

Calendar No. 273

115TH CONGRESS }
2d Session }

SENATE

{ REPORT
115-212

CARING FOR OUR VETERANS ACT OF 2017

MARCH 7, 2018.—Ordered to be printed

Mr. ISAKSON, from the Committee on Veterans' Affairs,
submitted the following

R E P O R T

[To accompany S. 2193]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs (hereinafter, "Committee"), having considered an original bill, S. 2193, to amend title 38, United States Code (hereinafter, "U.S.C."), to improve health care for veterans, and for other purposes, having considered the same, reports favorably thereon and recommends that the bill do pass.

INTRODUCTION

On January 12, 2017, Senator Heller introduced S. 113, the proposed Maximizing Efficiency and Improving Access to Providers at the Department of Veterans Affairs Act. S. 113 would require the Secretary of Veterans Affairs to carry out a pilot program to increase the use of medical scribes to maximize the efficiency of physicians at medical facilities of the Department of Veterans Affairs (hereinafter, "VA"). Senator Tester was an original cosponsor. The bill was referred to the Committee.

On January 12, 2017, Senator Heller introduced S. 114, the proposed VA Choice and Quality Employment Act of 2017. S. 114 would require VA to submit an annual report on performance awards and bonuses awarded to certain high-level VA employees. Senator Casey was an original cosponsor. Senators Collins and King were later added as cosponsors. The bill was referred to the Committee.

On January 12, 2017, Senator Heller introduced S. 115, the proposed Veterans Transplant Coverage Act. S. 115 would amend title 38, U.S.C., to authorize the Secretary of Veterans Affairs to provide for an operation on a live donor for purposes of conducting a trans-

plant procedure for a veteran. Senator Cornyn was later added as a cosponsor. The bill was referred to the Committee.

On March 9, 2017, Senator Murray introduced S. 591, the proposed Military and Veteran Caregiver Services Improvement Act of 2017. S. 591 would expand eligibility for the program of comprehensive assistance for family caregivers to include veterans who were injured or fell ill in the line of duty prior to September 11, 2001; include child care, financial planning, and legal services in the program of comprehensive assistance for family caregivers; authorize the transfer of entitlement to Post-9/11 education assistance to family members by veterans who are in the program of comprehensive assistance for family caregivers, without regard to length-of-service requirements; expand eligibility for special compensation for members of the uniformed services with catastrophic injuries or illnesses requiring assistance in everyday living; authorize the VA to provide certain caregiver assistance to family caregivers of a member in receipt of monthly special compensation; authorize flexible work schedules or telework for Federal employees who are caregivers of veterans; designate a veteran participating in the program of comprehensive assistance for family caregivers as an adult with a special need for purposes of the lifespan respite care program; establish an interagency working group to review policies relating to the caregivers of veterans and members of the Armed Forces; and require studies on members of the Armed Forces who commenced service after September 11, 2001, and veterans who have incurred a serious injury or illness, including a mental health injury, and their caregivers. Senators Baldwin, Bennet, Blumenthal, Brown, Cantwell, Collins, Coons, Durbin, Franken, King, Murphy, Sanders, Schatz, Shaheen, Tester, and Warner were original cosponsors. Senators Booker, Cardin, Casey, Cortez Masto, Duckworth, Hirono, Kaine, Manchin, Markey, Menendez, Merkley, Nelson, Peters, Stabenow, Van Hollen, Warren, and Wyden were later added as cosponsors. The bill was referred to the Committee.

On April 25, 2017, Senator Ernst introduced S. 925, the proposed Veterans E-Health and Telemedicine Support Act of 2017, or VETS Act of 2017. S. 925 would authorize VA health care professionals to provide treatment to patients via telemedicine regardless of where the covered health care professional or the patient is located. Senator Hirono was an original cosponsor, and Senators Booker, Boozman, Grassley, Hassan, Hatch, Kennedy, Rounds, Shaheen, Tester, Tillis, and Udall were later added as cosponsors. The bill was referred to the Committee.

On May 17, 2017, Senator Baldwin introduced S. 1153, the proposed Veterans Acquiring Community Care Expect Safe Services Act of 2017, or Veterans ACCESS Act. S. 1153 would require VA to prohibit or suspend certain health care providers from providing non-VA health care services to veterans. Senator Moran was an original cosponsor. The bill was referred to the Committee.

On May 25, 2017, Senator Crapo introduced S. 1279, the proposed Veterans Health Administration Reform Act of 2017. S. 1279 would authorize VA to furnish health care from non-VA health care providers through the establishment of a Care in the Community program. This program would include the creation of an education program on health care options from VA and a training program

for the administration of non-VA health care. S. 1279 would also make the reimbursement for emergency treatment and urgent care furnished in a non-VA facility more generous. Senator Risch was later added as a cosponsor. The bill was referred to the Committee.

On June 8, 2017, Senator Brown introduced S. 1319, the proposed Community Care Competency Act of 2017. S. 1319 would require VA to establish a continuing medical education program for non-VA medical professionals who treat veterans to increase knowledge and recognition of medical conditions common to veterans. Senator Durbin was later added as a cosponsor. The bill was referred to the Committee.

On June 8, 2017, Senator Tester introduced S. 1325, the proposed Better Workforce for Veterans Act of 2017. S. 1325 would amend VA authorities to improve the hiring, recruiting, and training of employees by removing the limitation on recruitment, relocation, or retention incentives. Senators Crapo, Hassan, Kaine, McCaskill, and Moran, were original cosponsors, and Senator Nelson was later added as a cosponsor. The bill was referred to the Committee.

On June 27, 2017, Senator Sullivan introduced S. 1449, the proposed Serving our Rural Veterans Act of 2017. S. 1449 would authorize payment by the VA for training and supervision of medical residents and interns at non-VA facilities. S. 1449 would also require VA to carry out a pilot program to establish or affiliate with residency programs at facilities operated by Indian tribes, tribal organizations, and the Indian Health Service (hereinafter, "IHS"). Senator Tester was an original cosponsor. The bill was referred to the Committee.

On July 20, 2017, Senator Hoeven introduced S. 1611, the proposed Veterans Access to Long Term Care and Health Services Act. S. 1611 would authorize VA to enter into Veterans Care Agreements (hereinafter, "VCAs") with health care providers to furnish hospital care, medical services, or extended care services if VA is unable to furnish the care. Senator Rounds was an original cosponsor, and Senator Cassidy was later added as a cosponsor. The bill was referred to the Committee.

On September 28, 2017, Senator Cassidy introduced S. 1871, the proposed VA Provider Equity Act. S. 1871 would make a doctor of podiatric medicine eligible for any supervisory position to the same degree as a Veterans Health Administration (hereinafter, "VHA") physician, and would increase the pay grade of podiatrists to match the compensation of other VHA surgeons, physicians, and dentists. Senators Baldwin, Donnelly, Grassley, Heitkamp, Peters, Shaheen, and Stabenow were later added as cosponsors. The bill was referred to the Committee.

On September 27, 2017, Senator Blumenthal introduced S. 1873, the proposed Veteran Partners' Efforts to Enhance Reintegration Act, or Veteran PEER Act. S. 1873 would require the Secretary of Veterans Affairs to carry out a program to establish peer specialists in Patient Aligned Care Teams (hereinafter, "PACT") at VA medical centers (hereinafter, "VAMC"). Senator Blunt was an original cosponsor, and Senators Baldwin, Brown, Collins, Hassan, Heller, Rounds, Warren, and Wicker were later added as cosponsors. The bill was referred to the Committee.

On November 15, 2017, Senator Baldwin introduced S. 2134, the proposed Andrew White Veterans Community Care Opioid Safety Act. S. 2134 would require VA to establish processes to ensure the safe practice of prescribing opioids by non-VA providers. Senators Blumenthal, Brown, Capito, Manchin, Moran, and Tester were original cosponsors, and Senator Hassan was later added as a cosponsor. The bill was referred to the Committee.

COMMITTEE HEARING

On May 17, 2017, the Committee held a hearing on legislation pending before the Committee. Testimony was received by Jennifer S. Lee, M.D., Deputy Under Secretary for Health for Policy and Services, Veterans Health Administration, U.S. Department of Veterans Affairs; Louis J. Celli, Jr., Director, National Veterans Affairs and Rehabilitation Division, The American Legion; Kayda Keleher, Associate Director, National Legislative Service, Veterans of Foreign Wars; Adrian Atizado, Deputy National Legislative Director, Disabled American Veterans; Allison Jaslow, Executive Director, Iraq and Afghanistan Veterans of America; and J. David Cox, National President, American Federation of Government Employees.

On June 7, 2017, the Committee held a hearing to examine the Veterans Choice Program and the future of care in the community. Testimony was received by the Honorable David J. Shulkin, M.D., Secretary of Veterans Affairs, Department of Veterans Affairs; Jeff Steele, Assistant Director, National Legislative Division, The American Legion; Adrian Atizado, Deputy National Legislative Director, Disabled American Veterans; Carlos Fuentes, Director of the National Legislative Service, Veterans of Foreign Wars; and Gabriel Stultz, Legislative Counsel, Paralyzed Veterans of America.

On July 11, 2017, the Committee held a hearing on legislation pending before the Committee, including two draft bills authored by Senators Isakson and Tester, primarily on the future of non-Department of Veterans Affairs health care. The draft legislation from the Chairman and Ranking Member largely informed the original bill reported from the Committee, which became S. 2193, the Caring for Our Veterans Act (hereinafter, "the Committee bill"). Testimony was received by Baligh Yehia, M.D., Deputy Under Secretary for Health for Community Care, Veterans Health Administration, Department of Veterans Affairs; Louis J. Celli, Director, National Veterans Affairs and Rehabilitation Division, The American Legion; Amy Webb, National Legislative Policy Advisor, AMVETS; Adrian Atizado, Deputy National Legislative Director, Disabled American Veterans; and Gabriel Stultz, Legislative Counsel, Paralyzed Veterans of America.

COMMITTEE MEETING

After reviewing the testimony from the foregoing hearings, the Committee met in open session on November 29, 2017, to consider the original bill, including provisions derived from the legislation noted above, including the two draft bills authored by Senators Isakson and Tester. The Committee voted, by roll call vote, to report favorably to the Senate the original bill at the Committee meeting.

SUMMARY OF THE ORIGINAL BILL AS REPORTED

The original bill as reported, consists of 57 sections, summarized below.

Section 1 provides a short title.

TITLE I—DEVELOPING AN INTEGRATED HIGH-PERFORMING NETWORK

SUBTITLE A—ESTABLISHING COMMUNITY CARE PROGRAMS

Section 101 would amend section 1703 of title 38, U.S.C., to establish a Veterans Community Care Program.

Section 102 would authorize VA to enter into VCAs with providers in the community to provide health care to veterans.

Section 103 would authorize VA to enter into VCAs with State Veterans Homes.

Section 104 would require VA to establish guidelines for health care access and standards for quality.

Section 105 would authorize access to walk-in care for eligible veterans.

Section 106 would require VA to perform market area assessments at least every 4 years and to submit a strategic plan for Congress at least every 4 years regarding an assessment of health care demand and capacity.

Section 107 would apply the TRICARE contractor and subcontractor compliance directive, Directive 2014–01 of the Office of Federal Contract Compliance Programs of the Department of Labor (hereinafter, “DOL”), to VCAs established in section 102.

Section 108 would authorize VA to deny, suspend, or revoke the eligibility of a non-VA health care provider to participate in the Veterans Community Care Program if the provider was previously removed from employment by VA or had their medical license revoked.

SUBTITLE B—PAYING PROVIDERS AND IMPROVING COLLECTIONS

Section 111 would establish a prompt payment process and standards to which VA should adhere when paying non-VA providers and require claims to be processed by a contracted third party administrator or other non-VA entity.

Section 112 would authorize VA to pay for services not subject to an agreement.

Section 113 would authorize VA to collect from a third party for care provided to non-veterans and authorize VA to seek collections when it pays for care rather than just furnishes it.

Section 114 would authorize VA to enter into an agreement with a third party entity to electronically process health care claims from community providers.

SUBTITLE C—EDUCATION AND TRAINING PROGRAMS

Section 121 would require VA to develop and administer an education program to inform veterans about their health care options.

Section 122 would require VA to develop and administer a training program for VA employees and contractors on how to administer non-VA health care programs.

Section 123 would establish a program to provide continuing medical education to non-VA medical professionals.

SUBTITLE D—OTHER MATTERS RELATING TO NON-DEPARTMENT OF
VETERANS AFFAIRS PROVIDERS

Section 131 would require VA to establish processes to ensure safe opioid prescribing practices by non-VA providers.

Section 132 would authorize VA to share certain medical record information with non-VA entities for purposes of providing health care and with third parties for the recovery of the cost of certain care.

Section 133 would require competency standards for non-VA health care providers that treat injuries or illnesses in clinical areas that VA has a special expertise.

SUBTITLE E—OTHER NON-DEPARTMENT HEALTH CARE MATTERS

Section 141 would require VA to submit to Congress a justification for any new supplemental appropriations request submitted outside of the standard budget process.

Section 142 would authorize VA, beginning in fiscal year (hereinafter, “FY”) 2019, to use any remaining amounts in the Veterans Choice Fund to pay for any health care services under chapter 17 of title 38, U.S.C., through non-VA providers.

Section 143 would provide a sunset date for the Veterans Choice Program of December 31, 2018.

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

TITLE II—IMPROVING DEPARTMENT OF VETERANS AFFAIRS HEALTH
CARE DELIVERY

SUBTITLE A—PERSONNEL PRACTICES

PART I—ADMINISTRATION

Section 201 would create a new authority to authorize VA health care professionals to practice telemedicine regardless of the location of the provider or patient during the treatment.

Section 202 would make a podiatrist eligible for any supervisory position to the same degree as a VHA physician, and would increase the pay grade of podiatrists to match the compensation of other VHA surgeons, physicians, and dentists.

Section 203 would include certified clinical perfusionists in the list of excepted positions and convert such positions to full title 38 status.

Section 204 would amend the statutory requirements for the position of the Chief Officer of the Readjustment Counseling Service (hereinafter, “RCS”).

Section 205 would make an exception for increasing the compensation scale and raises for VAMC directors and directors of Veterans Integrated Service Networks (hereinafter, “VISNs”).

Section 206 would require VA to identify and fully staff all mental health vacancies and all primary care and mental health vacancies in PACTs.

