mental and behavioral health care services to individuals under this section, the Secretary shall—

(1) seek to ensure that such services are furnished in settings that are therapeutically appropriate, taking into account the circumstances that resulted in the need for such services; and

(2) provide referral services to assist former members who are not eligible for services under this chapter to obtain services from sources outside the Department.

(e) INFORMATION The Secretary shall provide information on the mental and behavioral health care services available under this section. Efforts by the Secretary to provide such information—

(1) shall include notification of each eligible individual described in subsection (b) about the eligibility of the individual for covered mental and behavioral health care under this section not later than the later of—

(A) 180 days after the date of the enactment of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018; or

(B) 180 days after the date on which the individual was discharged or released from the active military, naval, or air service;

(2) shall include availability of a toll-free telephone number (commonly referred to as an 800 number);

(3) shall ensure that information about the mental health care services available under this section—

(A) is revised and updated as appropriate;

(B) is made available and visibly posted at appropriate facilities of the Department; and

(C) is made available to State veteran agencies and through appropriate public information services; and

(4) shall include coordination with the Secretary of Defense seeking to ensure that members of the Armed Forces and indi-

viduals who are being separated from active military, naval, or air service are provided appropriate information about programs, requirements, and procedures for applying for mental health care services under this section.

(f) ANNUAL REPORTS(1) Not less frequently than once each year, 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 mental and behavioral health care services provided under this section.

(2) Each report submitted under paragraph (1) shall include, with respect to the year preceding the submittal of the report, the following:

(A) The number of eligible individuals who were furnished mental or behavioral health care services under this section, disaggregated by the number of men who received such services and the number of women who received such services.

(B) The number of individuals who requested an initial mental health assessment under subsection (a)(1).

(C) Such other information as the Secretary considers appropriate.

* * * * * * *

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

* * * * * * *

§ 1725A. Access to walk-in care

(a) PROCEDURES TO ENSURE ACCESS TO WALK-IN CARE.—The Secretary shall develop procedures to ensure that eligible veterans are able to access walk-in care from qualifying non-Department entities or providers.

(b) ELIGIBLE VETERANS.—For purposes of this section, an eligible veteran is any individual who—

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

(2) has received care under this chapter within the 24-month period preceding the furnishing of walk-in care under this section.

(c) QUALIFYING NON-DEPARTMENT ENTITIES OR PROVIDERS.—For purposes of this section, a qualifying non-Department entity or provider is a non-Department entity or provider that has entered into a contract or other agreement with the Secretary to furnish services under this section.

(d) FEDERALLY-QUALIFIED HEALTH CENTERS.—Whenever practicable, the Secretary may use a 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))) to carry out this section.

(e) CONTINUITY OF CARE.—The Secretary shall ensure continuity of care for those eligible veterans who receive walk-in care services under this section, including through the establishment of a mechanism to receive medical records from walk-in care providers and provide pertinent patient medical records to providers of walk-in care.

(f) COPAYMENTS.—(1)(A) The Secretary may require an eligible veteran to pay the United States a copayment for each episode of hospital care or medical services provided under this section if the eligible veteran would be required to pay a copayment under this title.

(B) An eligible veteran not required to pay a copayment under this title may access walk-in care without a copayment for the first two visits in a calendar year. For any additional visits, a copayment at an amount determined by the Secretary may be required.

(C) An eligible veteran required to pay a copayment under this title may be required to pay a regular copayment for the first two walk-in care visits in a calendar year. For any additional visits, a higher copayment at an amount determined by the Secretary may be required.

(2) After the first two episodes of care furnished to an eligible veteran under this section, the Secretary may adjust the copayment required of the veteran under this subsection based upon the priority group of enrollment of the eligible veteran, the number of episodes of care furnished to the eligible veteran during a year, and other factors the Secretary considers appropriate under this section.

(3) The amount or amounts of the copayments required under this subsection shall be prescribed by the Secretary by rule.

(4) Section 8153(c) of this title shall not apply to this subsection.

(g) REGULATIONS.—Not later than one year after the date of the enactment of the Caring for Our Veterans Act of 2018, the Secretary shall promulgate regulations to carry out this section.

(h) WALK-IN CARE DEFINED.—In this section, the term "walk-in care" means non-emergent care provided by a qualifying non-Department entity or provider that furnishes episodic care and not longitudinal management of conditions and is otherwise defined through regulations the Secretary shall promulgate.

* * * * * * *

§ 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.**]** *(1) Subject to the provisions of this section, in any case in which the United States is required by law to furnish or pay for 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 from a third party the reasonable charges of care or services so furnished or paid for to the extent that the recipient or 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 or paid for 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] *the individual'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] *the individual* 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]

(D) that is incurred by an individual who is entitled to care (or payment of the expenses of care) under a health-plan contract.

(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] *the individual*—

(A) [the veteran's] *the individual'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.

(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] *the individual* (or [the veteran's] *the individual'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] *the individual* (or [the veteran's] *the individual'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] *the individual* by the Secretary under this chapter;

(ii) the United States has sent written notice by certified mail to [the veteran] *the individual* at [the veteran's] *the individual's* last-known address (or to [the veteran's] *the individual'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] *An individual* 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] *an individual* 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] *the individual*; and

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

(2) [A veteran] *An individual* described in this paragraph is [a veteran] *an individual* 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] *the individual*.

(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.

* * * * * * *

§ 1730B. Access to State prescription drug monitoring programs

(a) ACCESS TO PROGRAMS.—(1) Any licensed health care provider or delegate of such a provider shall be considered an authorized recipient or user for the purpose of querying and receiving data from the national network of State-based prescription drug monitoring programs to support the safe and effective prescribing of controlled substances to covered patients.

(2) Under the authority granted by paragraph (1)—

(A) licensed health care providers or delegates of such providers shall query such network in accordance with applicable regulations and policies of the Veterans Health Administration; and

(B) notwithstanding any general or specific provision of law, rule, or regulation of a State, no State may restrict the access

of licensed health care providers or delegates of such providers from accessing that State's prescription drug monitoring programs.

(3) No State shall deny or revoke the license, registration, or certification of a licensed health care provider or delegate who otherwise meets that State's qualifications for holding the license, registration, or certification on the basis that the licensed health care provider or delegate queried or received data, or attempted to query or receive data, from the national network of State-based prescription drug monitoring programs under this section.

(b) COVERED PATIENTS.—For purposes of this section, a covered patient is a patient who—

(1) receives a prescription for a controlled substance; and

(2) is not receiving palliative care or enrolled in hospice care.

(c) DEFINITIONS.—In this section:

(1) The term "controlled substance" has the meaning given such term in section 102(6) of the Controlled Substances Act (21 U.S.C. 802(6)).

(2) The term "delegate" means a person or automated system accessing the national network of State-based prescription monitoring programs at the direction or under the supervision of a licensed health care provider.

(3) The term "licensed health care provider" means a health care provider employed by the Department who is licensed, certified, or registered within any State to fill or prescribe medications within the scope of his or her practice as a Department employee.

(4) The term "national network of State-based prescription monitoring programs" means an interconnected nation-wide system that facilitates the transfer to State prescription drug monitoring program data across State lines.

(5) The term "State" means a State, as defined in section 101(20) of this title, or a political subdivision of a State.

§ 1730C. 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) COVERED HEALTH CARE PROFESSIONALS.—For purposes of this section, a covered health care professional is any 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 standards for quality relating to the provision of medicine 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.

(c) 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.

(d) RELATION TO STATE LAW.—(1) The provisions of this section shall supersede any provisions of the law of any State to the extent that such provision of State law are inconsistent with this section.

(2) No State shall deny or revoke the license, registration, or certification of a covered health care professional who otherwise meets the qualifications of the State for holding the license, registration, or certification on the basis that the covered health care professional has engaged or intends to engage in activity covered by subsection (a).

(e) RULE OF 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.).

(f) STATE DEFINED.—In this section, the term "State" means a State, as defined in section 101(20) of this title, or a political subdivision of a State.

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SUBCHAPTER V—PAYMENTS TO STATE HOMES

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§ 1745. Nursing home care, adult day health 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)⟧ *(or 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) 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).

(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 authorized by the Secretary or any Department official authorized by the Secretary,

and any such action is not an award for purposes of such laws that would otherwise require the use of competitive procedures for the furnishing of hospital care, medical services, and extended care services.

(B)(i) Except as provided in the agreement itself, in clause (ii), and unless otherwise provided in this section or 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 provision of law to which providers of services and suppliers under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) are not subject.

(ii) A State home that enters into an agreement under this section is subject to—

(I) all provisions of law regarding integrity, ethics, or fraud, or that subject a person to civil or criminal penalties;

(II) all provisions of law that protect against employment discrimination or that otherwise ensure equal employment opportunities; and

(III) all provisions in subchapter V of chapter 17 of this title.