Section 207 would require VA to make certain staffing capacity information publicly available on a VA Internet website.

Section 208 would require VA to integrate peer specialists into PACT.

Section 209 would require VA to establish a pilot program to increase the use of medical scribes at VA facilities.

Section 210 would express the sense of Congress that VA should make the resolution of staffing shortages a priority.

PART II—EDUCATION AND TRAINING

Section 211 would require VA to increase the number of graduate medical education (hereinafter, “GME”) positions by up to 1,500 and authorize VA to pay for the time the residents are training at non-VA facilities.

Section 212 would require VA to establish a pilot program to establish or affiliate with GME residency programs at facilities operated by Indian tribes, tribal organizations, and the IHS in rural areas.

Section 213 would authorize VA to reimburse any board-certified advanced practice registered nurse (hereinafter, “APRN”) up to \$1,000 per year for continuing professional education.

Section 214 would increase the maximum amount of payments that VA could make for participants of VA’s Education Debt Reduction Program (hereinafter, “EDRP”).

Section 215 would authorize VA to establish a demonstration program on training and employment of alternative dental health care providers for dental health care services for veterans in rural and underserved communities.

PART III—OTHER PERSONNEL MATTERS

Section 221 would establish an exception to a previous limitation on awards and bonuses for recruitment, relocation, and retention.

Section 222 would require VA to submit an annual report on performance awards and bonuses awarded to certain high-level VA employees.

Section 223 would expand the definition of compensation to include pay earned by employees when performing duties authorized by the Secretary or when the employee is approved to use annual, sick, family medical, military, or court leave, or other paid absences for which pay is not already regulated.

Section 224 would establish a higher maximum amount of basic pay for registered nurses.

SUBTITLE B—IMPROVEMENT OF UNDERSERVED FACILITIES OF THE DEPARTMENT

Section 231 would require VA to develop criteria for the designation of certain VA medical facilities as underserved and a plan to address the problem of underserved facilities.

Section 232 would require VA to establish a pilot program to provide tuition reimbursement and loan repayment for VA health care providers at underserved facilities.

Section 233 would require VA to establish a program to furnish mobile deployment teams to underserved facilities.

Section 234 would require VA to consider Vet Center employees eligible for EDRP.

SUBTITLE C—CONSTRUCTION AND LEASES

Section 241 would modify the definitions of major medical facility project and major medical facility lease.

Section 242 would authorize VA to enter into agreements with other Federal agencies for planning, designing, constructing, and/or leasing shared medical facilities.

Section 243 would modify the review process in VA's issuance of enhanced-use leases.

Section 244 would authorize VA to spend no more than \$117.3 million on the East Bay Community Based Outpatient Clinic, the Central Valley Engineering and Logistics support facility, and enhanced flood plain mitigation as part of the realignment of medical facilities in Livermore, California.

SUBTITLE D—OTHER HEALTH CARE MATTERS

Section 251 would direct VA to issue grants to non-VA entities to study the feasibility of using wellness programs in providing mental health counseling to veterans and their family members using Vet Centers.

Section 252 would authorize VA to provide for transplant procedures on live donors regardless of whether the donor is a veteran.

Section 253 would express the sense of the Senate that VHA should not be privatized.

TITLE III—FAMILY CAREGIVERS

Section 301 would expand eligibility for VA's Program of Comprehensive Assistance for Family Caregivers, in two phases, to all eras of veterans.

Section 302 would require VA to implement an information technology (hereinafter, "IT") system that fully supports the Family Caregiver Program and allows for data assessment and comprehensive monitoring.

Section 303 would modify the requirements for VA's annual report to Congress on the Family Caregiver Program.

TITLE IV—APPROPRIATION OF AMOUNTS

Section 401 would authorize and appropriate \$1 billion to VA to be used for educational assistance for providers, the increase of GME positions, and recruitment, relocation, and retention incentives.

Section 402 would authorize and appropriate \$4 billion to be used for the Veterans Choice Fund.

BACKGROUND AND DISCUSSION

TITLE I—DEVELOPING AN INTEGRATED HIGH-PERFORMING NETWORK

SUBTITLE A—ESTABLISHING COMMUNITY CARE PROGRAMS

Sec. 101. Establishment of Veterans Community Care Program.

Section 101 of the Committee bill, an original provision, would amend section 1703 of title 38, U.S.C., to provide VA the authority to build a network of providers in the community. Access to the network would be dependent on whether the veteran and their VA provider agree it would be in the best interest of the veteran to uti-

lize non-VA care, or if the quality and access of a VA medical service line does not equal the quality standards in the community and VA access guidelines.

Background. Section 1710 of title 38, U.S.C., requires VA to provide hospital care and medical services to eligible veterans. Section 1703 of title 38, U.S.C., authorizes VA to contract with non-VA facilities and providers to furnish hospital or medical services to eligible veterans when VA is not capable of providing economical care because of geographical inaccessibility or due to an inability to furnish such care or services required. Sections 1725 and 1728 of title 38, U.S.C., authorize VA to reimburse for certain types of care, such as emergency treatment, at non-VA facilities. Section 1786 of title 38, U.S.C., authorizes VA to provide necessary post-delivery care and services. Section 8111 of title 38, U.S.C., authorizes VA to enter into sharing agreements at other government facilities. Section 8153 of title 38, U.S.C., authorizes a VA facility to enter into a contract or agreement with non-VA health care entities to secure health care services that are either unavailable or not cost-effective to provide at a VA facility. Section 101 of Public Law (hereinafter, “P.L.”) 113–146, the Veterans Access, Choice, and Accountability Act of 2014 (hereinafter, “P.L. 113–146”), authorized veterans to receive care in the community if they would wait more than 30 days for care in a VA facility or lived more than 40 miles from a VA facility (hereinafter, “Veterans Choice Program”).

Committee Bill. Section 101(a)(1) would amend Section 1703 of title 38, U.S.C., to authorize care at non-VA facilities. Section 1703(a), as amended, would establish the Veterans Community Care Program to provide veterans with care in the community under certain circumstances and direct the Secretary to provide care coordination for veterans using the program. At a minimum, VA would ensure appointments are scheduled, ensure continuity of care, coordinate with adjacent regions should a veteran receive care in an adjoining network, and ensure a veteran does not experience a lapse of care or has an unusual or excessive burden in accessing care. The Committee expects that VA will execute all reasonable actions to ensure that a veteran receives a seamless transition from VA to community care and back to VA. The Committee believes that for this program to be a success for veterans, VA must provide high-quality customer service at every point in the process and truly put a veteran’s best interest at the forefront of this endeavor.

Section 1703(b), as amended, would define that a covered veteran for the purposes of this section is a veteran enrolled under section 1705 of title 38, U.S.C., or is not enrolled but is otherwise entitled to care at VA.

Section 1703(c), as amended, would specify that eligible non-VA health care providers would be providers who participate in the Medicare program, Federally Qualified Health Centers (hereinafter, “FQHCs”), facilities funded by IHS, or the Department of Defense (hereinafter, “DOD”).

Section 1703(d), as amended, would provide care in the community when VA does not offer the service the veteran needs, if the veteran resides in a state that does not have a full-service VA medical facility, or the veteran was eligible for the Veterans Choice Program, as of the day before the date of enactment of the Committee bill, because they lived more than 40 miles from a VA facil-

ity. Additionally, if the veteran and the veteran's primary care provider agree that it would be in the best medical interest of the veteran, they would receive care in the community. In determining whether care in the community is necessary, the provider should consider the driving distance between the veteran and the facility that provides the service the veteran needs; the nature of the care required; the frequency of the treatments needed; whether VA provides the service needed; whether the appointment can be provided within the access standards established by VA or a time frame a provider determines is clinically necessary; the veteran faces an unusual or excessive burden to access hospital care or services; or other conditions as determined by VA. The Committee does not intend for this to be an exhaustive list in determining the circumstances in which a veteran would be eligible for care in the community. The conditions specified in this subsection represent some factors the VA primary care provider and the veteran should take into consideration when determining whether to seek care in the community. The Committee also does not intend that the conversation between the veteran and their provider must be an in-person meeting. The conversation of where to receive care could be over the phone, through electronic mail, or with a representative of the provider.

Section 1703(e), as amended, would, in paragraph (1), authorize the Secretary to furnish hospital care, medical services, or extended care services through a health care provider specified in subsection (c) if a VA medical service line is not providing care that meets the access guidelines and standards for quality as established by the Secretary.

When measuring access, subparagraph (B) would require the Secretary to measure access of the VA medical service line when compared with the same medical service line at a different VA facility. Subparagraph (B) would also require the Secretary to measure quality at a VA medical service line by comparing it with two or more distinct quality measures at non-VA medical services lines. The Committee intends that as VA is able to compare more VA medical service line quality measures with the same quality measures in the community, that the scope of measurements will become more robust.

Section 1703(e) would require that not more than three medical service lines at any one VA facility be eligible under the authority provided under paragraph (1). Further, the authority provided in paragraph (1) would be limited to not more than 36 medical service lines nationwide. This means that not more than 36 instances of this authority may be used concurrently. The Committee believes that given the requirements in 1703(g), as amended, 36 medical service lines is a manageable number for VA to facilitate this authority and the concurrent remediation of a triggered service line.

Authority provided in paragraph (1) of 1703(e) would cease when the remediation described in subsection (g) is complete. The Committee intends that VA will take every measure to ensure a smooth transition of care back to VA for the veteran.

Section 1703(e) would require VA to publish in the Federal Register yearly and take all reasonable steps to provide direct notice to veterans affected by the authority provided in paragraph (1). VA would be required to provide to veterans the time period during

which care could be accessed in the community under this authority; the location or locations such care in the community can be accessed; and the clinical services available at each location under this authority. The Committee intends that this information be clear and concise so that no veteran is unsure of where to seek health care services.

Finally, it would be at the election of a veteran to use care in the community under the authority provided in section 1703(e)(1).

Section 1703(f), as amended, would provide for a clinical appeals process similar to the appeals process a veteran may follow in appealing a clinical decision for care provided within a VA facility. The Committee intends that this clinical appeals process be expedient so that no veteran faces an undue delay in health care services. The Committee strongly encourages VA to establish one clinical appeals process to be applied across VHA.

Section 1703(g), as amended, would require that not later than 30 days after VA determines that a medical service line is providing untimely care when compared with the same service line at other VA facilities or has deficient quality when compared with community providers, an assessment be submitted to Congress of the factors that led the Secretary to make such a determination. Included in that assessment must be a plan with specific actions, and the time to complete them, the Secretary intends to take to remediate the service line. The Committee intends that while veterans are provided the opportunity to seek community care under new section 101(e) that VA engage in robust efforts to remediate the service line.

Section 1703(g)(1)(A)-(G) sets forth the actions the Secretary should consider when developing the assessment required under 1703(g). Included among the actions the Secretary should consider to remediate the service line are special hiring authorities, including EDRP and recruitment, relocation and retention incentives; utilizing direct hiring authority; providing improved training opportunities; acquiring improved equipment; making structural modifications to the facility used by the service line; and other actions the Secretary considers appropriate. The Committee intends that the Secretary utilize all appropriate authorities to address deficiencies in a service line.

Section 1703(g)(2) would require the Secretary to identify those individuals at the local, VISN, and Central Office-levels responsible for the remediation efforts for a service line identified under new section 1703(e). The Committee believes that this level of accountability is necessary to ensure that appropriate actions are being taken to successfully remediate a service line.

Section 1703(g)(3) would require that within 180 days after the assessment required in 1703(g)(1), the Secretary submit to Congress a report on the progress of that medical service line in complying with the access guidelines and meeting the standards of quality established by the Secretary and any other actions the Secretary will take to ensure the service line is remediated. Further, 1703(g)(4) would require an annual analysis of the remediation actions and costs of such actions taken with respect to every service line triggered under 1703(e). These reporting requirements signal the Committee's intended level of oversight over the remediation process.

The Committee intends that the remediation of service lines be vigorously undertaken with the ultimate goal of veterans having access to a high-quality level of care at VA.

Section 1703(h), as amended, would direct the Secretary to establish access guidelines under section 1703B and quality standards under section 1703C for measuring whether the conditions under which medical care is authorized to be furnished through non-VA entities is met.

The Secretary would be directed to ensure these guidelines and standards, established under paragraph (1), provide veterans, VA employees, and community health care providers with relevant comparative information.

This subsection would also direct the Secretary to consult with Federal entities, including the DOD and the Department of Health and Human Services (hereinafter, "HHS"), the private sector, and nongovernmental entities in establishing the guidelines and standards.

No later than 270 days after the bill's enactment, the Secretary would be required to submit a report to Congress detailing the access guidelines and quality standards established under paragraph (1) and their development. At least every 3 years, the Secretary would be required to conduct a review of the guidelines and standards established under paragraph (1), and submit a report to Congress if there are any modifications.

This subsection would also direct the Secretary to ensure that community providers furnishing medical services under the authority of the Community Care program are able to meet the access guidelines and quality standards that the Secretary establishes under paragraph (1).

Section 1703(i), as amended, would allow VA to develop a tiered network to ensure high-quality health care, medical services, or extended care services would be available to veterans under this section. However, in developing a tiered network, VA is directed to not prioritize one provider over others in another tier.

Section 1703(j), as amended, would direct VA to enter into contracts to establish a network of health care providers. The section would also direct VA, to the extent practicable, to allow veterans to self-schedule appointments for care in the community using smartphone technology and direct VA, to the extent practicable, to schedule appointments for veterans in the community. However, the Committee intends that VA give consideration to the contractor performing the scheduling if a particular VAMC is not able to schedule in-house. In addition, section 1703(j) would direct VA to terminate a contract if an entity is not meeting certain criteria. Under the Veterans Choice Program, VA did not require a Third Party Administrator (hereinafter, "TPA") to monitor the time an individual is on hold or establish a standard for TPAs to adhere to. The Committee expects the Secretary to require future contractors under the Veterans Community Care Program to monitor the period of time an individual is placed on hold, assess the average time an individual is on hold disaggregated by geographic area and establish hold-time standards for contractors to adhere to. Further, a TPA that provided call center services for the Veterans Choice Program was not precluded from establishing a policy that limited the ability for an individual to troubleshoot more than three

claims. Medical providers that accepted veterans under the Veterans Choice Program expressed deep frustration at this policy because it limited the ability of medical providers to troubleshoot multiple outstanding claims. The Committee expects the Secretary to require future contractors under the Veterans Community Care Program to not limit the amount of claims an individual can troubleshoot per call. Section 1703(j) would also require VA to allow providers treating veterans under a contract or agreement under title 38, U.S.C., the ability to continue to provide care through the Veterans Community Care Program. Finally, section 1703(j) would require that when VA provides notice to an entity that is failing to meet contractual obligations, it would also provide a report to the Senate and House Veterans' Affairs Committees on such failure. Contractors have demonstrated significant challenges in executing their obligations under the Veterans Choice Program, to the detriment of the health care services provided to veterans. As such, the Committee believes that veterans would benefit with Congress' greater visibility into whether non-VA providers are meeting contractual obligations.

Section 1703(k), as amended, would direct that the rates VA would pay for care in the community may not exceed the rates established by the Centers for Medicare and Medicaid Services (hereinafter, "CMS"). The section gives VA flexibility with the rates for highly rural areas, the State of Alaska, and States with an All-Payer Model Agreement with CMS. The section would direct VA to negotiate rates that are not covered by CMS and, to the greatest extent practicable, use a value-based reimbursement model to promote the provision of high-quality care. While VA would be allowed to enter into value-based agreements, the Committee intends for the agreements with IHS to be based on the IHS fee schedule and not a value-based agreement.

Section 1703(l), as amended, would direct VA to bill veterans' other health insurance for non-service connected conditions treated through the Veterans Community Care Program. Section 1703(m), as amended, would require that a veteran not pay more for care received through the Veterans Community Care Program than they would for care received in a VA facility. Section 1703(n), as amended, would require VA to monitor the types of care and services provided under the authorities in this section and submit annual reports to Congress. Section 1703(o), as amended, would direct that VA cannot limit the type of care and services provided under the Veterans Community Care Program. Section 1703(p), as amended, would define a medical service line and appropriate committees of Congress.

Section 101(a)(2) would provide for a clerical amendment to the table of contents at the beginning chapter 17 of title 38, U.S.C.

Section 101(b) would provide an effective date for the Veterans Community Care Program. The section would be effective 30 days after VA submits a report required under section 101(q)(2) of P.L. 113-146 or on the date on which VA promulgates regulations, whichever is later. Section 101(c) would direct VA to prescribe regulations within 1 year of enactment.

Section 101(d) would require VA to continue existing contracts, memorandum of agreements, and memorandum of understanding VA had entered into prior to the enactment of this act with Alaska

Native and American Indian health systems and any agreements VA entered into with the Native Hawaiian health care system under section 103 of P.L. 113–146. It is the intent of this Committee that this legislation not supercede the authorities and agreements put into place to support these unique populations of veterans.

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

Section 102 of the Committee bill would authorize VA to enter into agreements to provide hospital care, medical care or extended care services on behalf of veterans.

Background. Under section 1703 of title 38, U.S.C., VA can enter into contracts for hospital care and medical services in non-VA facilities when VA 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.

Committee Bill. Section 102(a) would create a new section 1703A to authorize VA to purchase hospital care, medical services and extended care services as authorized by chapter 17 when VA cannot furnish such care itself or through existing contracts or sharing agreements. Section 1703A(a)(2)(A) would authorize VA to use VCAs when the Secretary, or any VA official authorized by 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 VA facilities or existing contracts or sharing agreements impracticable or inadvisable.

It is the Committee’s intent that section 102 would improve VA’s flexibility to meet veterans’ demand for hospital care, medical services and extended care services by authorizing VA to enter into VCAs that, in general, would not be subject to competition or other requirements associated with Federal contracts.

Section 1703A(a)(2)(B) would set forth requirements for review of VCAs, including the requirement to review each VCA of material size for at least 6 months within 2 years of it going into effect, and no less often than every 4 years thereafter, to determine if it is practical or advisable to provide such care or services within VA or through a contract or sharing agreement. While the Committee believes this authority is necessary to provide veterans high-quality and timely care in instances when VA cannot provide the health care services needed, it is the Committee’s intent that this authority be limited and routinely reviewed to determine whether the VCA contractors would more appropriately be part of VA’s network of providers.

Section 1703A(a)(3)(A) would authorize the Secretary to determine whether a VCA is of “material size” except for those for extended care services. Such VCAs would be considered to be of “material size” if they exceed \$5 million annually. It is the Committee’s intent that these agreements be reviewed to ensure that taxpayer dollars are being spent appropriately, that certain VCAs might be more appropriately be made part of the VA’s community care network and that veterans are receiving high-quality and timely care under the agreement.

Section 1703A(a)(3)(B) would authorize the Secretary to adjust the dollar amounts previously determined to be of “material size” by publishing a new amount in the Federal Register to account for changes in the cost of health care based upon recognized health care market surveys and other available data.

Section 1703A(b) defines entities and providers that would be eligible to provide services under a VCA. Eligible providers would include participants of the United States Medicare and Medicaid programs or other providers the VA Secretary deems appropriate.

Section 1703A(c) would require the Secretary to establish in regulation a process for the certification or recertification of eligible entities or providers. VA would include as part of its certification plan: deadlines for actions on applications for certification; standards for approval or denial of a certification, duration of a certification, revocation of a certification, and recertification of an eligible entity or provider; require the denial of a certification if the provider is excluded under other Federal laws from furnishing care or services for the Federal government; and procedures for screening entities and providers for the risk of fraud, waste, and abuse. The Committee intends that this process be straightforward and without undue burden on providers.

Section 1703A(d) would establish VCA rates, to the maximum extent practicable, to be Medicare rates. Section 1703A(e) would establish the terms of the Veterans Extended Care Agreements to specify the rates VA would reimburse, ensure the return of medical records to VA, ensure that the provider does not attempt to collect compensation from a third party or health care plan for extended care services provided under the agreements, ensure that only care authorized by VA would be provided under the agreement, and would establish a methodology for providers to submit bills to VA. Section 1703A(f) would establish the circumstances under which an agreement could be discontinued or not renewed. Section 1703A(g) would direct VA to establish a procedure to monitor the quality of care provided through the agreements. Section 1703A(h) would direct VA to establish procedures for providers to present disputes related to the agreements.

Section 1703A(i) would set forth the applicability of Federal laws. VCAs would not be treated as an award for the purpose of Federal laws that would require the use of competitive procedures to furnish care and services or a Federal contract for the acquisition of goods or services for purposes of Federal laws governing Federal contracts for the acquisition of goods or services.

Section 1703A(i)(2)(A) notes that VCAs would not be subject to any law for which Medicare servicers or suppliers are not subject. Section 1703A(j) would require that veterans treated under VCAs be subject to the same terms as if they had been treated in a VA facility. Section 1703A(k) would require that the Secretary promulgate regulations to carry out section 102.

Section 102(b) would make a clerical change to add section 1703A to the table of contents for chapter 17 of title 38, U.S.C.

Sec. 103. Conforming amendments for State veterans homes.

Section 103 of the Committee bill would amend section 1745(a) of title 38, U.S.C., to align VA’s procurement authority with State

Veterans Homes to match that provided for in Section 103 of the Committee Bill.

Background. Under section 1745 of title 38, U.S.C., VA can enter into contracts or agreements with state veterans homes to provide nursing home care for eligible veterans.

Committee Bill. Section 103(a) would make conforming technical amendments to section 1745(a) of title 38, U.S.C., to reflect the new authority provided to VA for the procurement of hospital care, medical services, and extended care services that, in general, would not be subject to the competition or other requirements associated with Federal contracts, while still subjecting eligible entities and providers to all laws that protect against employment discrimination or that otherwise ensure equal employment opportunities.

Section 1745(a), as amended, would delete the reference to agreements under section 1720(c)(1), which provide for agreements with non-VA nursing homes.

Section 1745(a) would add a new subsection (4)(A) providing that the Secretary or a designated VA official may enter into agreements with State Veterans Homes to provide nursing home services to eligible veterans that are not subject to the use of competitive contracting practices for furnishing hospital care and medical services.

Section 1745(a) would add a new subsection (B)(i) specifying that a State Veterans Home that enters into an agreement under section 1745(a) of title 38, U.S.C., is not subject to any provision of law to which service providers and suppliers of the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) are not subject in executing an agreement under this section.

Section 1745(a) would add a new subsection (B)(ii)(I) specifying that a State Veterans Home that enters into an agreement under section 1745(a) of title 38, U.S.C., is subject to all provisions of law regarding integrity, ethics, or fraud that subject a person to criminal or civil penalties.

Section 1745(a) would add a new subsection (B)(ii)(II) specifying that a State Veterans Home that enters into an agreement under section 1745(a) of title 38, U.S.C., is subject to all provisions of law that protect against employment discrimination or that otherwise ensure equal employment opportunities.

Section 1745(a) would add a new subsection (B)(iii) specifying that a State Veterans Home that enters into an agreement under section 1745(a) of title 38, U.S.C., is not to be treated as a Federal contractor or subcontractor for purposes of chapter 67 of title 41, U.S.C. (known as the “McNamara-O’Hara Service Contract Act of 1965”).

Finally, section 103(b) would specify that the new provisions in section 1745(a), as amended by section 103(a), shall apply to care provided on or after the date the Secretary makes effective the regulations that carry out Section 103.

Sec. 104. Access guidelines and standards for quality.

Section 104 of the Committee bill, an original provision, would, through a new section 1703B in title 38, U.S.C., direct VA to consult with other pertinent Federal entities to examine health care access measurements and establish local benchmarking access

guidelines. Section 104 would also create a new section 1703C directing VA to establish standards for quality for hospital care, medical services or extended care services provided at VA facilities and non-VA facilities.

Background. In April 2017, VA introduced a new website, www.accesstova.va.gov, to increase transparency on patient wait times and quality of care data. VA provides the wait times of veterans for certain types of care and services and publishes those wait times, by facility, on its website. When data is available, the VA website also compares the wait time to the average wait time in the community to determine whether the wait time for care at VA is better than or worse than the average wait for care in the local community.

VA also tracks the quality of care delivered within its facilities and provides the information on its access and quality website, as well as reports certain measures to the CMS Hospital Compare website. In a Government Accountability Office (hereinafter, “GAO”) report titled “VA Should Improve the Information It Publicly Reports on the Quality of Care at Its Medical Facilities,” GAO found that VA reports health care quality measures on two separate VA websites, the access and quality website and an older website. As of June 2017, the access and quality website provided information on 15 of the 110 measures that VA reports on its older website. Additionally, GAO found that VA may not be ensuring that the health care quality measures are both complete and accurate. GAO recommended that VA report a broader range of health care quality measures in an accessible and understandable manner on its website and conduct a systematic assessment across VAMCs to ensure the accuracy and completeness of the data used to inform the health care quality metrics. The Committee recognizes that VA plans to expand the access and quality website to include additional measures and encourages VA to continue to focus its efforts on ensuring the content is accessible and understandable for veterans seeking to make informed decisions about where they receive their health care. The Committee also expects the access guidelines and standards for quality established under this section to be incorporated into the access and quality website where applicable.

Committee Bill. Section 104(a) would add new sections 1703B and 1703C to title 38, U.S.C., to direct VA to create access guidelines and standards for quality of health care veterans receive from VA and non-VA providers.

Section 1703B would direct VA to develop local benchmarking access guidelines that would be used to inform both providers and veterans when making clinical decisions regarding the timeliness of veterans care. When developing these guidelines, VA would be directed to consult with other pertinent Federal entities, including, but not limited to, DOD, HHS, and CMS, to study health care access measurements.

Section 1703C would direct VA to implement standards for quality that apply to care provided at VA and non-VA facilities. Specifically, 1703C(a) would direct VA to develop standards for the quality of care provided under section 1703, as amended by section 101 of the Committee bill, in coordination with other pertinent Federal entities, including, but not limited to, DOD, HHS, and CMS. In developing these standards, VA is to consider existing health care

quality measures that are applied to public and private health care systems. VA would be directed to collect and consider data, such as, a survey of veterans to assess their satisfaction with their care; datasets that include, at a minimum, timely care, effective care, safety (including complications, readmissions, and death), and efficiency with which the care was provided.

Section 1703C(b) would direct VA to not later than 1 year after the standards for quality are established to publish the ratings for those quality measures on the CMS Hospital Compare website. To ensure VA has the most up to date standards of quality, section 1703C(b) would also direct VA to publish potential changes to the standards for quality in the Federal Register, not later than 2 years after establishing the initial standards for quality.

In establishing access guidelines and standards for quality, the Committee directs VA to consider the nature of care provided to veterans and the profile of the patient receiving that care. For instance, veterans with spinal cord injuries may be readmitted for wound care more than veterans with other injuries.

Section 104(b) would provide a clerical amendment to amend the table of sections in Chapter 17 of title 38, U.S.C.

Sec. 105. Access to walk-in care.

Section 105 of the Committee bill, an original provision, would direct the Secretary to establish procedures and regulations to ensure eligible veterans are able to access walk-in care from qualifying non-VA entities or providers.

Background. P.L. 113–146 amended chapter 17 of title 38, U.S.C. to allow veterans to seek and receive medical care from non-VA entities if VA cannot schedule an appointment within 30 days of the clinically indicated date, their residence is more than 40 miles from a VA facility with a primary care physician, or they are faced with an unusual or excessive burden to travel to the closest VA medical facility. The goal of P.L. 113–146 was to expand veterans’ access to timely and quality care, particularly when a VA facility was unable to provide it. In April 2017, VA began a pilot program in Phoenix to allow veterans to seek non-emergency and non-urgent care at CVS “Minute Clinics.” The purpose of the program is to help veterans receive care in a convenient manner at these facilities when “clinically appropriate.”

Committee Bill. Section 105 would amend chapter 17 of title 38, U.S.C. by creating a new section 1725A to provide walk-in care from non-VA entities or providers. The Committee’s intent in authorizing access to walk-in care is to offer veterans convenient care for non-urgent health care needs.

Section 1725A(a) would direct the Secretary to establish procedures and regulations to ensure eligible veterans are able to access walk-in care from qualifying non-VA entities or providers. The Committee believes that the Secretary should make clear what health care conditions are non-urgent and establish a mechanism, such as, an advice line, to help veterans determine whether care under this section is appropriate to meet their health care needs.

Section 1725A(b) would define eligible veterans as those who are enrolled under chapter 1705(a) of title 38, U.S.C. and who have been enrolled and have received medical care from VA within the

24-month period preceding the furnishing of walk-in care under this new program.