(iii) Notwithstanding subparagraph (B)(ii)(I), a State home that enters into an agreement under this section may not be treated as a Federal contractor or subcontractor for purposes of chapter 67 of title 41 (known as the "McNamara-O'Hara Service Contract Act of 1965").

(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.

(d)(1) The Secretary shall enter into an agreement with each State home for payment by the Secretary for medical supervision model adult day health care provided to a veteran described in subsection (a)(1) on whose behalf the State home is not in receipt of payment for nursing home care from the Secretary.

(2)(A) Payment under each agreement between the Secretary and a State home under paragraph (1) for each veteran who receives medical supervision model adult day health care under such agreement shall be made at a rate established through regulations prescribed by the Secretary to adequately reimburse the State home

for the care provided by the State home, including necessary transportation expenses.

(B) The Secretary shall consult with the State homes in prescribing regulations under subparagraph (A).

(C) The rate established through regulations under subparagraph (A) shall not take effect until the date that is 30 days after the date on which those regulations are published in the Federal Register.

(3) Payment by the Secretary under paragraph (1) to a State home for medical supervision model adult day health 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) In this subsection, the term "medical supervision model adult day health care" means adult day health care that includes the coordination of physician services, dental services, nursing services, the administration of drugs, and such other requirements as determined appropriate by the Secretary.

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SUBCHAPTER VIII—HEALTH CARE OF PERSONS OTHER THAN VETERANS

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§ 1788. 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.—In carrying out this section, 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 chapter. 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.

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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 1 701(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] *with sections 1703A, 8111, and 8153* of this title;

(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 employer 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 max-

imum 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 III—READJUSTMENT AND RELATED BENEFITS

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CHAPTER 37—HOUSING AND SMALL BUSINESS LOANS

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SUBCHAPTER III—ADMINISTRATIVE PROVISIONS

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§ 3729. Loan fee

(a) REQUIREMENT OF FEE.—(1) Except as provided in subsection (c), a fee shall be collected from each person obtaining a housing loan guaranteed, insured, or made under this chapter, and each person assuming a loan to which section 3714 of this title applies. No such loan may be guaranteed, insured, made, or assumed until the fee payable under this section has been remitted to the Secretary.

(2) The fee may be included in the loan and paid from the proceeds thereof.

(b) DETERMINATION OF FEE.—(1) The amount of the fee shall be determined from the loan fee table in paragraph (2). The fee is expressed as a percentage of the total amount of the loan guaranteed, insured, or made, or, in the case of a loan assumption, the unpaid principal balance of the loan on the date of the transfer of the property.

(2) The loan fee table referred to in paragraph (1) is as follows:

LOAN FEE TABLE

Type of loan	Active duty veteran	Reservist	Other obligor
(A)(i) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710 (a) other than with 5-down or 10-down (closed before January 1, 2004)	2.00	2.75	NA
(A)(ii) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710 (a) other than with 5-down or 10-down (closed on or after January 1, 2004, and before October 1, 2004)	2.20	2.40	NA
(A)(iii) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710 (a) other than with 5-down or 10-down (closed on or after October 1, 2004, and before September 30, ⟦2027⟧ *2028*)	2.15	2.40	NA
(A)(iv) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710 (a) other than with 5-down or 10-down (closed on or after September 30, ⟦2027⟧ *2028*)	1.40	1.65	NA

LOAN FEE TABLE—Continued

Type of loan	Active duty veteran	Reservist	Other obligor
(B)(i) Subsequent loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other subsequent loan described in section 3710 (a) (closed before September 30, 【2027】 *2028*)	3.30	3.30	NA
(B)(ii) Subsequent loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other subsequent loan described in section 3710 (a) (closed on or after September 30, 【2027】 *2028*)	1.25	1.25	NA
(C)(i) Loan described in section 3710 (a) to purchase or construct a dwelling with 5-down (closed before September 30, 【2027】 *2028*)	1.50	1.75	NA
(C)(ii) Loan described in section 3710 (a) to purchase or construct a dwelling with 5-down (closed on or after September 30, 【2027】 *2028*)	0.75	1.00	NA
(D)(i) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 10-down (closed before September 30, 【2027】 *2028*)	1.25	1.50	NA
(D)(ii) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 10-down (closed on or after September 30, 【2027】 *2028*)	0.50	0.75	NA
(E) Interest rate reduction refinancing loan	0.50	0.50	NA
(F) Direct loan under section 3711	1.00	1.00	NA

LOAN FEE TABLE—Continued

Type of loan	Active duty veteran	Reservist	Other obligor
(G) Manufactured home loan under section 3712 (other than an interest rate reduction refinancing loan)	1.00	1.00	NA
(H) Loan to Native American veteran under section 3762 (other than an interest rate reduction refinancing loan)	1.25	1.25	NA
(I) Loan assumption under section 3714	0.50	0.50	0.50
(J) Loan under section 3733 (a)	2.25	2.25	2.25

(3) Any reference to a section in the "Type of loan" column in the loan fee table in paragraph (2) refers to a section of this title.

(4) For the purposes of paragraph (2):

(A) The term "active duty veteran" means any veteran eligible for the benefits of this chapter other than a Reservist.

(B) The term "Reservist" means a veteran described in section 3701 (b)(5)(A) of this title who is eligible under section 3702(a)(2)(E) of this title.

(C) The term "other obligor" means a person who is not a veteran, as defined in section 101 of this title or other provision of this chapter.

(D) The term "initial loan" means a loan to a veteran guaranteed under section 3710 or made under section 3711 of this title if the veteran has never obtained a loan guaranteed under section 3710 or made under section 3711 of this title.

(E) The term "subsequent loan" means a loan to a veteran, other than an interest rate reduction refinancing loan, guaranteed under section 3710 or made under section 3711 of this title if the veteran has previously obtained a loan guaranteed under section 3710 or made under section 3711 of this title.

(F) The term "interest rate reduction refinancing loan" means a loan described in section 3710(a)(8), 3710(a)(9)(B)(i), 3710(a)(11), 3712(a)(1)(F), or 3762(h) of this title.

(G) The term "0-down" means a downpayment, if any, of less than 5 percent of the total purchase price or construction cost of the dwelling.

(H) The term "5-down" means a downpayment of at least 5 percent or more, but less than 10 percent, of the total purchase price or construction cost of the dwelling.

(I) The term "10-down" means a downpayment of 10 percent or more of the total purchase price or construction cost of the dwelling.

(c) WAIVER OF FEE.—(1) A fee may not be collected under this section from a veteran who is receiving compensation (or who, but for the receipt of retirement pay or active service pay, would be entitled to receive compensation) or from a surviving spouse of any

veteran (including a person who died in the active military, naval, or air service) who died from a service-connected disability.

(2)(A) A veteran described in subparagraph (B) shall be treated as receiving compensation for purposes of this subsection as of the date of the rating described in such subparagraph without regard to whether an effective date of the award of compensation is established as of that date.

(B) A veteran described in this subparagraph is a veteran who is rated eligible to receive compensation—

(i) as the result of a pre-discharge disability examination and rating; or

(ii) based on a pre-discharge review of existing medical evidence (including service medical and treatment records) that results in the issuance of a memorandum rating.

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PART IV—GENERAL ADMINISTRATIVE PROVISIONS

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CHAPTER 55—MINORS, INCOMPETENTS, AND OTHER WARDS

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§ 5503. Hospitalized veterans and estates of incompetent institutionalized veterans

(a)(1)(A) Where any veteran having neither spouse nor child is being furnished domiciliary care by the Department, no pension in excess of $90 per month shall be paid to or for the veteran for any period after the end of the third full calendar month following the month of admission for such care.

(B) Except as provided in subparagraph (D) of this paragraph, where any veteran having neither spouse nor child is being furnished nursing home care by the Department, no pension in excess of $90 per month shall be paid to or for the veteran for any period after the end of the third full calendar month following the month of admission for such care. Any amount in excess of $90 per month to which the veteran would be entitled but for the application of the preceding sentence shall be deposited in a revolving fund at the Department medical facility which furnished the veteran nursing care, and such amount shall be available for obligation without fiscal year limitation to help defray operating expenses of that facility.

(C) No pension in excess of $90 per month shall be paid to or for a veteran having neither spouse nor child for any period after the month in which such veteran is readmitted for care described in subparagraph (A) or (B) of this paragraph and furnished by the Department if such veteran is readmitted within six months of a period of care in connection with which pension was reduced pursuant to subparagraph (A) or (B) of this paragraph.