Section 1725A(c) would direct that a qualifying non-VA entity or provider is one that has entered into a contract with the Secretary in order to provide these services, and section 1725A(d) would allow veterans to seek walk-in care at FQHCs when appropriate. It is the Committee's intent that the authority in this section be exercised nation-wide, among several types of entities or providers to ensure adequate coverage, so that all veterans have the option of utilizing this convenient, walk-in care. Section 1725A(e) would direct the Secretary to ensure there is a continuity of care for veterans receiving walk-in care, including a mechanism to receive medical records from the walk-in clinics.

Section 1725A(f) would establish the procedures for copays for walk-in care. Those veterans not required to pay a copayment for VA medical services would have access to two walk-in visits per year without requiring a copayment. All visits thereafter would require a copayment determined by a sliding copayment scale as established by the Secretary. Veterans who are required to pay a copayment for medical services provided by VA, would be required to pay their regular copayments for the first two walk-in visits within a calendar year and would be required to pay a higher copayment, as determined by the Secretary, for additional visits. It is the Committee's expectation that the higher copayment amount not exceed \$50 per visit.

Section 1725A(g) would require the Secretary to publish regulations and rules, to carry out Section 105, no later than 1 year after the enactment of the bill. Section 1725A(h) would define walk-in care as non-emergent care provided by a qualifying non-VA entity or provider that furnishes episodic care and not longitudinal management of conditions.

Section 105(b) would provide an effective date as the date on which final regulations are promulgated. Section 105(c) would provide a clerical amendment to amend the table of sections in Chapter 17 of title 38, U.S.C.

Sec. 106. Strategy regarding the Department of Veterans Affairs High Performing Integrated Health Care Network.

Section 106 of the Committee bill, a freestanding original provision, would require the Secretary to perform market area assessments at least every 4 years and prescribe the elements that need to be included in the assessments. Section 106 of the Committee bill would also direct VA to submit a strategic plan to Congress every 4 years. The strategic plan would provide information on the health care capacity provided at each VA facility, the capacity provided through community care providers, and the demand for health care disaggregated by geographic market areas.

Background. VA intends to perform market area assessments to analyze the health care demand and service-delivery capacity in each of its 96 health care markets.¹ The methodology for the market area assessments was developed and validated through recent pilots in three market areas. Private-sector experts will enable VA

¹“VA Market Area Health System Optimization,” briefing to Senate Committee on Veterans Affairs, September 25, 2017.

market-assessment teams to assess the current and future veteran demand for medical care, the health care services available at VA, and the health care services available in the local community.² While the Committee is pleased VA is conducting this assessment, the Committee believes VA needs a more coordinated approach and a plan to utilize the assessments to better manage the health care provided under laws administered by VA.

Committee Bill. Section 106 would require VA to conduct quadrennial market area assessments and develop an analytically sound strategic plan based on information provided in the market area assessments. Specifically, section 106(a) would direct VA to conduct market area assessments every 4 years that would include an assessment of the demand for health care from VA disaggregated by geographic area; an inventory of the health care capacity at VA facilities; the capacity, number of providers, geographic location of the providers and types of care and services to be provided at non-VA facilities; capacity assessment from other Federal direct delivery systems and non-contracted health care providers regarding their ability to provide care to veterans; VA academic affiliates providing care to veterans; the effects on the capacity of health care by the access guidelines and standards for quality established under section 1703(h), as amended by section 101; and the number of appointments for care at VA and non-VA facilities. This section would direct VA to submit the market area assessments to the appropriate committees of Congress. Section 106(a) further directs VA to use the market area assessment to determine the capacity of the provider networks established under section 1703(j), as amended by section 101, and to inform the President's Budget Request for VA. Section 106(a) would take effect September 30, 2018.

Section 106(b) would direct VA to submit to Congress a strategic plan 1 year after enactment of the Committee bill and every 4 years thereafter that would specify a 4-year forecast for the demand for health care from VA by geographic location; the capacity to provide health care at each facility; and the capacity of care to be provided through community providers. When developing the strategic plan, VA should consider access guidelines and standards for quality developed under section 1703(h), as amended by section 101; market area assessments; VA's needs in providing services for conditions that are related to military service where there is limited community expertise; consult with relevant stakeholders in the Federal government, private sector, members of Congress, veterans service organizations, and other policy experts; identify emerging trends, issues, or potential opportunities that could affect health care for veterans; develop recommendations for short-term and long-term priorities for health care delivered by VA; conduct a survey of veterans who have used the system to gauge their satisfaction with VHA; and other matters VA considers appropriate. Section 106(c) would define the appropriate committees of Congress.

²Statement of Regan L. Crump, Assistant Deputy Under Secretary for Health for Policy and Planning, House Committee on Veterans' Affairs, October 12, 2017.

Sec. 107. Applicability of Directive of Office of Federal Contract Compliance Programs.

Section 107 of the Committee bill, a freestanding original provision, would set forth the applicability of the DOL Office of Federal Contract Compliance Programs (hereinafter, “OFCCP”) on provider agreements and agreements for state homes, to mirror the applicability of contractors under the TRICARE Program.

Background. Executive Order (hereinafter, “E.O.”) 11246 charges DOL with protecting the rights of workers employed by Federal contractors from discrimination on the basis of their race, color, religion, sex, sexual orientation, gender identity, or national origin with the responsibility of ensuring equal employment opportunities.

In 2014, due to confusion over applicability of the E.O. on TRICARE subcontractors under section 1072 of title 10, U.S.C., DOL established a 5-year moratorium on enforcement of the obligations required of TRICARE subcontractors. During this moratorium, DOL said it would work with other Federal agencies to clarify the coverage of health care providers under Federal statutes applicable to subcontractors.

Committee Bill. Section 107(a) would apply the same moratorium on enforcement of obligations required of TRICARE subcontractors to those entities that enter into VCAs, as established under section 102 of the Committee bill, and agreements for state homes found in section 1745(a) of title 38, U.S.C., as amended by section 103. Section 107(b) would prohibit the directive described in subsection (a) from being altered or rescinded before May 7, 2019. Section 107(c) would define the TRICARE Program. It is the intent of the Committee that DOL collaborate with VA to clarify the E.O.’s coverage of health care providers.

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

Section 108 of the Committee bill, a freestanding provision derived from S. 1153, would require the Secretary to deny, suspend, or revoke the eligibility of a non-VA health care provider to participate in the community care program if the provider was previously removed from employment by VA or had their medical license revoked.

Background. While VA does have controls in place to ensure that only high quality providers provide care to veterans in the community, it is limited to checking the Department of Health and Human Services’ List of Excluded Individuals and Entities and checking to ensure the providers have a current and unrestricted license. While VA does take these steps to ensure they only have high quality providers, VA does not take the next step to check whether the provider has ever had their license revoked. In addition, under the current practice at VA, a former VA employee who was terminated from employment at VA, but has not yet been reported to their state licensing board, may still be able to provide care to veterans through contracts or agreements with the VA.

Committee Bill. Section 108 would direct VA to deny, suspend, or revoke the eligibility of a non-VA provider to participate in VA’s community care program if the provider was previously removed from employment at VA or had their license revoked. Specifically,

section 108(a) would direct VA, 1 year after enactment of the bill, to deny, revoke, or suspend a provider's ability to provide care in the community if that provider was removed from employment at VA because their conduct resulted in their inability to deliver safe and appropriate health care or violated the requirements of their medical license that resulted in the loss of their license. Section 108(b) would allow VA to deny, suspend, or revoke the eligibility of a provider to participate in VA's community care programs if the provider is under investigation by their state medical licensing board and VA believes it is necessary to protect the health, safety, and welfare of veterans. Section 108(c) would direct VA to deny, suspend, or revoke a provider's ability to participate in VA's care in the community programs if that provider has been suspended from service as a health care provider in VA.

Section 108(d) would direct that, 2 years after enactment, GAO submit a report to Congress on VA's implementation of this section. The section directs that elements that should be included in that report are the aggregate number of providers denied, suspended, or revoked from delivering care in the community; an evaluation on the impact on patient access to care under VA's community care programs; an explanation of VA's coordination with state medical boards and whether those boards were involved in implementation of this section; and other recommendations to complement eligibility criteria of VA health care providers and health care providers eligible to provide care through VA's community care programs. Section 108(e) would define "non-Department health care services" to be services provided under subchapter I of Chapter 17 of title 38, U.S.C.; section 101 of P.L. 113-146; purchased through the Medical Community Care Account; or purchased with funds deposited in the Veterans Choice Fund.

SUBTITLE B—PAYING PROVIDERS

Sec. 111. Prompt Payment to Providers.

Section 111 of the Committee bill, an original provision, would establish a new section 1703D of title 38, U.S.C., to require VA to adhere to a specified prompt payment standard when paying for hospital care, medical services, or extended care services furnished by health care entities or providers under this chapter.

Background. P.L. 113-146 included the sense of Congress that VA should comply with the Prompt Payment Rule, section 1315 of title 5, Code of Federal Regulations, or any similar regulation or ruling. The sense of Congress expressed that this should apply to VA payment for health care to non-VA providers. The law also required that VA implement a claims processing system that complies with the Prompt Payment Act in chapter 39 of title 31, U.S.C.

A May 2016 GAO report, "Proper Plan Needed to Modernize System for Paying Community Providers," indicated that according to VA FY 2015 data, it processed about 66 percent of claims within 30 days or less. According to GAO, VHA did not pay interest penalties on most late payments to community providers until an Office of General Counsel opinion was issued in October 2015, indicating that the Prompt Payment Act does apply to VA care in the community claims.

Committee Bill. Section 111(a) would establish new section 1703D of title 38, U.S.C. Subsection (a) of this new section would require VA to pay for hospital care, medical services, or extended care services furnished under chapter 17 of title 38, U.S.C., within 45 calendar days of receipt of a clean paper claim or 30 calendar days of receipt of a clean electronic claim. If a claim is denied, VA would be required to notify the health care provider or entity regarding the reason for denial and any additional information required within 45 calendar days of denial of a paper claim and 30 calendar days of denial of an electronic claim. These claims should be paid, denied, or adjudicated within 30 calendar days from the receipt of the requested information.

Under subsection (b) of new section 1703D of title 38, U.S.C., health care providers or entities furnishing care or services would be required to submit claims for payment to VA not later than 180 days after the date on which the care was furnished. Subsection (c) would require that sections 3729 through 3733 of title 31, U.S.C., apply to fraudulent claims submitted to VA, and if the Secretary determines that a health care entity or provider submitted a fraudulent claim, the Secretary would be required to bar them from providing care under this chapter.

Section (d) would require that any claim that has not been denied with notice, made pending with notice, or paid to the health care entity or provider by VA within the time periods specified in subsection (a) be overdue. VA would be authorized, consistent with chapter 39 of title 31, U.S.C., to require that interest be paid on clean claims. Interest would be determined in accordance with the rate established by the Secretary of the Treasury under section 3902 of title 31 and published in the Federal Register.

Section (d)(3) would require VA to annually submit to Congress a report on payment of overdue claims under this subsection, disaggregated by paper and electronic claims. The reports would be required to include the amount paid in overdue claims, disaggregated by the amount of the overdue claim and the amount of interest paid on such overdue claim, the number of overdue claims and the average number of days late each claim was paid, disaggregated by VA facility and VISN.

Section (e) would require VA to deduct the amount of any overpayment from payments due to a health care entity or provider after making reasonable efforts to notify the provider or entity of the right to dispute or request a compromise.

Section 1703D(f) of title 38, U.S.C., would require VA to provide health care entities and providers furnishing care under this chapter with a list of information required to establish a clean claim. This information should be determined after consultation with public and private sector health care entities. Entities and providers must be notified of any changes to the information required not later than 30 days before the modifications take effect.

Section 1703D(g) of title 38, U.S.C., would require VA to act through a non-VA entity to process claims for compensation for hospital care, medical services, or extended care services furnished by a health care entity under chapter 17 of title 38, U.S.C. This could include a non-VA entity that is under contract or agreement for the program established under section 1703(a) to title 38,

U.S.C., or a non-VA entity that specializes in such processing for other Federal agency health care systems.

Section 1703D(h) of title 38, U.S.C., would require VA, with 90 days of enactment, to submit to 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 funds for certain hospital care, medical services, or extended care services that are non-underwritten. VA may coordinate with DOD, HHS, and the Department of the Treasury in developing this report.

Under the Veterans Choice Program, third-party contracting entities pay health care providers for the cost of care, and VA reimburses the contracting entities. The Committee encourages VA to examine whether this construct would be appropriate to continue under the Veterans Community Care Program, as established in Section 101 of the Committee bill.

Section 1703D(i) of title 38, U.S.C., would define “clean electronic claim” as the transmission of data for purposes of payment of covered health care expenses submitted to VA that contains all of the required data elements necessary for accurate adjudication. It would define “clean paper claim” as a paper claim for payment of covered health care expenses submitted to VA that contains all of the required data elements necessary for accurate adjudication. This subsection would define “fraudulent claims” as an intentional and deliberate misrepresentation of a material fact or facts by a health care entity or provider made to receive a claim that was not legally payable to the provider. It would also define “health care entity or provider” as any non-VA health care entity or provider. Section 111(b) would provide for a clerical amendment to insert 1703D in the table of sections.

In an effort to maximize VA’s resources and time to provide health care to veterans, the Committee recommends the VA leverage industry partners—via third party administrators—to process all non-VA health care claims. The Committee further recognizes the VA’s need to oversee claims processing undertaken by non-VA employees. As such, the Committee encourages the VA to develop policies allowing for prepayment claim reviews which entails the random selection of claims for manual review by VA to ensure the accuracy of claims processing.

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

Section 112 of the Committee bill, an original provision, would add a new section to Subchapter IV of chapter 81 to authorize the Secretary to compensate non-VA providers for medical care they provided to a veteran, despite those providers not being a party to the contract, agreement, or other arrangement that furnishes that care.

Background. Through the course of providing medical care for certain conditions, it is common for treating physicians to collaborate with colleagues for care that is clinically necessary. In the case of medical care for veterans, a non-VA provider may not have a formal agreement with VA to provide care to veterans but still operate in collaboration with an entity or provider who does. For exam-

ple, during a surgery, a hospital may have a formal agreement with VA to provide care, but the anesthesiologist may not, so he or she would generate a separate bill for VA.