(D) In the case of a veteran being furnished nursing home care by the Department and with respect to whom subparagraph (B) of this paragraph requires a reduction in pension, such reduction

shall not be made for a period of up to three additional calendar months after the last day of the third month referred to in such subparagraph if the Secretary determines that the primary purpose for the furnishing of such care during such additional period is for the Department to provide such veteran with a prescribed program of rehabilitation services, under chapter 17 of this title, designed to restore such veteran's ability to function within such veteran's family and community. If the Secretary determines that it is necessary, after such period, for the veteran to continue such program of rehabilitation services in order to achieve the purposes of such program and that the primary purpose of furnishing nursing home care to the veteran continues to be the provision of such program to the veteran, the reduction in pension required by subparagraph (B) of this paragraph shall not be made for the number of calendar months that the Secretary determines is necessary for the veteran to achieve the purposes of such program.

(2) The provisions of paragraph (1) shall also apply to a veteran being furnished such care who has a spouse but whose pension is payable under section 1521(b) of this title. In such a case, the Secretary may apportion and pay to the spouse, upon an affirmative showing of hardship, all or any part of the amounts in excess of the amount payable to the veteran while being furnished such care which would be payable to the veteran if pension were payable under section 1521(c) of this title.

(b) Notwithstanding any other provision of this section or any other provision of law, no reduction shall be made in the pension of any veteran for any part of the period during which the veteran is furnished hospital treatment, or institutional or domiciliary care, for Hansen's disease, by the United States or any political subdivision thereof.

(c) Where any veteran in receipt of an aid and attendance allowance described in subsection (r) or (t) of section 1114 of this title is hospitalized at Government expense, such allowance shall be discontinued from the first day of the second calendar month which begins after the date of the veteran's admission for such hospitalization for so long as such hospitalization continues. Any discontinuance required by administrative regulation, during hospitalization of a veteran by the Department, of increased pension based on need of regular aid and attendance or additional compensation based on need of regular aid and attendance as described in subsection (l) or (m) of section 1114 of this title, shall not be effective earlier than the first day of the second calendar month which begins after the date of the veteran's admission for hospitalization. In case a veteran affected by this subsection leaves a hospital against medical advice and is thereafter admitted to hospitalization within six months from the date of such departure, such allowance, increased pension, or additional compensation, as the case may be, shall be discontinued from the date of such readmission for so long as such hospitalization continues.

(d)(1) For the purposes of this subsection—

(A) the term "Medicaid plan" means a State plan for medical assistance referred to in section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)); and

(B) the term "nursing facility" means a nursing facility described in section 1919 of such Act (42 U.S.C. 1396r), other

than a facility that is a State home with respect to which the Secretary makes per diem payments for nursing home care pursuant to section 1741(a) of this title.

(2) If a veteran having neither spouse nor child is covered by a Medicaid plan for services furnished such veteran by a nursing facility, no pension in excess of $90 per month shall be paid to or for the veteran for any period after the month of admission to such nursing facility.

(3) Notwithstanding any provision of title XIX of the Social Security Act, the amount of the payment paid a nursing facility pursuant to a Medicaid plan for services furnished a veteran may not be reduced by any amount of pension permitted to be paid such veteran under paragraph (2) of this subsection.

(4) A veteran is not liable to the United States for any payment of pension in excess of the amount permitted under this subsection that is paid to or for the veteran by reason of the inability or failure of the Secretary to reduce the veteran's pension under this subsection unless such inability or failure is the result of a willful concealment by the veteran of information necessary to make a reduction in pension under this subsection.

(5)(A) The provisions of this subsection shall apply with respect to a surviving spouse having no child in the same manner as they apply to a veteran having neither spouse nor child.

(B) The provisions of this subsection shall apply with respect to a child entitled to pension under section 1542 of this title in the same manner as they apply to a veteran having neither spouse nor child.

(6) The costs of administering this subsection shall be paid for from amounts available to the Department of Veterans Affairs for the payment of compensation and pension.

(7) This subsection expires on [September 30, 2027] *September 30, 2028*.

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PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 73—VETERANS HEALTH ADMINISTRATION - ORGANIZATION AND FUNCTIONS

SUBCHAPTER I—ORGANIZATION

Sec.
7301. Functions of Veterans Health Administration: in general.

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SUBCHAPTER II—GENERAL AUTHORITY AND ADMINISTRATION

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7330C. Quadrennial Veterans Health Administration review.

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SUBCHAPTER II—GENERAL AUTHORITY AND ADMINISTRATION

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§ 7330C. Quadrennial Veterans Health Administration review

(a) MARKET AREA ASSESSMENTS.—(1) Not less frequently than every four years, the Secretary of Veterans Affairs shall perform market area assessments regarding the health care services furnished under the laws administered by the Secretary.

(2) Each market area assessment established under paragraph (1) shall include the following:

(A) An assessment of the demand for health care from the Department, disaggregated by geographic market areas as determined by the Secretary, including the number of requests for health care services under the laws administered by the Secretary.

(B) An inventory of the health care capacity of the Department of Veterans Affairs across the Department's system of facilities.

(C) An assessment of the health care capacity to be provided through contracted community care providers and providers who entered into a provider agreement with the Department under section 1703A of title 38, as added by section 102, including the number of providers, the geographic location of the providers, and categories or types of health care services provided by the providers.

(D) An assessment obtained from other Federal direct delivery systems of their capacity to provide health care to veterans.

(E) An assessment of the health care capacity of non-contracted providers where there is insufficient network supply.

(F) An assessment of the health care capacity of academic affiliates and other collaborations of the Department as it relates to providing health care to veterans.

(G) An assessment of the effects on health care capacity of the access standards and standards for quality established under sections 1703B and 1703C of this title.

(H) The number of appointments for health care services under the laws administered by the Secretary, disaggregated by—

(i) appointments at facilities of the Department of Veterans Affairs; and

(ii) appointments with non-Department health care providers.

(3)(A) The Secretary shall submit to the appropriate committees of Congress the market area assessments established in paragraph (1).

(B) The Secretary also shall submit to the appropriate committees of Congress the market area assessments completed by or being performed on the day before the date of the enactment of the Caring for Our Veterans Act of 2018.

(4)(A) The Secretary shall use the market area assessments established under paragraph (1) to—

(i) determine the capacity of the health care provider networks established under section 1703(h) of this title;

(ii) inform the Department budget, in accordance with subparagraph (B); and

(iii) inform and assess the appropriateness of the access standards established under section 1703B of this title and standards for quality under section 1703C and to make recommendations for any changes to such standards.

(B) The Secretary shall ensure that the Department budget for any fiscal year (as submitted with the budget of the President under section 1105(a) of title 31) reflects the findings of the Secretary with respect to the most recent market area assessments under paragraph (1) and health care utilization data from the Department and non-Department entities or providers furnishing care and services to covered veterans as described in section 1703(b).

(b) STRATEGIC PLAN TO MEET HEALTH CARE DEMAND.—(1) Not later than one year after the date of the enactment of the Caring for Our Veterans Act of 2018 and not less frequently than once every four years thereafter, the Secretary shall submit to the appropriate committees of Congress a strategic plan that specifies a four-year forecast of—

(A) the demand for health care from the Department, disaggregated by geographic area as determined by the Secretary;

(B) the health care capacity to be provided at each medical center of the Department; and

(C) the health care capacity to be provided through community care providers.

(2) In preparing the strategic plan under paragraph (1), the Secretary shall—

(A) assess the access standards and standards for quality established under sections 1703B and 1703C of this title;

(B) assess the market area assessments established under subsection (a);

(C) assess the needs of the Department based on identified services that provide management of conditions or disorders related to military service for which there is limited experience or access in the national market, the overall health of veterans throughout their lifespan, or other services as the Secretary determines appropriate;

(D) consult with key stakeholders within the Department, the heads of other Federal agencies, and other relevant governmental and nongovernmental entities, including State, local, and tribal government officials, members of Congress, veterans service organizations, private sector representatives, academics, and other policy experts;

(E) identify emerging issues, trends, problems, and opportunities that could affect health care services furnished under the laws administered by the Secretary;

(F) develop recommendations regarding both short- and long-term priorities for health care services furnished under the laws administered by the Secretary;

(G) after consultation with veterans service organizations and other key stakeholders on survey development or modification of an existing survey, consider a survey of veterans who have used hospital care, medical services, or extended care services furnished by the Veterans Health Administration during the most

recent two-year period to assess the satisfaction of the veterans with service and quality of care;

(H) conduct a comprehensive examination of programs and policies of the Department regarding the delivery of health care services and the demand of health care services for veterans in future years;

(I) assess the remediation of medical service lines of the Department as described in section 1706A in conjunction with the utilization of non-Department entities or providers to offset remediation; and

(J) consider such other matters as the Secretary considers appropriate.

(c) RESPONSIBILITIES.—The Secretary shall be responsible for—

(1) overseeing the transformation and organizational change across the Department to achieve such high performing integrated health care network;

(2) developing the capital infrastructure planning and procurement processes, whether minor or major construction projects or leases; and

(3) developing a multi-year budget process that is capable of forecasting future year budget requirements and projecting the cost of delivering health care services under a high-performing integrated health care network.