Committee Bill. Section 112(a) would provide the Secretary with the authority to pay non-VA providers for care the Secretary has determined is clinically necessary, notwithstanding the absence of formalized contracts, agreements, or other arrangements to provide such care. It also would require the Secretary to take reasonable efforts to enter into contracts, agreements, or other arrangements with such providers to ensure that any future care is provided subject to some type of formalized agreement. Section 112(b) would provide for a clerical amendment to insert the item addressed in Section 112(a) into the table of sections at the beginning of chapter 81.

With this provision, the Committee intends for VA to pay for non-VA medical care that the Secretary considers necessary regardless of the relationship the non-VA providers have with VA. The Committee also expects that after paying for such care, VA would make reasonable attempts to establish formalized agreements with those providers to ensure that future care they provide is subject to such agreements.

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

Section 113 of the Committee bill, an original provision, would amend section 1729 of title 38, U.S.C., to authorize VA to collect from a third party for care furnished to non-veterans. It would also authorize VA to seek collections when VA pays for care, rather than furnishes it, and remove duplicative language regarding VA's authority to collect from other health insurance for treatment of a non-service-connected disability.

Background. Section 1729 of title 38, U.S.C. authorizes VA to collect reasonable charges from a third party, to the extent the veteran would be eligible, for care or services furnished to veterans for a non-service-connected disability. In some cases, VA pays for the care, but does not furnish it. In addition, in some circumstances, VA furnishes care to non-veterans, including certain Civilian Health and Medical Program of the Department of Veterans Affairs (hereinafter, "CHAMPVA") beneficiaries and in emergency situations. However, the current statute does not explicitly authorize VA to collect reasonable charges related to the cost of care for individuals who are not veterans.

Committee Bill. Section 113(a) would authorize VA to collect from a third party for care furnished to non-veterans by amending section 1729 of title 38, U.S.C., to refer to "individuals" instead of "veterans."

Section 113(b) would amend section 1729(a)(1) of title 38, U.S.C., to authorize VA to seek collections when VA pays for care, rather than furnishes it.

Section 113(c) would amend section 1729(a)(2)(D) to remove duplicative language. Paragraph 2 of the subsection states that VA's authorization to collect applies to a non-service-connected disability that meets criteria established in the following subparagraphs. Current subparagraph (D) restates that the statute applies to veterans who do not have a service-connected disability and who are

entitled to care, or payment of the expenses of care, under a health plan contract. The Committee bill would eliminate the duplicative reference to non-service-connected disability. It is the Committee's understanding that this change simply removes duplicative language and will have no impact on how VA interprets or implements its authority to collect from third parties.

Sec. 114. Processing of Claims for Reimbursement Through Electronic Interface.

Section 114 of the Committee bill, an original and freestanding provision, would authorize VA to enter into an agreement with a third-party entity to process health care claims for reimbursement using an electronic interface.

Background. VA currently processes claims for non-VA care and does not utilize an electronic interface. VA's current process includes manual steps and does not include an online portal for use by community providers to check the status of their claims.

Committee Bill. Section 114 would authorize VA to enter into an agreement with a third-party entity to utilize an electronic interface to process claims for reimbursement for health care provided under the laws administered by the Secretary.

As noted in Section 111 of this report, the Committee recommends the VA leverage industry partners to process all non-VA health care claims. The Committee also encourages the VA to develop policies allowing for prepayment claim review to ensure the accuracy of claims processing.

SUBTITLE C—EDUCATION AND TRAINING PROGRAMS

Sec. 121. Education program on health care options.

Section 121 of the Committee bill, a freestanding provision derived from S. 1279, would add a new section to title 38, U.S.C., requiring the Secretary to develop and administer an education program that informs veterans of their health care options.

Background. Veterans have numerous options for how they receive health care, including directly from VA providers at VA facilities, from VA-reimbursed community providers, and from providers of their choice through private insurance, Medicare, Medicaid, the TRICARE program, IHS, and tribal health programs. While VA offers a wide range of information on its website aimed at informing veterans on their options for health care, VA does not currently operate a program designed to educate veterans about enrollment priority, financial obligations for care, interaction between insurance and health care, and where to direct complaints about health care received.

Committee Bill. Section 121(a) would direct VA to develop and administer an education program to teach veterans about their health care options through VA. The Committee intends that VA ensure that veterans are provided clear guidance on how to compare health care options available to them. The Committee expects that during the implementation of the Caring for Our Veterans Act, veterans will have questions comparing VA to community care options for which they qualify. As such, the Committee directs VA to provide guidance on how to interpret and utilize access guide-

lines and standards for quality to inform a veteran's health care decision.

Section 121(b) would direct that the required elements of the training program include education about eligibility criteria for care, enrollment priority groups, and financial obligations for receiving services; teaching veterans about the interaction between health insurance (including Medicare, Medicaid, and the TRICARE program.) and VA health care; and information about where to direct complaints about health care received.

Section 121(c) would require the Secretary to ensure that materials produced through the program are made available to veterans who may not have Internet access. The Committee expects VA to make a good-faith effort to communicate with veterans through various mediums about their health care options through VA.

Section 121(d) would require the Secretary to evaluate the effectiveness of the education program and annually submit a report to Congress on the findings of the evaluation.

Section 121(e) defines the terms "Medicaid," "Medicare," and "TRICARE program."

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

Section 122 of the Committee bill, a freestanding provision derived from S. 1279, would add a new section to title 38, U.S.C., requiring the Secretary to establish a training program for VA employees and contractors on how to administer non-VA health care.

Background. VA has relied on non-VA entities to provide health care to veterans for many years, but the reliance increased after implementation of P.L. 113-146. Despite the increasing use of non-VA providers to provide care for veterans, there is no mechanism for providing VA employees and non-VA providers with information they need to most effectively treat veterans.

Committee Bill. With section 122, the Committee intends to better educate VA employees and contractors to ensure veterans have as positive a health care experience as possible.

Section 122(a) would direct which non-VA health care programs would be covered as part of the proposed training program. These include the program to reimburse for non-VA emergency room care; the Veterans Community Care Program under section 1703, as amended by section 101; and the management of opioid prescriptions by non-VA providers pursuant to improvements under section 131.

Section 122(b) would require the Secretary to evaluate the effectiveness of the training program annually and submit the findings of the evaluation to Congress.

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

Section 123 of the Committee bill, a freestanding provision which is derived from S. 1319, would establish a program to provide continuing medical education to non-VA providers. The program would be accredited in as many states as possible, conforming to the rules and regulations of state medical licensing agencies and medical credentialing organizations.

Background. Health care providers are usually required under state law to meet education requirements in order to retain their state medical license. For example, all but five states require physicians to meet continuing medical education requirements in cycles that range between annual and every 4 years. These requirements are intended to ensure that health care providers stay current on medical technology, treatment procedures, and medical research findings to provide the highest quality care to their patients. Community health care providers for veterans must ensure they meet state continuing medical education requirements, sometimes by self-financing the training.

Committee Bill. Section 123(a) would direct the topics to be addressed within the proposed program. Specifically, the program would include education on identifying and treating mental and physical conditions of veterans and their family members; VA's health care system; and any other matters the Secretary considers appropriate.

Section 123(b) would establish parity between medical professionals treating veterans outside VA and those within VA on the continuing medical education material provided, in order to support core competencies throughout the community.

Section 123(c) would direct how the program would be administered. The Secretary would determine the curriculum and number of credit hours to be provided, ensure the program would be accredited in as many states as practicable, and be provided at no cost to non-VA medical professionals. The Secretary would also monitor utilization of the program, evaluate its effectiveness, and report annually to Congress on findings in these areas. Section 123(d) defines the term "non-Department medical professional."

This section underscores the Committee's belief that educated community health care providers are better positioned to deliver high-quality care and services to veterans than providers who lack an understanding of the specific needs of veterans. The Committee also recognizes that by providing continuing medical education at no cost, community providers may be more likely to work with VA to provide care and services to veterans.

SUBTITLE D—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 of the Committee bill, a freestanding provision derived from S. 2134, would establish the processes by which VA ensures that non-VA health care providers participating in the Community Care program are safely prescribing opioids.

Background. P.L. 114–198, the Jason Simcakoski Memorial and Promise Act (hereinafter, "P.L. 114–198"), amended section 1701 of title 38, U.S.C., to modify the agency's opioid prescribing guidelines, increasing oversight and accountability in VA's pain management and prescription services for veterans. Despite these efforts, the prescribing methods of contract providers may not meet the same rigorous safety standards. A July 2017 VA Office of Inspector General (hereinafter, "OIG") report on opioid prescribing by com-

munity providers found that many are not subject or do not adhere to VA's opioid safety reforms. The report also found that VA was not consistently tracking veteran's prescription history and information from community providers.

Committee Bill. Section 131 would direct the Secretary to create processes and guidelines to ensure community providers adhere to the same standards as VA in safely prescribing opioids. Section 131(a) would direct the Secretary to certify that community providers review the agency's guidelines for prescribing opioids as set forth by P.L. 114–198. Section 131(b) would direct the Secretary to establish a process for information sharing with community providers to include veterans complete prescription history on their electronic health records.

Section 131(c) would require all providers participating in the new VA Community Care Program to submit opioid prescriptions to VA for prior authorization or directly to a VA pharmacy for dispensing, and would require VA to record and monitor the prescriptions. The subsection includes exceptions in cases where there is an immediate medical need for the prescription or when obtaining a prescription at a VA pharmacy would impose undue hardship on the veteran. The Secretary is required to report quarterly to Congress on community providers' compliance and noncompliance. It is the Committee's intent that this section serve as an oversight measure by directing the Secretary to monitor and report community providers who are not following the proper safety guidelines and regulations for dispensing opioids.

Section 131(d) would ensure that VAMC and VISN directors have authority to take appropriate action against community providers they believe are using prescribing practices inconsistent with the standards of appropriate and safe care. Subsection (e) would provide the authority to deny or revoke eligibility of non-VA providers based on their opioid prescribing practices. The Committee believes that opioid prescribing among community providers must be closely monitored and regulated, and that these sections would provide the agency with the authority and tools to evaluate and manage contracts with community providers based on criteria to meet safety standards. Subsection (f) would provide a definition for a covered health care provider as a non-VA provider who provides health care to veterans under laws administered by VA.

Sec. 132. Improving information sharing with community providers.

Section 132 of the Committee bill, an original provision, would amend the existing provision in section 7332(b)(2)(H) regarding VA's ability to disclose protected health information to community providers and create a new exception in subparagraph (I) that would allow VA to share records with third parties to recover or collect reasonable charges for care provided.

Background. Under section 7332 of title 38, U.S.C., VA must keep confidential, with certain exceptions, medical records connected to patient activities associated with substance use disorders, human immunodeficiency virus infections, and sickle cell anemia.

Committee Bill. Section 132 would amend section 7332(b)(2) of title 38, U.S.C., by striking subparagraph (H) to insert three new paragraphs. It would add a new paragraph (H)(i) providing that the Secretary could share records with non-VA providers for the pur-

pose of furnishing hospital care, medical services, or extended care services to patients.

Section 7332(b)(2), as amended, would replace the existing paragraph (H)(ii) with a new paragraph providing that the entity to which such a protected record is disclosed may not disclose to another party or use the protected record for a purpose other than that for which the disclosure was made.

Section 7332(b)(2) would add a new paragraph (I) providing authority to VA to disclose medical records for purposes of recovering or collecting reasonable charges from the patients' other health plan contracts or other responsible third parties for care furnished by VA to a patient for a non-service connected disability.

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

Section 133 of the Committee bill, a freestanding original provision, would require the Secretary to establish competency standards and requirements for non-VA providers that treat injuries or illnesses in clinical areas that VA has a special expertise.

Background. The 2016 bi-partisan Commission on Care final report recognized,

. . . the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net.

With an increase in medical services provided by non-VA providers, there is a concern that community providers may not be able to provide the same level and quality of care, particularly in treating the unique nature of the injuries and illnesses among veterans.

Committee Bill. Section 133(a) would direct VA to establish competency standards and requirements for non-VA providers. These standards and requirements would be for clinical areas for which VA has clinical expertise, such as traumatic brain injury, military sexual trauma, and post traumatic stress disorder. Section 133(b) would require that these standards and requirements be met, through training or other means established by the Secretary, as a condition upon entering into a contract under the Veterans Community Care Program.

With this provision, it is the intent of the Committee to require the Secretary to ensure community providers meet the same competency and quality standards of VA.

SUBTITLE E—OTHER NON-DEPARTMENT HEALTH CARE MATTERS

Sec. 141. Plans for Use of Supplemental Appropriations Required.

Section 141 of the Committee bill, a freestanding original provision, would direct the Secretary to provide additional information to Congress when the Secretary requests funding outside the standard budget process.

Background. VA has demonstrated a lack of ability to effectively anticipate funding requirements and utilization timelines for their community care programs, most notably for the Veterans Choice Program as created in P.L. 113–146. In mid-2017, with little notice provided to Congress, VA provided guidance to VA medical facilities that Choice-related community care would need to be triaged as a result of dwindling money in the Veterans Choice Fund. As a result, P.L. 115–46, the VA Choice and Quality Employment Act of 2017 (hereinafter, “P.L. 115–46”), authorized and appropriated \$2.1 billion into the Veterans Choice Fund in mid-August, to prevent a delay in care for veterans. More recently, VA notified Congress that the \$2.1 billion, which VA believed would take 6 months to exhaust, would be expended in mid-January 2018.

Committee Bill. Section 141 would require that when the Secretary submits a request for funding outside the standard annual budget process, it must come 45 days prior to the date that any veteran program would be impacted, and must include a justification for the request, including a detailed business plan for execution and timeline for how long the additional funding is projected to last. Further, the Secretary must certify that the request was developed using a sound actuarial analysis. While the Committee is supportive of providing community care to veterans, the Committee also expects VA to utilize taxpayer dollars responsibly, and make appropriate and sufficient requests through the standard Federal budgeting process.

Sec. 142. Veterans Choice Fund flexibility.

Section 142 of the Committee bill, an original provision, would amend section 802 of P.L. 113–146 to authorize VA, beginning in FY 2019, to use remaining amounts in the Veterans Choice Fund to pay for any health care services under Chapter 17 of title 38, U.S.C., at non-VA facilities or through non-VA providers furnishing care in VA facilities.