(d) APPROPRIATE COMMITTEES OF CONGRESS DEFINED.—In this section, the term "appropriate committees of Congress" means—

(1) the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate; and

(2) the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives.

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.]

(H)(i) To a non-Department entity (including private entities and other Federal agencies) for purposes of providing health care, including hospital care, medical services, and extended care services, to patients or performing other health care-related activities or functions.

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

(I) To a third party in order to recover or collect reasonable charges for care furnished to, or paid on behalf of, a patient in connection with a non-service connected disability as permitted by section 1729 of this title 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 the Act entitled "An Act to provide for the recovery from tortiously liable third persons of the cost of hospital and medical care and treatment furnished by the United States" (Public Law 87–693; 42 U.S.C. 2651 et seq.; commonly known as the "Federal Medical Care Recovery Act").

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

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

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

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

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

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

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

infected with such virus, identified as being a sexual partner of such patient or subject.

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

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

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

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CHAPTER 74—VETERANS HEALTH ADMINISTRATION - PERSONNEL

SUBCHAPTER I—APPOINTMENTS

Sec.
7401. Appointments in Veterans Health Administration.

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7413. Treatment of podiatrists; clinical oversight standards.

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SUBCHAPTER I—APPOINTMENTS

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§ 7404. Grades and pay scales

(a)(1)(A) The annual rates or ranges of rates of basic pay for positions provided in section 7306 and 7401(4) of this title shall be prescribed from time to time by Executive order as authorized by chapter 53 of title 5 or as otherwise authorized by law.

(B) Section 5377 of title 5 shall apply to a position under section 7401(4) of this title as if such position were included in the definition of "position" in section 5377(a) of title 5.

(2) The pay of physicians and dentists serving in positions to which an Executive order applies under paragraph (1) shall be determined under subchapter III of this chapter instead of such Executive order.

(3)(A) The rate of basic pay for a position to which an Executive order applies under paragraph (1) and is not described by paragraph (2) shall be set in accordance with section 5382 of title 5 as if such position were a Senior Executive Service position (as such term is defined in section 3132(a) of title 5).

(B) A rate of basic pay for a position may not be set under subparagraph (A) in excess of—

(i) in the case the position is not described in clause (ii), the rate of basic pay payable for level III of the Executive Schedule; or

(ii) in the case that the position is covered by a performance appraisal system that meets the certification criteria established by regulation under section 5307(d) of title 5, the rate of basic pay payable for level II of the Executive Schedule.

(C) Notwithstanding the provisions of subsection (d) of section 5307 of title 5, the Secretary may make any certification under that subsection instead of the Office of Personnel Management and without concurrence of the Office of Management and Budget.

(b) The grades for positions provided for in paragraph (1) of section 7401 of this title shall be as follows. The annual ranges of rates of basic pay for those grades shall be prescribed from time to time by Executive order as authorized by chapter 53 of title 5 or as otherwise authorized by law:

[PHYSICIAN AND DENTIST SCHEDULE] *PHYSICIAN AND SURGEON (MD/DO), PODIATRIC SURGEON (DPM), AND DENTIST AND ORAL SURGEON (DDS, DMD) SCHEDULE*

[Physician grade] *Physician and surgeon grade.*

Dentist grade.

NURSE SCHEDULE

Nurse V.

Nurse IV.

Nurse III.

Nurse II.

Nurse I.

CLINICAL [PODIATRIST, CHIROPRACTOR, AND] *CHIROPRACTOR AND* OPTOMETRIST SCHEDULE

Chief grade.

Senior grade.

Intermediate grade.

Full grade.

Associate grade.

(c) Notwithstanding the provisions of section 7425(a) of this title, a person appointed under section 7306 of this title who is not eligible for pay under subchapter III shall be deemed to be a career appointee for the purposes of sections 4507 and 5384 of title 5.

(d) Except as provided under subsection (e), subchapter III, and section 7457 of this title, pay for positions for which basic pay is paid under this section may not be paid at a rate in excess of the rate of basic pay authorized by section 5316 of title 5 for positions in Level V of the Executive Schedule.

(e) The position of Chief Nursing Officer, Office of Nursing Services, shall be exempt from the provisions of section 7451 of this title and shall be paid at a rate determined by the Secretary, not to exceed the maximum rate established for the Senior Executive Service under section 5382 of title 5.

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§ 7413. Treatment of podiatrists; clinical oversight standards

(a) PODIATRISTS.—Except as provided by subsection (b), a doctor of podiatric medicine who is appointed as a podiatrist under section 7401(1) of this title is eligible for any supervisory position in the Veterans Health Administration to the same degree that a physician appointed under such section is eligible for the position.

(b) ESTABLISHMENT OF CLINICAL OVERSIGHT STANDARDS.—The Secretary, in consultation with appropriate stakeholders, shall establish standards to ensure that specialists appointed in the Veterans Health Administration to supervisory positions do not provide direct clinical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties.

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CHAPTER 76—HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

SUBCHAPTER I—GENERAL

Sec.
7601. Establishment of program; purpose.

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SUBCHAPTER VIII—SPECIALTY EDUCATION LOAN REPAYMENT PROGRAM

Sec.
7691. Establishment.
7692. Purpose.
7693. Eligibility; preferences; covered costs.
7694. Specialty education loan repayment.
7695. Choice of location.
7696. Term of obligated service.
7697. Relationship to Educational Assistance Program.

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 assistance 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, [or 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, [or 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, [or 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 VII—EDUCATION DEBT REDUCTION PROGRAM

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§ 7683. Education debt reduction

(a) IN GENERAL.—Education debt reduction payments under the Education Debt Reduction Program shall consist of—

(1) payments to individuals selected to participate in the program of principal and interest on loans described in section 7682(a)(2) of this title; or

(2) payments for the principal and interest on such loans of such individuals to the holders of such loans.

(b) FREQUENCY OF PAYMENT.—(1) The Secretary may make education debt reduction payments to or for any given participant in the Education Debt Reduction Program on a monthly or annual basis, as determined by the Secretary.

(2) The Secretary shall make such payments at the end of the period determined by the Secretary under paragraph (1).

(c) PERFORMANCE REQUIREMENT.—The Secretary may make education debt reduction payments to or for a participant in the Education Debt Reduction Program for a period only if the Secretary determines that the individual maintained an acceptable level of performance in the position or positions served by the participant during the period.

(d) MAXIMUM ANNUAL AMOUNT.—(1) The amount of education debt reduction payments made to or for a participant under the Education Debt Reduction Program may not exceed **[**$120,000**]** *$200,000* over a total of five years of participation in the Program, of which not more than **[**$24,000**]** *$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 education debt repayments 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.

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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; preferences; 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) PREFERENCES.—In selecting individuals for participation in the Specialty Education Loan Repayment Program under this subchapter, the Secretary may give preference to the following:

(1) Individuals who are, or will be, participating in residency programs in health care facilities—

(A) located in rural areas;

(B) operated by Indian tribes, tribal organizations, or the Indian Health Service; or

(C) affiliated with underserved health care facilities of the Department.

(2) 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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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED-USE LEASES OF REAL PROPERTY

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

Sec.
8101. Definitions.

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SUBCHAPTER IV—SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

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8159. Authority to pay for services authorized but not subject to an agreement.

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SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

§ 8101. Definitions

For the purposes of this subchapter:

(1) The term "alter", with respect to a medical facility, means to repair, remodel, improve, or extend such medical facility.

(2) The terms "construct" and "alter", with respect to a medical facility, include such engineering, architectural, legal, fiscal, and economic investigations and studies and such surveys, designs, plans, construction documents, specifications, procedures, and other similar actions as are necessary for the construction or alteration, as the case may be, of such medical facility and as are carried out after the completion of the advanced planning (including the development of project requirements and design development) for such facility.

(3) The term "medical facility" means any facility or part thereof which is, or will be, under the jurisdiction of the ❚Secretary for the provision of health-care services (including hospital, nursing home,❚ *Secretary, or as otherwise authorized by law, for the provision of health-care services (including hospital, outpatient clinic, nursing home,* or domiciliary care or medical services), including any necessary building and auxiliary structure, garage, parking fa-

cility, mechanical equipment, trackage facilities leading thereto, abutting sidewalks, accommodations for attending personnel, and recreation facilities associated therewith.

(4) The term "committee" means the Committee on Veterans' Affairs of the House of Representatives or the Committee on Veterans' Affairs of the Senate, and the term "committees" means both such committees.

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§ 8103. Authority to construct and alter, and to acquire sites for, medical facilities

(a) Subject to section 8104 of this title, the Secretary—

(1) may construct or alter any medical facility and may acquire, by purchase, lease, condemnation, donation, exchange, or otherwise, such land or interests in land as the Secretary considers necessary for use as the site for such construction or alteration;

(2) may acquire, by purchase, lease, condemnation, donation, exchange, or otherwise, any facility (including the site of such facility) that the Secretary considers necessary for use as a medical facility; and

(3) in order to assure compliance with section 8110(a)(2) of this title, in the case of any outpatient medical facility for which it is proposed to lease space and for which a qualified lessor and an appropriate leasing arrangement are available, shall execute a lease for such facility within 12 months after funds are made available for such purpose.

(b) Whenever the Secretary considers it to be in the interest of the United States to construct a new medical facility to replace an existing medical facility, the Secretary (1) may demolish the existing facility and use the site on which it is located for the site of the new medical facility, or (2) if in the judgment of the Secretary it is more advantageous to construct such medical facility on a different site in the same locality, may exchange such existing facility and the site of such existing facility for the different site.

(c) Whenever the Secretary determines that any site acquired for the construction of a medical facility is not suitable for that purpose, the Secretary may exchange such site for another site to be used for that purpose or may sell such site.

(d)(1) The Secretary may provide for the acquisition of not more than three facilities for the provision of outpatient services or nursing home care through lease-purchase arrangements on real property under the jurisdiction of the Department of Veterans Affairs.

(2)(A) In carrying out this subsection and notwithstanding any other provision of law, the Secretary may lease, with or without compensation and for a period of not to exceed 35 years, to another party any of the real property described in paragraph (1) of this subsection.

(B) Such real property shall be used as the site of a facility referred to in paragraph (1) of this subsection—

(i) constructed and owned by the lessee of such real property; and

(ii) leased under paragraph (3)(A) of this subsection to the Department for such use and for such other activities as the Secretary determines are appropriate.

(3)(A) The Secretary may enter into a lease for the use of any facility described in paragraph (2)(B) of this subsection for not more than 35 years under such terms and conditions as may be in the best interests of the Department.

(B) Each agreement to lease a facility under subparagraph (A) of this paragraph shall include a provision that—

(i) the obligation of the United States to make payments under the agreement is subject to the availability of appropriations for that purpose; and

(ii) the ownership of such facility shall vest in the United States at the end of such lease.

(4)(A) The Secretary may sublease any space in such a facility to another party at a rate not less than—

(i) the rental rate paid by the Secretary for such space under paragraph (3) of this subsection; plus

(ii) the amount the Secretary pays for the costs of administering such facility (including operation, maintenance, utility, and rehabilitation costs) which are attributable to such space.

(B) In any such sublease, the Secretary shall include such terms relating to default and nonperformance as the Secretary considers appropriate to protect the interests of the United States.

(5) The Secretary shall use the receipts of any payment for the lease of real property under paragraph (2) for the payment of the lease of a facility under paragraph (3).

(6) The authority to enter into an agreement under this subsection—

(A) shall not take effect until the Secretary has entered into agreements under section 316 of this title to carry out at least three collocations; and

(B) shall expire on October 1, 1993.

(e)(1) In the case of any super construction project, the Secretary shall enter into an agreement with an appropriate non-Department Federal entity to provide full project management services for the super construction project, including management over the project design, acquisition, construction, and contract changes.

(2) An agreement entered into under paragraph (1) with a Federal entity shall provide that the Secretary shall reimburse the Federal entity for all costs associated with the provision of project management services under the agreement.

(3) In this subsection, the term "super construction project" means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $100,000,000.

(f) To the maximum extent practicable, the Secretary shall use industry standards, standard designs, and best practices in carrying out the construction of medical facilities.

[(g) The Secretary shall ensure that each employee of the Department with responsibilities, as determined by the Secretary, relating to the infrastructure construction or alteration of medical facilities, including such construction or alteration carried out pursuant to contracts or agreements, undergoes a program of ongoing professional training and development. Such program shall be designed to ensure that employees maintain adequate expertise relating to industry standards and best practices for the acquisition of design and construction services. The Secretary may provide the

program under this subsection directly or through a contract or agreement with a non-Federal entity or with a non-Department Federal entity.]

(g)(1)(A) Not later than September 30 of the fiscal year following the fiscal year during which the VA Asset and Infrastructure Review Act of 2018 is enacted, the Secretary shall implement the covered training curriculum and the covered certification program.

(B) In designing and implementing the covered training curriculum and the covered certification program under paragraph (1), the Secretary shall use as models existing training curricula and certification programs that have been established under chapter 87 of title 10, United States Code, as determined relevant by the Secretary.

(2) The Secretary may develop the training curriculum under paragraph (1)(A) in a manner that provides such training in any combination of—

(A) training provided in person;

(B) training provided over an internet website; or

(C) training provided by another department or agency of the Federal Government.

(3) The Secretary may develop the certification program under paragraph (1)(A) in a manner that uses—

(A) one level of certification; or

(B) more than one level of certification, as determined appropriate by the Secretary with respect to the level of certification for different grades of the General Schedule.

(4) The Secretary may enter into a contract with an appropriate entity to provide the covered training curriculum and the covered certification program under paragraph (1)(A).

(5)(A) Not later than September 30 of the second fiscal year following the fiscal year during which the VA Asset and Infrastructure Review Act of 2018 is enacted, the Secretary shall ensure that the majority of employees subject to the covered certification program achieve the certification or the appropriate level of certification pursuant to paragraph (3), as the case may be.

(B) After carrying out subparagraph (A), the Secretary shall ensure that each employee subject to the covered certification program achieves the certification or the appropriate level of certification pursuant to paragraph (3), as the case may be, as quickly as practicable.

(6) In this subsection:

(A) The term "covered certification program" means, with respect to employees of the Department of Veterans Affairs who are members of occupational series relating to construction or facilities management, or employees of the Department who award or administer contracts for major construction, minor construction, or nonrecurring maintenance, including as contract specialists or contracting officers' representatives, a program to certify knowledge and skills relating to construction or facilities management and to ensure that such employees maintain adequate expertise relating to industry standards and best practices for the acquisition of design and construction services.

(B) The term "covered training curriculum" means, with respect to employees specified in subparagraph (A), a training curriculum relating to construction or facilities management.

§ 8104. Congressional approval of certain medical facility acquisitions

(a)(1) The purpose of this subsection is to enable Congress to ensure the equitable distribution of medical facilities throughout the United States, taking into consideration the comparative urgency of the need for the services to be provided in the case of each particular facility.

(2) No funds may be appropriated for any fiscal year, and the Secretary may not obligate or expend funds (other than for advance planning and design), for any major medical facility project or any major medical facility lease unless funds for that project or lease have been specifically authorized by law.

[(3) For the purpose of this subsection:

[(A) The term "major medical facility project" means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $10,000,000, but such term does not include an acquisition by exchange.

[(B) The term "major medical facility lease" means a lease for space for use as a new medical facility at an average annual rental of more than $1,000,000.**]**

(3) For purposes of this subsection, the term "major medical facility project" means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $20,000,000, but such term does not include an acquisition by exchange, non-recurring maintenance projects of the Department, or the construction, alteration, or acquisition of a shared Federal medical facility for which the Department's estimated share of the project costs does not exceed $20,000,000.

(b) Whenever the President or the Secretary submit to the Congress a request for the funding of a major medical facility project (as defined in subsection (a)(3)(A)) or a major medical facility lease (as defined in subsection (a)(3)(B)), the Secretary shall submit to each committee, on the same day, a prospectus of the proposed medical facility. Any such prospectus shall include the following:

(1) A detailed estimate of the total costs of the medical facility to be constructed, altered, leased, or otherwise acquired under this subchapter, including a description of the location of such facility and, in the case of a prospectus proposing the construction of a new or replacement medical facility, a detailed report of the consideration that was given to acquiring an existing facility by lease or purchase and to the sharing of health-care resources with the Department of Defense under section 8111 of this title. Such detailed estimate shall include an identification of each of the following:

(A) Total construction costs.

(B) Activation costs.

(C) Special purpose alterations (lump-sum payment) costs.

(D) Number of personnel.

(E) Total costs of ancillary services, equipment, and all other items.

(2) Demographic data applicable to such facility, including information on projected changes in the population of veterans

to be served by the facility over a five-year period, a ten-year period, and a twenty-year period.

(3) Current and projected workload and utilization data regarding the facility, including information on projected changes in workload and utilization over a five-year period, a ten-year period, and a twenty-year period.

(4) Projected operating costs of the facility, including both recurring and non-recurring costs (including and identifying both recurring and non-recurring costs (including activation costs and total costs of ancillary services, equipment and all other items)) over a five-year period, a ten-year period, and a twenty-year period.