Background. Section 802 of P.L. 113–146 authorized the Veterans Choice Fund to fund the Veterans Choice Program. Section 802 authorized and appropriated \$10 billion for the Veterans Choice Fund to be available until expended for the Veterans Choice Program. In 2017, P.L. 115–46 authorized and appropriated \$2.1 billion into the Veterans Choice Fund, to remain available until expended. When VA indicated to the Committee that the \$2.1 billion in the Veterans Choice Fund would be expended in mid-January 2018. Congress appropriated an additional \$2.1 billion in P.L. 115–96, a bill to make continuing appropriations (hereinafter, “P.L. 115–96”). Section 402 of the Committee bill would provide an additional \$4 billion for the Veterans Choice Fund.

Committee Bill. Section 142 would authorize the Secretary, beginning in FY 2019, to use the remaining funds in the Veterans Choice Fund to pay for any health care services described in Chapter 17 of title 38, U.S.C., provided at non-VA facilities or through non-VA providers in VA facilities. The Committee intends the funds in the Veterans Choice Fund to be used for non-Veterans Choice Program care only after the new community care program established under section 101 of the Committee bill is fully implemented.

Sec. 143. Sunset of Veterans Choice Program.

Section 143 of the Committee bill, an original provision, would amend section 101(p) of P.L. 113–146 to end the Secretary’s authority to administer the Veterans Choice Program after December 31, 2018.

Background. Section 101 of P.L. 113–146 established the Veterans Choice Program. Section 101(p) authorized the program until funds appropriated for the Veterans Choice Program were expended or 3 years after the date of enactment of the law. Section 2 of P.L. 115–26, an Act to amend the Veterans Access, Choice, and Accountability Act of 2014, eliminated that end date.

Committee Bill. Section 143 would remove the Secretary’s authority to furnish care and services under section 101(p) of P.L. 113–146 after December 31, 2018.

Sec. 144. Conforming amendments.

Section 144 of the Committee bill, an original provision, would amend existing authorities to account for changes made by section 101 of the bill to consolidate and create the Veterans Community Care Program.

Background. VA currently uses several different authorities within title 38, U.S.C., to provide care for veterans in the community, such as sections 8111 and 8153. In addition, Section 101 of the Committee bill would amend section 1703 of title 38, U.S.C., and section 102 of the Committee bill would provide VA with new statutory authority to enter into provider agreements. Certain sections of law referencing section 1703 would need to be amended to reflect the new authority.

Committee Bill. Section 144 would make conforming amendments to other sections of the United States Code. Specifically, section 144(a)(1) would amend the authorities allowing VA to provide outpatient dental services at non-VA facilities; allowing VA Readjustment Counseling Centers to enter into contracts to provide care; and clarify the facilities referenced in VA’s burial plot allowance. Section 144(a)(2) would amend the Social Security Act to ensure the proper reference regarding hospitals that receive payments from the Medicare program if those hospitals provide inpatient care to veterans for procedures that the local VA facility is not able to provide. Section 144(a)(3) would amend P.L. 103–466, the Veterans Benefits Improvements Act of 1994, to ensure the appropriate reference to continue VA’s authority to use contracts to diagnose or treat veterans with Gulf War Illness. Section 144(b) would establish the effective date for subsection (a) as the date described in section 101(b).

TITLE II—IMPROVING DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE DELIVERY

SUBTITLE A—PERSONNEL PRACTICES

PART I—ADMINISTRATION

Sec. 201. Licensure of health care professionals of the Department of Veterans Affairs providing treatment via telemedicine.

Section 201 of the Committee bill, which is derived from S. 925, would add a new section to title 38, U.S.C., providing VA with au-

thority for its covered health care professionals to provide health care services to a patient no matter where the provider or patient is located using telemedicine services.

Background. Telemedicine has proven to help VA deliver health care services to veterans located in areas where VA or private sector health care providers may be unavailable or for veterans who are, for whatever reason, unable to travel to a health care provider. Therefore, telemedicine has the potential to enable VA to provide timelier, convenient service to veterans. Codifying VA's ability to provide such services via telemedicine, whether the veteran or provider is located in the same or different states, whether or not they are in a Federal building, the veteran's home, or VA facility, will aide VA in using its resources most efficiently. There exists no explicit authorization for the provision of telemedicine services by VA. Under section 7301 of title 38, U.S.C., VA is charged with providing medical and hospital services for the medical care and treatment of veterans. Under section 1722B of title 38, U.S.C., VA may waive copayments for veterans who receive telehealth and telemedicine services under the laws administered by the Secretary.

Committee Bill. Section 201(a) would amend chapter 17 of title 38, U.S.C., to add a new section 1730B regarding the licensure of covered health care professionals to provide telemedicine services. Section 1730B(a) would provide covered VA health care professionals with the ability to practice in any state, notwithstanding the location of the health care provider or the patient, when the treatment is occurring by telemedicine.

Section 1730B(b)(1) would require that the "covered health care professional" eligible to provide services under Section 1730B be an employee of the VA appointed under title 38 or title 5. Section 1730B(b)(2) would require that the "covered health care professional" eligible to provide services under Section 1730B be authorized by the Secretary to provide health care under Chapter 17 of title 38, U.S.C. Section 1730B(b)(3) would require that the "covered health care professional" eligible to provide services under Section 1730B be required to adhere to all of VA's standards of quality related to the provision of medicine. Section 1730B(b)(4) would require that the "covered health care professional" eligible to provide services under section 1730B be required to hold "an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional."

Section 1730B(c) would provide that neither the covered health care professional nor the patient are required to be located in a Federal Government facility during the health care services conducted by telemedicine. Section 1730B(d)(1) would provide that this section's provisions supersede any and all laws of any State that are inconsistent with the section. Section 1730B(d)(2) would provide that no State may take action to deny or revoke the license or other credential of a covered health care professional because the professional has engaged or intends to engage in an action covered by subsection (a). Section 1730B(e) would clarify that this bill is not intended to remove, limit, or otherwise affect a covered health care professional's obligations under the Controlled Substances Act (21 U.S.C. 801 et seq.).

Section 201(b) bill would amend the table of sections at the beginning of chapter 17 of title 38, U.S.C., to add the new section 1730B.

Finally, section 201(c) would require VA, not later than 1 year after the earlier of either the date services under the new section begin or the regulations to carry out the section are promulgated, submit to Congress a report on veteran and provider satisfaction with the program, statistics on the program's use, as well as any savings to VA from the program's use.

As VA noted in its proposed rule 82 FR 45756, "to furnish care to all beneficiaries and use its resources most efficiently, VA needs to operate its telehealth program with health care providers who will provide services via telehealth to beneficiaries in States in which they are not licensed, registered, certified, or located, or where they are not authorized to furnish care using telehealth. Currently, doing so may jeopardize these providers' credentials, including fines and imprisonment for unauthorized practice of medicine, because of conflicts between VA's need to provide telehealth across the VA system and some States' laws or licensure, registration, certification, or other requirements that restrict or limit the practice of telehealth." Additionally, consonant with the definition of "State" in subsection 101(20) of title 38, U.S.C., no political subdivision of a state may attempt to abrogate the authority granted in subsection 1730B.

The Committee does not intend for this section to create any coverage for non-VA employed health care providers. They are not subject to the same rigorous oversight and accountability standards that VA-employed health care professionals are.

The Committee supports the use of this authority, particularly for the purposes of addressing the mental health needs of veterans and preventing veteran suicide. Further development of VA's telemental health delivery hubs throughout the Nation should proceed apace to offer veterans more convenient treatment options. To further the goals of this Committee bill, we urge VA to ensure that covered health care providers can maximally benefit from telework or other suitable work arrangements.

The Committee additionally believes that rural veterans are particularly suited to benefit from this authority. However, the Committee is aware that there are significant barriers to rural veterans taking advantage of this authority, particularly as a result of the lack of a robust Internet or wireless infrastructure in many parts of the country. To that end, the Committee calls on VA to work with partners in the community, such as veterans service organizations or local governments, to find innovative ways to help these veterans benefit from this authority. VA should examine whether these organizations could establish veteran-cost-free telemedicine delivery areas in their facilities, particularly for veterans who lack access to Internet or wireless services, as a way to help maximize the use of the services and help veterans feel comfortable with this modality of care.

Sec. 202. Role of podiatrists in Department of Veterans Affairs.

Section 202 of the Committee bill, which is derived from S. 1871, would amend chapter 74 of title 38, U.S.C., by adding a new section 7413 to make podiatrists eligible for any supervisory position

in VHA to the same degree that a physician appointed under section 7401(1) is eligible and would increase the pay grade of podiatrists to match the compensation of VHA surgeons, physicians, and dentists. This section would require the Secretary to establish standards to ensure that specialists appointed to supervisory VHA positions do not provide direct clinical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties.

Background. The Committee is concerned VA is experiencing recruitment and retention issues for podiatrists. According to a February 2017 VA white paper on podiatry pay, the podiatrist compensation package has remained unchanged since 1976, except for those changes that include adjustments for basic pay and locality rates. VA indicated there is a growing health care demand for primary and specialty podiatric services, especially among veterans suffering from polytraumatic injuries and spinal cord injuries, in addition to the approximately 1.8 million veterans who are at risk of major foot wounds, infection, and amputation. According to CBO, VA employs about 400 podiatrists nationwide at an average salary of \$130,000. Under this section, CBO anticipates that the base salary for podiatrists would increase by about 15 percent to \$150,000 and VA would be able to hire an additional 30 podiatrists because the increased salary would make working for VA more attractive.

Committee Bill. Section 202(a) would make a podiatrist eligible for any supervisory position to the same degree as a VHA physician. This section requires the Secretary to establish standards to ensure that specialists appointed to supervisory VHA positions do not provide direct clinical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties. Section 202(b) increases the pay grade of podiatrists to match the compensation of other VHA surgeons, physicians, and dentists. The Committee expects these changes to aid in the recruitment and retention of podiatrists at VHA.

Sec. 203. Modification of treatment of certified clinical perfusionists of the Department.

Section 203 of the Committee bill, an original provision, would amend sections 7401 and 7455 of title 38, U.S.C., to include certified clinical perfusionists in the list of excepted positions and convert such positions to full title 38 status.

Background. Perfusionists are members of a surgical team providing highly specialized care during open heart surgery through the operation of the cardiopulmonary bypass machine (heart-lung machine). Currently, perfusionists are designated as title 38 hybrid employees and fall under the medical instrument technician qualification standard which limits their General Schedule level and salary. VA has experienced difficulty recruiting and retaining perfusionists, requiring some VAMCs to contract for perfusionist services.

Committee Bill. Section 203 would amend sections 7401 and 7455 of title 38, U.S.C., to provide certified clinical perfusionists in the list of excepted positions and convert such positions to full title 38 status to assist in the recruitment and retention of highly skilled perfusionists.

Sec. 204. Amending statutory requirements for the position of the Chief Officer of the Readjustment Counseling Service.

Section 204 of the Committee bill, which is derived from S. 1325, would amend section 7309(b)(2) of title 38, U.S.C., to remove the requirement that the Chief Officer of the RCS have at least 3 years of experience in providing and administrating direct counseling services or outreach service that is specifically within RCS.

Background. Section 7309(b)(2) of title 38, U.S.C., provides the statutory requirements for an individual to be eligible for hiring as the Chief Officer of the RCS.

Committee Bill. Section 204 would amend section 7309(b)(2) of title 38, U.S.C., by removing the requirement that the Chief Officer of the RCS have provided counseling or outreach as well as been an administrator in the RCS, specifically. No changes are made to the other requirements that the individual have advanced degrees in mental health or social work, have 3 years of experience providing direct counseling services and 3 years administering such services, meet the quality standards and requirements of VA, and be a combat veteran of the Armed Forces.

VA has stated that the pool of applicants for the position of RCS Chief Officer has been unhelpfully narrowed by the requirements of sections 7309(b)(2)(B) and (C). This has led to extended periods without a permanent Chief Officer of the RCS. As noted by the February 2017 Department of Veterans Affairs Advisory Committee on the Readjustment of Veterans' Annual Report, the Chief Officer position had been vacant from December 31, 2012 until May 2016. While the bill removes the requirement that the individual have a minimum of 3 years of employment specifically in the RCS as a direct counselor and 3 years as an administrator, it is the Committee's expectation that VA will continue to look to promote from within and ensure the unique culture and services provided by RCS flourish in the future. The Committee will conduct oversight over the administration of the RCS to ensure that the readjustment needs of combat veterans and other eligible veterans and their family members are met appropriately. Key to that is the promotion of the psychosocial readjustment counseling offered at RCS facilities in combination with the combat experience required of its employees; the Chief Officer of RCS must be fully experienced in this culture.

Sec. 205. Technical amendment to appointment and compensation system for directors of medical centers and directors of Veterans Integrated Service Networks.

Section 205 of the Committee bill, an original provision, would amend section 7404(d) of title 38, U.S.C., to make an exception for increasing the compensation scale and raises for VAMC directors and directors of VISNs.

Background. P.L. 115-41, the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 (hereinafter, "Accountability Act"), allowed VA to directly appoint VAMC directors and directors of VISNs. While the bill included a conforming amendment to section 7404(a) of title 38, U.S.C., the bill did not include a conforming amendment to section 7404(d) of title 38, U.S.C., to allow for higher pay for these individuals.

Committee Bill. Section 205 would amend section 7404(d) of title 38, U.S.C., to make an exception for increasing the compensation scale and raises for VAMC directors and directors of VISNs.

Sec. 206. Identification and staffing of certain health care vacancies.

Section 206 of the Committee bill, a freestanding original provision, would require the Secretary to identify and fully staff certain VA vacancies and submit a report within 210 days on progress made in filling such vacancies.

Background. Because of its decentralized structure, VHA is unable to determine a point-in-time count of VA mental health vacancies and primary care and mental health vacancies in the VA's PACTs. This information is essential for VHA to be able to address any systematic understaffing problems that may exist within service lines across VISNs or at certain types of VAMCs. Also, despite VA's knowledge of health care provider vacancies in the past, VHA has been slow to fill them.

Committee Bill. Section 206(a) would require the Secretary to identify and fully staff within 180 days VA mental health vacancies, as well as primary care and mental health vacancies in VA PACTs.

Section 206(b) would require the Secretary to submit a report to Congress within 210 days specifying whether VA has complied with the requirements of this section and, if not, how many vacancies remain, and why VA was unable to fill them.

With this provision, the Committee expects VA to aggressively address understaffing issues before they reach crisis levels.

Sec. 207. Department of Veterans Affairs personnel transparency.