(5) The priority score assigned to the project or lease under the Department's prioritization methodology and, if the project or lease is being proposed for funding before a project or lease with a higher score, a specific explanation of the factors other than the priority score that were considered and the basis on which the project or lease is proposed for funding ahead of projects or leases with higher priority scores.

(6) In the case of a prospectus proposing the construction of a new or replacement medical facility, each of the following:

(A) A detailed estimate of the total costs (including total construction costs, activation costs, special purpose alterations (lump-sum payment) costs, number of personnel and total costs of ancillary services, equipment and all other items) for each alternative to construction of the facility that was considered.

(B) A comparison of total costs to total benefits for each such alternative.

(C) An explanation of why the preferred alternative is the most effective means to achieve the stated project goals and the most cost-effective alternative.

(7) In the case of a prospectus proposing funding for a major medical facility lease, a detailed analysis of how the lease is expected to comply with Office of Management and Budget Circular A-11 and section 1341 of title 31 (commonly referred to as the "Anti-Deficiency Act"). Any such analysis shall include—

(A) an analysis of the classification of the lease as a "lease-purchase", "capital lease", or "operating lease" as those terms are defined in Office of Management and Budget Circular A-11;

(B) an analysis of the obligation of budgetary resources associated with the lease; and

(C) an analysis of the methodology used in determining the asset cost, fair market value, and cancellation costs of the lease.

(c)(1) Not less than 30 days before obligating funds for a major medical facility project approved by a law described in subsection (a)(2) of this section in an amount that would cause the total amount obligated for that project to exceed the amount specified in the law for that project (or would add to total obligations exceeding such specified amount) by more than 10 percent, the Secretary shall provide the committees with notice of the Secretary's intention to do so and the reasons for the specified amount being exceeded.

(2) The Secretary shall—

(A) enter into a contract or agreement with an appropriate non-department Federal entity with the ability to conduct forensic audits on medical facility projects for the conduct of an external forensic audit of the expenditures relating to any major medical facility or super construction project for which the total expenditures exceed the amount requested in the initial budget request for the project submitted to Congress under section 1105 of title 31 by more than 25 percent; and

(B) enter into a contract or agreement with an appropriate non-department Federal entity with the ability to conduct forensic audits on medical facility projects for the conduct of an external audit of the medical center construction project in Aurora, Colorado.

(d)(1) Except as provided in paragraph (2), in any case in which the Secretary proposes that funds be used for a purpose other than the purpose for which such funds were appropriated, the Secretary shall promptly notify each committee, in writing, of the particulars involved and the reasons why such funds were not used for the purpose for which appropriated.

(2)(A) In any fiscal year, unobligated amounts in the Construction, Major Projects account that are a direct result of bid savings from a major construction project may only be obligated for major construction projects authorized for that fiscal year or a previous fiscal year.

(B) Whenever the Secretary obligates amounts for a major construction project under subparagraph (A), the Secretary shall submit to the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate and the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives notice of the following:

(i) The major construction project that is the source of the bid savings.

(ii) If the major construction project that is the source of the bid savings is not complete—

(I) the amount already obligated by the Department or available in the project reserve for such project;

(II) the percentage of such project that has been completed; and

(III) the amount available to the Department to complete such project.

(iii) The other major construction project for which the bid savings amounts are being obligated.

(iv) The bid savings amounts being obligated for such other major construction project.

(C) The Secretary may not obligate an amount under subparagraph (A) to expand the purpose of a major construction project except pursuant to a provision of law enacted after the date on which the Secretary submits to the committees described in subparagraph (B) notice of the following:

(i) The major construction project that is the source of the bid savings.

(ii) The major construction project for which the Secretary intends to expand the purpose.

(iii) A description of such expansion of purpose.

(iv) The amounts the Secretary intends to obligate to expand the purpose.

(e) The Secretary may accept gifts or donations for any of the purposes of this subchapter.

(f) The Secretary may not obligate funds in an amount in excess of $500,000 from the Advance Planning Fund of the Department toward design or development of a major medical facility project (as defined in subsection (a)(3)(A)) until—

(1) the Secretary submits to the committees a report on the proposed obligation; and

(2) a period of 30 days has passed after the date on which the report is received by the committees.

(g) The limitation in subsection (f) does not apply to a project for which funds have been authorized by law in accordance with subsection (a)(2).

(h)(1) Not less than 30 days before entering into a major medical facility lease, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives—

(A) notice of the Secretary's intention to enter into the lease;

(B) a detailed summary of the proposed lease;

(C) a description and analysis of any differences between the prospectus submitted pursuant to subsection (b) and the proposed lease; and

(D) a scoring analysis demonstrating that the proposed lease fully complies with Office of Management and Budget Circular A-11.

(2) Each committee described in paragraph (1) shall ensure that any information submitted to the committee under such paragraph is treated by the committee with the same level of confidentiality as is required by law of the Secretary and subject to the same statutory penalties for unauthorized disclosure or use as the Secretary.

(3) Not more than 30 days after entering into a major medical facility lease, the Secretary shall submit to each committee described in paragraph (1) a report on any material differences between the lease that was entered into and the proposed lease described under such paragraph, including how the lease that was entered into changes the previously submitted scoring analysis described in subparagraph (D) of such paragraph.

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SUBCHAPTER IV—SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

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§ 8159. Authority to pay for services authorized but not subject to an agreement

(a) IN GENERAL.—If, in the course of furnishing hospital care, a medical service, or an extended care service authorized by the Secretary and pursuant to a contract, agreement, or other arrangement with the Secretary, a provider who is not a party to the contract, agreement, or other arrangement furnishes hospital care, a medical service, or an extended care service that the Secretary considers necessary, the Secretary may compensate the provider for the cost of such care or service.

(b) NEW CONTRACTS AND AGREEMENTS.—The Secretary shall take reasonable efforts to enter into a contract, agreement, or other arrangement with a provider described in subsection (a) to ensure that future care and services authorized by the Secretary and furnished by the provider are subject to such a contract, agreement, or other arrangement.

SUBCHAPTER V—ENHANCED-USE LEASES OF REAL PROPERTY

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§ 8162. Enhanced-use leases

(a)(1) The Secretary may in accordance with this subchapter enter into leases with respect to real property that is under the jurisdiction or control of the Secretary. Any such lease under this subchapter may be referred to as an "enhanced-use lease". The Secretary may dispose of any such property that is leased to another party under this subchapter in accordance with section 8164 of this title. The Secretary may exercise the authority provided by this subchapter notwithstanding section 8122 of this title, subchapter II of chapter 5 of title 40, sections 541-555 and 1302 of title 40, or any other provision of law (other than Federal laws relating to environmental and historic preservation) inconsistent with this section. The applicability of this subchapter to section 421(b) of the Veterans' Benefits and Services Act of 1988 (Public Law 100-322; 102 Stat. 553) is covered by subsection (c).

(2) The Secretary may enter into an enhanced-use lease only for the provision of supportive housing and if the lease is not inconsistent with and will not adversely affect the mission of the Department.

(3) The provisions of sections 3141-3144, 3146, and 3147 of title 40 shall not, by reason of this section, become inapplicable to property that is leased to another party under an enhanced-use lease.

(4) A property that is leased to another party under an enhanced-use lease may not be considered to be unutilized or underutilized for purposes of section 501 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11411).

(b)(1) If the Secretary has determined that a property should be leased to another party through an enhanced-use lease, the Secretary shall, at the Secretary's discretion, select the party with whom the lease will be entered into using such selection procedures as the Secretary considers appropriate.

(2) The term of an enhanced-use lease may not exceed 75 years.

(3)(A) For any enhanced-use lease entered into by the Secretary, the lease consideration provided to the Secretary shall consist solely of cash at fair value as determined by the Secretary.

(B) The Secretary shall receive no other type of consideration for an enhanced-use lease besides cash.

(C) The Secretary may enter into an enhanced-use lease without receiving consideration.

(D) The Secretary may not waive or postpone the obligation of a lessee to pay any consideration under an enhanced-use lease, including monthly rent.

(4) The terms of an enhanced-use lease may provide for the Secretary to use minor construction funds for capital contribution payments.

(5) The terms of an enhanced-use lease may not provide for any acquisition, contract, demonstration, exchange, grant, incentive, procurement, sale, other transaction authority, service agreement, use agreement, lease, or lease-back by the Secretary or Federal Government.

[(6) The Secretary may not enter into an enhanced-use lease without certification in advance in writing by the Director of the Office of Management and Budget that such lease complies with the requirements of this subchapter.**]**

(6) The Office of Management and Budget shall review each enhanced-use lease before the lease goes into effect to determine whether the lease is in compliance with paragraph (5).

(c) The entering into an enhanced-use lease covering any land or improvement described in section 421(b)(2) of the Veterans' Benefits and Services Act of 1988 (Public Law 100-322; 102 Stat. 553) or section 224(a) of the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008, other than an enhanced-use lease under the Los Angeles Homeless Veterans Leasing Act of 2016, shall be considered to be prohibited by such sections unless specifically authorized by law.

(d)(1) Nothing in this subchapter authorizes the Secretary to enter into an enhanced-use lease that provides for, is contingent upon, or otherwise authorizes the Federal Government to guarantee a loan made by a third party to a lessee for purposes of the enhanced-use lease.

(2) Nothing in this subchapter shall be construed to abrogate or constitute a waiver of the sovereign immunity of the United States with respect to any loan, financing, or other financial agreement entered into by the lessee and a third party relating to an enhanced-use lease.

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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(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B))).

(iii) The Department of Defense.

(iv) The Indian Health Service.

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

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

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

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

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

(2) the veteran—

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

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

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

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

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

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

(C) resides—

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

(I) hospital care;

(II) emergency medical services; and

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

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

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

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

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

(aa) geographical challenges;

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

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

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

(c) ELECTION AND AUTHORIZATION.—

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

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

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

(ii) notify the eligible veteran by the most effective means available, including electronic communication or notification in writing, describing the care or serv-

ices the eligible veteran is eligible to receive under this section.

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

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

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

(d) CARE AND SERVICES THROUGH AGREEMENTS.—

(1) AGREEMENTS.—

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

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

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

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

(3) CERTAIN PROCEDURES.—

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

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

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

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

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

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

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

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

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

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

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

(e) 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.

(l) MEDICAL RECORDS.—

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

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

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

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

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

[(p) AUTHORITY TO FURNISH CARE AND SERVICES.—

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

[(2) DATE SPECIFIED.—The date specified in this paragraph is the date on which the Secretary has exhausted all amounts deposited in the Veterans Choice Fund established by section 802.

[(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.]

(p) AUTHORITY TO FURNISH CARE AND SERVICES.—The Secretary may not use the authority under this section to furnish care and services after the date that is one year after the date of the enactment of the Caring for Our Veterans Act of 2018.

(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 VII—OTHER VETERANS MATTERS

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SEC. 705. LIMITATION ON AWARDS AND BONUSES PAID TO EMPLOYEES OF DEPARTMENT OF VETERANS AFFAIRS.

(a) LIMITATION.—The Secretary of Veterans Affairs shall ensure that the aggregate amount of awards and bonuses paid by the Secretary in a fiscal year under chapter 45 or 53 of title 5, United States Code, or any other awards or bonuses authorized under such title or title 38, United States Code, does not exceed the following amounts:

(1) With respect to each of fiscal years 2017 through 2018, [$230,000,000] *$250,000,000, of which not less than $20,000,000 shall be for recruitment, relocation, and retention bonuses*.

(2) With respect to each of fiscal years 2019 through 2021, [$225,000,000] *$290,000,000, of which not less than $20,000,000 shall be for recruitment, relocation, and retention bonuses*.

(3) With respect to each of fiscal years 2022 through 2024, $360,000,000.

(b) SENSE OF CONGRESS.—It is the sense of Congress that the limitation under subsection (a) should not disproportionately impact lower-wage employees and that the Department of Veterans Affairs is encouraged to use bonuses to incentivize high-performing employees in areas in which retention is challenging.

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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)] *in paragraphs (3) and (4)*, 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.

(4) PERMANENT AUTHORITY FOR OTHER USES.—Beginning on March 1, 2019, amounts remaining in the Veterans Choice Fund may be used to furnish hospital care, medical services, and extended care services 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. Such amounts shall be available in addition to amounts available in other appropriations accounts for such purposes.

(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)⟧ *to paragraphs (3) and (4) of subsection (c)* 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 De-

partment 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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SOCIAL SECURITY ACT

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART E—MISCELLANEOUS PROVISIONS

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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, audit-

ing, 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 directly 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,

(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 participating 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 car (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 provider 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(l)(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 providers 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, not-

withstanding 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 re-

quired 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 en-

sure 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.

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SECTION 104 OF THE VETERANS' BENEFITS IMPROVEMENTS ACT OF 1994

SEC. 104. DEVELOPMENT OF MEDICAL EVALUATION PROTOCOL.

(a) UNIFORM MEDICAL EVALUATION PROTOCOL.—(1) The Secretary of Veterans Affairs shall develop and implement a uniform and comprehensive medical evaluation protocol that will ensure appropriate medical assessment, diagnosis, and treatment of Persian Gulf War veterans who are suffering from illnesses the origins of which are (as of the date of the enactment of this Act) unknown and that may be attributable to service in the Southwest Asia theater of operations during the Persian Gulf War. The protocol shall include an evaluation of complaints relating to illnesses involving the reproductive system.

(2) If such a protocol is not implemented before the end of the 120-day period beginning on the date of the enactment of this Act, the Secretary shall, before the end of such period, submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report as to why such a protocol has not yet been developed.

(3)(A) The Secretary shall ensure that the evaluation under the protocol developed under this section is available at all Department medical centers that have the capability of providing the medical assessment, diagnosis, and treatment required under the protocol.

(B) The Secretary may enter into contracts with non-Department medical facilities for the provision of the evaluation under the protocol.

(C) In the case of a veteran whose residence is distant from a medical center described in subparagraph (A), the Secretary may provide the evaluation through a Department medical center described in that subparagraph and, in such a case, may provide the veteran the travel and incidental expenses therefor pursuant to the provisions of section 111 of title 38, United States Code.

(4)(A) If the Secretary is unable to diagnose the symptoms or illness of a veteran provided an evaluation, or if the symptoms or illness of a veteran do not respond to treatment provided by the Secretary, the Secretary may use the authority [in section 1703] *in sections 1703A, 8111, and 8153* of title 38, United States Code, in order to provide for the veteran to receive diagnostic tests or treatment at a non-Department medical facility that may have the capability of diagnosing or treating the symptoms or illness of the veteran. The Secretary may provide the veteran the travel and incidental expenses therefor pursuant to the provisions of section 111 of title 38, United States Code.

(B) The Secretary shall request from each non-Department medical facility that examines or treats a veteran under this paragraph such information relating to the diagnosis or treatment as the Secretary considers appropriate.

(5) In each year after the implementation of the protocol, the Secretary shall enter into an agreement with the National Academy of Sciences under which agreement appropriate experts shall review the adequacy of the protocol and its implementation by the Department of Veterans Affairs.

(b) RELATIONSHIP TO OTHER COMPREHENSIVE CLINICAL EVALUATION PROTOCOLS.—The Secretary, in consultation with the Secretary of Defense, shall ensure that the information collected through the protocol described in this section is collected and maintained in a manner that permits the effective and efficient cross-reference of that information with information collected and maintained through the comprehensive clinical protocols of the Department of Defense for Persian Gulf War veterans.

(c) CASE DEFINITIONS AND DIAGNOSES.—The Secretary shall develop case definitions or diagnoses for illnesses associated with the service described in subsection (a)(1). The Secretary shall develop such definitions or diagnoses at the earliest possible date.

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2010

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TITLE I—CAREGIVER SUPPORT

SEC. 101. ASSISTANCE AND SUPPORT SERVICES FOR CAREGIVERS.

(a) ASSISTANCE AND SUPPORT SERVICES.—

(1) (Amendatory-Omitted)

(2) (Amendatory-Omitted)

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by this subsection shall take effect on the date that is 270 days after the date of the enactment of this Act.

(B) IMPLEMENTATION.—The Secretary of Veterans Affairs shall commence the programs required by subsections (a) and (b) of section 1720G of title 38, United States Code, as added by paragraph (1) of this subsection, on the date on which the amendments made by this subsection take effect.

(b) IMPLEMENTATION PLAN AND REPORT.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall—

(A) develop a plan for the implementation of the program of comprehensive assistance for family caregivers required by section 1720G(a)(1) of title 38, United States Code, as added by subsection (a)(1) of this section; and

(B) submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on such plan.

(2) CONSULTATION.—In developing the plan required by paragraph (1)(A), the Secretary shall consult with the following:

(A) Individuals described in section 1720G(a)(2) of title 38, United States Code, as added by subsection (a)(1) of this section.

(B) Family members of such individuals who provide personal care services to such individuals.

(C) The Secretary of Defense with respect to matters concerning personal care services for members of the Armed Forces undergoing medical discharge from the Armed Forces who are eligible to benefit from personal care services furnished under the program of comprehensive assistance required by section 1720G(a)(1) of such title, as so added.

(D) Veterans service organizations, as recognized by the Secretary for the representation of veterans under section 5902 of such title.

(E) National organizations that specialize in the provision of assistance to individuals with the types of disabilities that family caregivers will encounter while providing personal care services under the program of comprehensive assistance required by section 1720G(a)(1) of such title, as so added.