Section 207 of the Committee bill, a freestanding original provision, would require the Secretary to make staffing capacity information and data, such as vacancies and active job postings, publicly available on a VA website.

Background. P.L. 113-146 requires the OIG to annually determine the five occupations within VHA for which there are the largest staffing shortages. A May 2014 OIG report, that preceded the requirements of P.L. 113-146, addressing ongoing concerns on VA's scheduling practices and excessive wait times acknowledged staffing shortages as one of many contributing factors. Concerns on inadequate staffing and hiring practices have been identified in OIG reports dating back to 2013. To date, the OIG has conducted its fourth report as required by P.L. 113-146 and its most recent analysis from September 2017 determined that for critical need occupations, a significant percentage of the total gains continues to be offset by staff losses and that VHA still does not have adequate, comprehensive operational staffing models for critical need occupations.

Committee Bill. Section 207 would require the Secretary to make staffing capacity information publicly available on a VA website. This provision would also require the information to be updated monthly, a semi-annual OIG review, and an annual report to Congress. The Committee intends that this information will assist VA in filling vacancies and provide greater transparency for stakeholders and Congress into challenges VA is having in recruiting and retaining personnel.

Sec. 208. Program on establishment of peer specialists in Patient Aligned Care Team settings within medical centers of Department of Veterans Affairs.

Section 208 of the Committee bill, a freestanding provision, which is derived from S. 1873, would require the Secretary to carry out a program to establish peer specialists in PACTs at VAMCs.

Background. VA has used peer specialists to assist veterans who are in treatment for mental health and substance abuse disorders. Peer specialists are veterans who are VA employees that serve as part of a care management team that promotes veterans' recovery by sharing their own recovery stories, providing encouragement, and teaching skills needed for successful recovery. The limited authority for utilizing the peer support model in the primary care setting has hindered the VA's ability to effectively engage veterans who would benefit from mental health or substance use treatment services. The stigma associated with veterans seeking care for mental health and substance use may result in veterans missing a key entry point to the effective VA peer support model of care.

Committee Bill. Section 208(a) would require the Secretary to establish a program to place not fewer than two peer specialists in PACTs at VAMCs to promote mental health, behavioral health, and substance use disorder care in primary care settings.

Section 208(b) would require the Secretary to establish the program in not fewer than 25 VAMCs by December 31, 2018, and 50 VAMCs by December 31, 2019.

Section 208(c)(1) would require the Secretary to locate the program in not fewer than 5 VAMCs that are designated as polytrauma centers and not fewer than 10 VAMCs that are not designated as polytrauma centers.

Section 208(c)(2) would require the Secretary to consider the feasibility and advisability of selecting VAMCs to operate the program in areas that are rural or underserved, not in close proximity to an active duty military installation, and different geographic locations, such as census tracts established by the Bureau of the Census.

Section 208(d) would require the Secretary to ensure that in carrying out the program the needs of female veterans are specifically considered and addressed and female peer specialists are made available to female veterans treated at each location.

Section 208(e) would require the Secretary to consider ways in which the peer specialists at each location can conduct outreach to community health care providers who are providing services to veterans as well as the veterans receiving services.

Section 208(f)(1) would require the Secretary to submit to Congress a report on the pilot program no later than 180 days after commencement and every 180 days thereafter until the Secretary determines the program is being carried out at the last location selected under subsection 208(c). The report would be required to include the findings and conclusions of the Secretary with respect to the program, an assessment of the program's benefits to veterans and family members, and an assessment of the effectiveness of outreach described in subsection 208(e).

Section 208(f)(2) would require the Secretary to submit to Congress a final report on the pilot program no later than 180 days after the Secretary determines the program is being carried out at the last location selected under subsection 208(c). The report would

detail the Secretary's recommendations as to the feasibility and advisability of expanding the program to additional locations.

With section 208, the Committee intends to examine the value of utilizing the peer support model in primary care settings.

Sec. 209. Pilot program on increasing the use of medical scribes to maximize the efficiency of physicians at medical facilities of the Department of Veterans Affairs.

Section 209 of the Committee bill, a freestanding provision, which is derived from S. 113, would require VA to establish a pilot program to evaluate the use of medical scribes by VA physicians.

Background. The Joint Commission, which is a non-profit organization that accredits and certifies health care organizations, including VA, defines a scribe as “an unlicensed person hired to enter information into the electronic medical record or chart at the direction of a physician or practitioner . . . Scribes are used most frequently, but not exclusively, in emergency departments where they accompany the physician or practitioner and record information into the medical record, with the goal of allowing the physician or practitioner to spend more time with the patient and have accurate documentation.³”

According to the Journal of the American Board of Family Medicine, “Available evidence suggests medical scribes may improve clinician satisfaction, productivity, time-related efficiencies, revenue, and patient—clinician interactions.” However, because a significant amount of research on the use of medical scribes has not been conducted, there are limits on the reliability of the evidence from the small number of studies that have been done.⁴

Committee Bill. Section 209(a) of the Committee bill would require VA to carry out a pilot program to increase the use of medical scribes to maximize the efficiency of physicians at VA medical facilities.

Sections 209(b) and 209(c) would require VA to carry out the pilot program for 18 months at not fewer than five VA medical facilities at which the Secretary has determined have a high volume of patients or that are located in and at which the Secretary has determined there is a shortage of physicians and the physicians have high caseloads.

Section 209(d) would require VA to enter into a contract for purposes of carrying out the pilot with one or more appropriate nongovernmental entities. An appropriate nongovernmental entity is defined as an entity that trains and employs professional medical scribes who specialize in the collection of medical data entry into electronic health records.

Section 209(e) would require VA to collect data on the pilot program in an effort to determine its effectiveness in increasing the efficiency of VA physicians. This data should include the average wait time for a veteran to receive care from a physician prior the pilot's implementation and the average wait time for such care after implementation; the average number of patients that such

³The Joint Commission, <https://www.jointcommission.org/standards—information/jcfaq-details.aspx?StandardsFAQId=1206>, accessed December 11, 2017.

⁴“The Use of Medical Scribes in Health Care Settings: A Systematic Review and Future Directions.” Cameron G. Shultz, PhD, MSW and Heather L. Holmstrom, MD; May-June 2015; <http://www.jabfm.org/content/28/3/371.full>.

physician is able to see daily prior to implementation and the average number of patients such physician is able to see daily after implementation; the average amount of time such physician spends daily on documentation prior to implementation and the average amount of time such physician spends on documentation daily after implementation; the satisfaction and retention scores of each such physician prior to the pilot's implementation and after; the patient satisfaction scores for each such physician prior to the pilot's implementation and after; and the patient satisfaction scores for their health care experience both before and after the pilot's implementation.

Section 209(f) would require VA to submit to Congress a report on the pilot program no later than 180 days after commencement and every 180 days thereafter for the duration of the pilot program. The report would be required to include the number of VA medical facilities participating in the pilot and an assessment of the effects that participation in the pilot program has had on each medical facility, including maximizing the efficiency of physicians at each facility, reducing average wait times for appointments, improving access of patients to electronic medical records, mitigating physician shortages by increasing the productivity of physicians, all data collected under subsection (e), and recommendations from the Secretary with respect to extending or expanding the pilot program.

Section 209(g) would define medical scribe as a member of the medical team hired and trained specifically and exclusively to perform documentation in an electronic health record to maximize the productivity of a physician.

This pilot is an effort to continue to evaluate ways to increase physician efficiency and better serve veterans. Increasing physician efficiency could especially benefit medical facilities that have a shortage of physicians and those physicians with a high caseload.

Sec. 210. Sense of Congress regarding Department of Veterans Affairs staffing levels.

Section 210 of the Committee bill, a freestanding original provision, would express the Sense of Congress that VA should make resolution of staffing shortages a top priority.

Background. While VA has acknowledged staffing shortages as a significant problem in the past, those shortages persist while VA initiates other organizational efforts.

Committee Bill. Section 210(a) would describe Congressional findings that VA needs to fill at least 35,000 positions and that not filling those positions cause delays in veterans receiving benefits and services. Section 210(b) would express the Sense of Congress that VA should prioritize filling vacant positions.

It is not clear to the Committee that VA has taken the issue of staffing shortages seriously. This provision emphasizes the importance with which the Committee believes VA should be treating this fundamental problem, as the health of millions of veterans depends on sufficiently staffed health care facilities.

PART II—EDUCATION AND TRAINING

Sec. 211. Graduate Medical Education and Residency.

Section 211 of the Committee bill, a freestanding original provision, would require VA to increase the number of GME positions by up to 1,500 positions at facilities that include non-VA facilities.

Background. Section 7302 of title 38, U.S.C., requires VA to carry out education and training programs, including medical residency programs. According to VA, it has the largest education and training program for health professionals in the United States. VA indicates that an estimated 70 percent of physicians in the United States have received training from VA.

P.L. 93–82, the Veterans Health Care Expansion Act of 1973, authorized VA to enter into agreements with academic affiliates to administer resident salary and benefits. It also authorized VA to only reimburse academic affiliates for the cost of the time period in which the resident is training at a VA facility.

P.L. 113–146 required VA to increase its number of GME residency positions by up to 1,500 over a 5-year period, beginning in 2015. P.L. 114–315, the Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016, extended the timeline by an additional 5 years. The law requires that when adding these positions, VA prioritize primary care, mental health, and other specialties determined appropriate, while also establishing these new positions in VA facilities without a GME program or in communities with a high concentration of veterans.

Committee Bill. Section 211(a) would require VA to increase the number of GME residency positions by up to 1,500 in the 10-year period beginning on the date of enactment. VA would be authorized to add these positions not only at VA facilities, but also at facilities operated by an Indian tribe, tribal organization, or IHS; an FQHC; a community health center; a DOD facility; or another health care facility the Secretary considers appropriate. VA would be authorized to pay stipends and benefits to these residents, regardless of whether they are placed in a VA facility. When determining residency positions, the Secretary would be required to consider several factors, including whether the facility is located in a rural location, whether the local community is medically underserved, and the ratio of veterans to VA health care providers in the area surrounding a facility. When determining specialties to be included in the residency positions, the Secretary would also be required to consider the types of specialties that improve quality and coverage of services to veterans and whether the specialty is included in VA's most recent staffing shortage determination.

Section 211(b) would require residents to submit applications to VA with an agreement to commit to a period of obligated service in return for stipend and benefit support.

Section 211(c) would require VA to notify individuals in writing upon their acceptance into the program.

Section 211(d) would require the residents and VA to have an agreement in writing regarding the terms of the residency, including by requiring a service obligation equal to the number of years of stipend support.

Section 211(e) would authorize VA to prescribe conditions of employment, including training and amount and terms of pay.

Section 211(f) would require residents to fulfill a period of obligated service as a full-time employee of VA in the clinical practice of the participant's profession or in another health-care section assigned by VA. VA would be required to notify individuals of their commencement date of service no later than 60 days prior.

Section 211(g) would establish penalties for those who fail to accept payment or instruct the educational institution in which the person is enrolled not to accept payment for a residency agreed to under subsection (d) and for residents who fail to fulfill their service obligation as a result of dismissal for disciplinary reasons, voluntary termination of residency, or loss of state license, registration, or certification to practice their health care profession.

Section 211(h) would authorize VA to recover funds, according to the specified formula, from those who breach their agreement.

Section 211(i) would require VA to submit to Congress an annual report detailing the positions filled under this section, as well as the location, associated academic affiliate, and any challenges faced in filling the positions.

The Committee understands that VA's authorization to only pay for the time the resident is training at VA limits VA's ability to create additional GME positions. In providing this additional authority, the intent is to provide more residents with the opportunity to train at VA, and in return, provide them with the opportunity for full-time employment at VA. The Committee recognizes that there are challenges to recruitment and retention, including in rural facilities, and understands that additional resources and incentives for training and hiring physicians may be beneficial for VA.

Sec. 212. Pilot program to establish or affiliate with graduate medical residency programs at facilities operated by Indian tribes, tribal organizations, and the Indian Health Service in rural areas.

Section 212 of the Committee bill, a freestanding provision which is derived from S. 1449, would require VA to establish a pilot program to establish or affiliate with GME programs at specified non-VA facilities.

Background. VA is only authorized to fund GME programs within VA facilities; however, both native and non-native veterans in some states, such as Alaska, Montana, and Hawaii, rely heavily on health care provided through facilities operated by Indian tribes, tribal organizations, or IHS. These entities provide care to veterans through a memorandum of understanding, national reimbursement agreement, and agreements entered into under sections 102 and 103 of P.L. 113-146. Due to the rural nature of many of these facilities, recruitment of health care providers can be difficult.

Committee Bill. Within the 1,500 new GME positions required by Section 211, section 212(a)-(d) would require VA, in consultation with IHS, to carry out an 8-year pilot program to establish or affiliate with GME residency training programs at five facilities operated by an Indian tribe, a tribal organization, or the IHS that is located in a rural or remote area. Section 212(e) would require VA to reimburse participating facilities for specified expenses associated with the pilot program. Section 212(f) would require residents participating in the program to fulfill a period of obligated service and would be eligible for student loan repayment through VA and

IHS. Any period of obligated service required would be served concurrently with any required service under the loan repayment programs. Section 212(g) would require that participants in the pilot program be considered a position referred to in section 211(a)(1) for purposes of the limitation on the number of authorized new positions. Section 211(h) would require VA to submit to Congress a report on the feasibility and advisability of expanding the pilot program and making it permanent, 3 years before the termination of the program.

This pilot program is intended to assist with recruiting health care providers in areas that face recruitment challenges and strengthen VA partnerships with other facilities that serve a large number of veterans. It will also provide additional opportunities for residents to gain specific rural health experience.

Sec. 213. Reimbursement of continuing professional education requirements for board certified advanced practice registered nurses.

Section 213 of the Committee bill, an original provision, would amend section 7411 of title 38, U.S.C., to require VA to reimburse continuing professional education expenses for APRNs.

Background. Section 7411 of title 38, U.S.C., requires VA to reimburse full-time, board-certified physicians or dentists appointed under section 7401(1) of title 38, U.S.C., for continuing professional education up to \$1,000 per year. This does not include APRNs. VA has indicated that it agrees with recommendations from the National Institute of Health and other health care organizations on the value of continuing education for APRNs and its important role in the provision of high-quality care.

Committee Bill. Section 213 would amend section 7421 of title 38, U.S.C., to require VA to reimburse APRNs for up to \$1,000 per year for continuing medical education expenses.