(F) National organizations that specialize in provision of assistance to family members of veterans who provide personal care services to such veterans.

(G) Such other organizations with an interest in the provision of care to veterans and assistance to family caregivers as the Secretary considers appropriate.

(3) REPORT CONTENTS.—The report required by paragraph (1)(B) shall contain the following:

(A) The plan required by paragraph (1)(A).

(B) A description of the individuals, caregivers, and organizations consulted by the Secretary of Veterans Affairs under paragraph (2).

(C) A description of such consultations.

(D) The recommendations of such individuals, caregivers, and organizations, if any, that were not adopted and incorporated into the plan required by paragraph (1)(A), and the reasons the Secretary did not adopt such recommendations.

(c) ANNUAL EVALUATION REPORT.—

(1) IN GENERAL.—Not later than 2 years after the date described in subsection (a)(3)(A) and annually thereafter, 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 comprehensive report on the implementation of section 1720G of title 38, United States Code, as added by subsection (a)(1).

(2) CONTENTS.—The report required by paragraph (1) shall include the following:

(A) With respect to the program of comprehensive assistance for family caregivers required by subsection (a)(1) of such section 1720G and the program of general caregiver

support services required by subsection (b)(1) of such section—

(i) the number of caregivers that received assistance under such programs;

(ii) the cost to the Department of providing assistance under such programs;

(iii) a description of the outcomes achieved by, and any measurable benefits of, carrying out such programs;

(iv) an assessment of the effectiveness and the efficiency of the implementation of such programs*, including a description of any barriers to accessing and receiving care and services under such programs*; and

(v) such recommendations, including recommendations for legislative or administrative action, as the Secretary considers appropriate in light of carrying out such programs.

(B) With respect to the program of comprehensive assistance for family caregivers required by such subsection (a)(1)—

(i) a description of the outreach activities carried out by the Secretary under such program**[**; and**]***;*

(ii) an assessment of the manner in which resources are expended by the Secretary under such program, particularly with respect to the provision of monthly personal caregiver stipends under paragraph (3)(A)(ii)(v) of such subsection (a)**[**.**]***; and*

(iii) an evaluation of the sufficiency and consistency of the training provided to family caregivers under such program in preparing family caregivers to provide care to veterans under such program.

(C) With respect to the provision of general caregiver support services required by such subsection (b)(1)—

(i) a summary of the support services made available under the program;

(ii) the number of caregivers who received support services under the program;

(iii) the cost to the Department of providing each support service provided under the program; and

(iv) such other information as the Secretary considers appropriate.

(d) REPORT ON EXPANSION OF FAMILY CAREGIVER ASSISTANCE.—

(1) IN GENERAL.—Not later than 2 years after the date described in subsection (a)(3)(A), 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 feasibility and advisability of expanding the provision of assistance under section 1720G(a) of title 38, United States Code, as added by subsection (a)(1), to family caregivers of veterans who have a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service before September 11, 2001.

(2) RECOMMENDATIONS.—The report required by paragraph (1) shall include such recommendations as the Secretary con-

siders appropriate with respect to the expansion described in such paragraph.

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DISSENTING VIEWS

The Minority offers the following dissenting views for H.R. 5674, VA Maintaining Internal Systems and Strengthening Outside Networks (MISSION) Act of 2018:

This Committee, along with our Senate counterparts, have spent the better part of this Congress outlining how to consolidate the Department of Veterans Affairs' (VA) seven community care programs, all with different eligibility criteria and payment rates, into a single, consolidated, easy to use and administer program. The policy outlined in H.R. 5674 is the result of that hard work. While the Minority largely agrees with said policy, we do have concerns.

Overall, the Minority is pleased that moving forward all community care will be funded using discretionary dollars. However, we are concerned the coming fiscal cliff could catastrophically jeopardize VA's ability to continue providing care and services to our nation's veterans.

Ranking Member Walz offered an amendment that would consider the authorization of appropriations in H.R. 5674 as a change in the concepts and definitions in section 251(b)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. § 901(b)(1)). This Change in Concepts and Definitions, opposed by the Majority, is vital to ensuring the mandatory costs in H.R. 5674 that are shifted to discretionary costs will be covered with an adjustment to discretionary appropriations levels that are specified for those authorizations of appropriations. Without this language covering the costs within the current caps established by the Bipartisan Budget Act (P.L. 115–123) will be difficult if not impossible. Without the inclusion of this language this bill is setting up a situation where the cost of the Community Care program will exhaust its funds in the middle of FY 2019 and force VA to cannibalize itself to meet the needs of this program.

President Trump's VA budget already proposed spending half of the $4 billion increase in VA's budget caps under the Bipartisan Budget Act deal on community care instead of VA's infrastructure—a violation of the deal. The $4 billion cap increase for VA under the Bipartisan Budget Act deal was for addressing VA's significant infrastructure needs. Without a change in concepts and definitions, this bill will renege on that deal as VA would be forced to find the funds under the caps (to prevent triggering across the board cuts under sequestration) to pay for community care.

Passing this bill without the change in the concepts and definitions would amount to an unfunded mandate that would force cuts to VA programs, including medical services provided by VA providers, VA research, and maintenance and construction for VA medical facilities. The significant costs associated with sending veterans to the private sector for care under this program could also require significant cuts to other non-defense discretionary pro-

grams such as veterans homelessness programs like HUD–VASH, veteran treatment courts, and veteran job training and employment assistance programs administered by other federal agencies. Without the change in concepts and definitions language, veterans and their families would be affected by these cuts, while more and more health care is administered by private providers.

Furthermore, given the budgetary concerns outlined above and the substantial preliminary score that accompanied HR 5674, nearly $51 billion over five years, the minority is concerned that certain provisions in this bill will become unfunded mandates giving veterans a false promise. In some instances, these veterans have been waiting for nearly a decade to receive parity in services. It would be unconscionable to not deliver on those pledges following implementation of this legislation. Restricting eligibility should not be used as a pay for in the future. Time and again the Minority has opposed robbing Peter to pay Paul and in this instance the Administration would seek to rob Paul to pay Paul. That is simply unacceptable.

At the time of writing these views, VA does not have a permanent Secretary, Undersecretary for Health or a Deputy Undersecretary for Health for Community Care. The Minority is troubled the lack of permanent leadership at VA will have a detrimental effect on the Department's ability to implement such a large piece of complex legislation. Without permanent leadership in place, Congress will not have anyone to hold accountable as VA undertakes the monumental task of consolidating multiple community care programs into a single multi-billion dollar a year program funded with taxpayer money. If history at this agency has taught us anything, interim and acting officials generally do not own the issue or problem. Instead they simply seek to maintain the status quo until a successor can be named. Given the task at hand, that would be a disaster. The Minority implores the administration to name permanent leadership in these roles as quickly as possible. The task ahead is too important.

In addition, the eligibility criteria laid out in HR 5674 for the new Veterans Community Care Program are complex, arguably more so then the current Veterans Choice Program, and in some instances nuanced, which will require careful oversight by this Committee to ensure accurate interpretation as regulations are written and policies and procedures are implemented. For example, while the Committee failed to adopt an amendment by Representative Brownley at the May 8, 2018 markup that sought to explicitly indicate traffic should be considered an "environmental factor" providers and veterans should consider as they determine whether a veteran would be best placed to receive care at a VA facility or in the community, the Minority expects as VA writes regulations related to this topic that they would allow traffic to be a consideration under "environmental factor". During the markup, Chairman Roe indicated he agreed with the premise but had been limited in his ability to support the amendment due to a preexisting deal he had with Ranking Member Walz regarding the broader legislation.

Finally, while the Commission on Care recommended a Base Realignment and Closure (BRAC)-like review was needed for VA, declaring it would, "offer a level of rigor far beyond what currently

exists for repurposing and selling capital assets"[1], we are not convinced such a model is entirely appropriate in the case of VA. That being said, the Minority is not opposed to the concept of realigning VA's capital assets to right-size the agency. To the contrary. We believe that process is long overdue.

The Minority would like to express their appreciation to the Majority for working with us to remedy some of the specific concerns we had related to the Commission and its process. However, we remain concerned that Title II does not provide the Secretary enough tools and authorities on the front end of the process as he or she makes their recommendations to the Commission. For example, Minority staff had advocated for inclusion of provisions that would have provided the Secretary the authority to enter into more public-private partnerships and the ability to enter into agreements or contracts with the Secretary of Health and Human Services for mutually beneficial coordination, use or exchange of health care resources between VA and the Public Health Service which would give the Secretary additional options to consider as they drafted recommendations to the Commission.

TIMOTHY J. WALZ.

[1] Commission on Care, page 60, June 30, 2016, "Commission on Care Final Report," https://s3.amazonlaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_0630_16_FOR-WEB.pdf.