Sec. 214. Increase in maximum amount of debt that may be reduced under Education Debt Reduction Program of Department of Veterans Affairs.

Section 214 of the Committee bill, an original provision, would increase the maximum amount of loan repayment that can be provided to medical professionals under VA's EDRP.

Background. Section 7683 of title 38, U.S.C., provides VA with the authority to carry out EDRP, which provides educational assistance to VHA employees. EDRP has enabled VHA to incentivize employees to work for VA or remain with VA by assisting in the payment of educational debt.

With passage of P.L. 113-146, Congress raised the maximum amount of loan repayment under EDRP from \$60,000 to \$120,000 over a 5-year period with not more than \$24,000 being paid in any 1 year of participation of the Program. Despite this effort, VHA still faces challenges in incentivizing employees to remain with the Agency because private-sector loan repayment programs are more generous.

Committee Bill. Section 214(a) of the Committee bill would increase the maximum amount of loan repayment from \$120,000 to \$240,000, and increase the maximum yearly payment under EDRP

from \$24,000 to \$48,000. The Committee believes maximum use of this authority will assist VA in attracting high-quality providers.

Section 214(b) would require a study, within 1 year of enactment, on the demand for educational debt reduction, to be submitted to the Senate and House Committees on Veterans' Affairs. Included in the study would be the requirement that VA consider vacancies within VHA that are EDRP-eligible, the types of medical professionals in demand in the nation and VA projections on the number and type of medical professions that meet veteran demand.

Sec. 215. Demonstration program on training and employment of alternative dental health care providers for dental health care services for veterans in rural and other underserved communities.

Section 215 of the Committee bill, a freestanding original provision, would authorize the Secretary to carry out a demonstration program to establish programs to train and employ alternative dental health care providers.

Background. Coupled with the shortage of dental professionals at VA, veterans who reside in rural areas face increased barriers to accessing dental services. According to the VHA Office of Rural Health's May 2017's "Lessons Learned: A Rural Case Study, Challenges Increasing Access to Dental Care Among Rural Veterans":

For individuals living in rural communities, including Veterans, oral health is a significant public health issue due to the documented disparities associated with access and use of dental services. More specifically, rural Veterans face numerous barriers accessing dental services, including lack of transportation, affordability, and limited access to dental providers. These individuals are more likely to report an unmet dental need and only access dental services in response to discomfort or pain. The limited availability of dental services also contributes to oral health disparities by reducing access to dental care.

The Centers for Disease Control and Prevention reports that nearly 70 percent of Americans over the age of 65 have been diagnosed with a form of periodontal disease. While some conditions include inflammation of the gums, others are more serious and result in damage to the soft tissue and/or bone. Poor oral health can negatively affect a veteran's emotional well-being as well as his or her ability to speak or eat.

Committee Bill. In order to address the barriers to rural veterans accessing dental services, Section 215(a) would authorize the Secretary to carry out a demonstration program to establish programs to train and employ alternative dental health care providers to increase access to dental health care services for veterans who are entitled to VA dental health care services and reside in rural and other underserved areas.

Section 215(b) would prioritize demonstration sites in States that do not have a VA facility that offers on-site dental services. Section 215(c) would authorize dental services via telehealth when appropriate and feasible. Section 215(d) would authorize the appropriation of such sums as are necessary to carry out the demonstration program.

Section 215(e) would define “alternative dental health care providers” the same as the term is defined in section 340G–1(a)(2) of the Public Health Service Act (section 256g–1(a)(2) of title 42, U.S.C.). Section 340G–1(a)(2) defines “alternative dental health care providers” as community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists and dental health aides.

PART III—OTHER PERSONNEL MATTERS

Sec. 221. Exception on limitation on awards and bonuses for recruitment, relocation, and retention.

Section 221 of the Committee bill, which is derived from S. 1325, would amend section 705(a) of P.L. 113–146 to remove recruitment, relocation, or retention incentives from the calculation of the annual aggregate of awards and bonuses payable by the Secretary.

Background. Section 705(a) of P.L. 113–146 limited the Secretary to an annual aggregate of \$360,000,000 for the payment of awards and bonuses. Section 951(a) of P.L. 114–198 amended section 705(a) of P.L. 113–146 to limit the Secretary to an annual aggregate of \$230,000,000 for FYs 2017 through 2018, \$225,000,000 for FYs 2019 through 2021, and \$360,000,000 for FYs 2022 through 2024 for the payment of awards and bonuses.

Committee Bill. Section 221 would amend section 705(a) of P.L. 113–146 to remove recruitment, relocation, or retention incentives from the calculation of the annual aggregate of awards and bonuses payable by the Secretary.

The Committee believes that these particular incentives are valuable tools for VA’s employee recruitment and retention needs and their use should not be hampered by being aggregated with other employee awards and bonuses.

Sec. 222. Annual report on performance awards and bonuses awarded to certain high-level employees of the Department.

Section 222 of the Committee bill, which is derived from S. 114, would amend chapter 7 of title 38, U.S.C., by adding a new section 726 to require the Secretary to submit an annual report on the performance awards and bonuses presented to regional office directors, directors of VAMCs, and directors of VISNs.

Background. As VA has come under scrutiny in recent years, Congress has brought greater accountability to the agency and focused more on the performance awards and bonuses for Senior Executive Service employees at the VA. Furthermore, Members of Congress have in-depth insights about how their local VA facilities are performing through accounts from their constituents and interactions with local VA leadership. The Committee believes that Members advocating for their constituents and veterans, as well as the American public, are owed a level of transparency on bonuses that are funded by taxpayer dollars. Therefore, this section would require an annual report on bonuses of local VA officials so Members and the public can ensure bonuses are awarded to top performers.

Committee Bill. Section 222(a) would amend chapter 7 of title 38, U.S.C., by adding a new section 726 to require the Secretary to

submit an annual report on the performance awards and bonuses presented to regional office directors, directors of VAMCs, and directors of VISNs. Each report shall include the amount of each award or bonus, the job title of each recipient, and the location where each recipient individual works. Section 222(b) would provide for a clerical amendment to insert new section 726 in the table of sections at the beginning of chapter 7.

Sec. 223. Authority to regulate additional pay for certain health care employees of the Department.

Section 223 of the Committee bill, an original provision, would amend section 7454 of title 38, U.S.C., by expanding the definition of compensation to include pay earned by employees when performing duties authorized by the Secretary or when the employee is approved to use annual, sick, family medical, military, or court leave, or other paid absences for which pay is not already regulated.

Background. This section would allow VA to better regulate the pay for title 38 hybrid employees and title 5 health care workers. Hybrid employees are covered by title 38 for appointment, advancement, and certain pay matters and covered by title 5 for performance appraisal, leave, hours of duty, adverse actions, probationary period, reemployment rights, reduction-in-force, and retirement rules. In 2005, the U.S. Court of Federal Claims found VA liable in a class action law suit (*Quimby et al. v. U.S.*) for weekend pay and night differential during periods of leave and other paid time off for two categories of VA employees: registered nurses, physician assistants, and dental auxiliaries; and title 38 hybrid employees. The court ruled that the Secretary does not have authority under section 7454 of title 38, U.S.C., or other statute to regulate the weekend pay and night differential for hybrid employees during periods of leave and absence, as hybrid employees receive leave and other benefits under title 5 not title 38.

In 2012, the court ruled against VA in a companion case (*Adams et al. v. U.S.*) in which the plaintiffs alleged that VA title 5 health care workers who are appointed under section 7408 of title 38 and receive weekend pay under section 7454 of title 38 were wrongfully deprived of weekend pay during periods of leave and other paid absence. Again, the contention was that the Secretary does not have authority under section 7454 of title 38 to regulate weekend pay for periods of leave and absence for employees using leave under title 5. This section would give VA this authority.

Committee Bill. Section 223 would amend section 7454 of title 38, U.S.C., by expanding the definition of compensation to include pay earned by employees when performing duties authorized by the Secretary or when the employee is approved to use annual, sick, family medical, military, or court leave, or other paid absences for which pay is not already regulated. This section would allow the Secretary to issue policy prohibiting weekend pay and night differential for periods of leave consistent with government-wide regulations.

Sec. 224. Modification of pay cap for nurses.

Section 224 of the Committee bill, an original provision, would amend section 7451(c) of title 38, U.S.C., to establish a higher max-

imum amount of basic pay for registered nurses up to level III of the Executive Schedule and for registered nurses serving as a nurse executive or a grade for the position of certified nurse anesthetists up to level I of the Executive Schedule.

Background. According to the OIG FY 2017 VHA occupational staffing shortages report, the occupational series with the second largest staffing shortage is nurses. Medical officers and nurses have been the top two critical need occupations since the OIG first began the reports in 2014. According to the FY 2017 VHA nurse staffing report to Congress, the second most frequently identified reason for nurses leaving is for advancement (unique opportunity elsewhere). The report indicates that VHA nurses have an average turnover rate of 9.9 percent and an average vacancy rate of 8.7 percent. Currently, the maximum rate of basic pay for nurses for any grade may not exceed the rate of basic pay established for positions at level IV of the Executive Service.

Committee Bill. Section 224 of the Committee bill would amend paragraph (2) of section 7451(c) of title 38, U.S.C., to increase the pay cap for registered nurses. Specifically, the new paragraph 2 of section 7451(c) would raise the rate of basic pay for a registered nurse serving as a nurse executive or a certified registered nurse anesthetist not to exceed level I of the Executive Schedule under section 5312 of title 5, U.S.C. The rate of basic pay for all other registered nurses would be increased not to exceed level III of the Executive Schedule under section 5314 of title 5, U.S.C.

SUBTITLE B—IMPROVEMENT OF UNDERSERVED FACILITIES OF THE
DEPARTMENT

Sec. 231. 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 231 of the Committee bill, a freestanding original provision, would require the Secretary to consider a number of facility characteristics in developing criteria to designate those facilities as underserved, with VISN directors using the criteria to determine annually which facilities in their networks meet the designation. It would also require the Secretary to submit an annual plan to Congress for addressing the problem of underserved facilities.

Background. In accordance with P.L. 113–146, veterans are eligible to receive care within their community if their local VA facility cannot schedule an appointment within 30 days of the clinically indicated date. While this is one metric VHA uses to assess clinical capacity within individual VHA facilities, it does not comprehensively measure the extent to which those facilities are medically underserved. HHS’ Health Resources and Services Administration uses geographic, population, and facility-based criteria to designate Health Professional Shortage Areas, which indicate provider shortages in primary care, dental health, or mental health.

Section 231(a) would require the Secretary to develop criteria within 180 days to designate VAMCs, ambulatory care facilities, and community based outpatient clinics as underserved facilities.

Section 231(b) lists the considerations the Secretary would need to take when developing criteria for designating facilities as underserved. Considerations include the ratio of veterans to health care

providers in a geographic area; the range of clinical specialties covered; whether the local community is medically underserved; the type, number, and age of open consults; and whether the facility is meeting VA wait-time goals.

Section 231(c) would require VISN directors to annually perform an analysis to determine which facilities within the VISN qualify as underserved pursuant to the criteria developed under subsection (a).

Section 231(d) would require the Secretary to submit a plan to Congress addressing the problem of underserved facilities. The plan would be required to address a number of topics, including increasing personnel or temporary personnel assistance; providing special hiring incentives, using direct hiring authority; and improving training opportunities.

Committee Bill. In order to address a range of problems across VHA programs, it is critical for VISN and facility leadership to be aware of facilities that are in need of resources. The Committee expects VHA leaders to use the data required by this provision to better target resources to where the needs exist.

Sec. 232. Pilot program on tuition reimbursement and loan repayment for health care providers of the Department of Veterans Affairs at underserved facilities.

Section 232 of the Committee bill, a freestanding original provision, would require the Secretary to create a pilot program to provide tuition reimbursement and loan repayment to medical students and health care providers in exchange for their commitment to working in underserved VHA facilities.

Committee Bill. In order to address a range of problems across VHA programs, it is critical for VISN and facility leadership to be aware of facilities that are in need of resources. The Committee expects VHA leaders to use the data required by this provision to better target resources to where the needs exist.

Background. VHA facilities with staff vacancies face challenges in providing timely health care to the veterans they serve. In addition, approximately 25 percent of all U.S. veterans reside in rural communities, where basic and preventative health care may not be available. In particular, these communities have fewer physicians, hospitals, and other health care delivery resources. The National Health Services Corps operates two programs—a scholarship program and a loan repayment program—to provide financial incentives to certain students and health care practitioners in exchange for commitment to work in underserved communities. While VA's EDRP aims to fill clinical positions that are difficult to recruit or retain by offering student loan reduction payments, it does not have a particular focus on addressing the recruitment and retention challenges that rural facilities face.

Committee Bill. Section 232(a) would require the Secretary to commence a pilot program to assess the feasibility and advisability of providing tuition reimbursement and loan repayment to medical students and health care providers who commit to serving in underserved facilities within 90 days of enactment.

Section 232(b) would set the duration of the pilot program at 6 years from the date of commencement.

Section 232(c) would require the Secretary to select no fewer than three VAMCs and seven ambulatory care facilities or community based outpatient clinics located in at least eight different states to participate in the pilot program. No fewer than two of the VAMCs and five of the ambulatory care facilities or community based outpatient clinics would be located in states or United States territories that are among the ten states or territories with the highest percentage of land designated as highly rural by the Department of Agriculture or the highest percentage of enrolled veterans living in rural, highly rural, or insular island areas. Participating facilities would be required to be located in not fewer than eight states.

Section 232(d) would designate half of the amount spent on the program to be for tuition reimbursement or loan repayment for individuals practicing in a general practice position. The other half would be for individuals practicing in a specialist position or in an occupation included in the most recent staffing shortage determination by the VA OIG.

Section 232(e) would authorize the Secretary to provide an individual attending medical school with full tuition reimbursement in exchange for a 5-year commitment to serve at an underserved facility.

Section 232(f) would authorize the Secretary to provide individuals who commit to serving 3 years at an underserved facility with up to \$50,000 student loan repayment. Current VHA health care providers at underserved facilities may receive up to \$30,000 student loan repayment. The Committee intends that this increased loan repayment authority be used to incentivize providers to work in underserved facilities at VA.

Section 232(g) describes the procedure for the United States to recoup amounts provided to pilot participants who fail to satisfy the period of obligated service and would require that any individual who fails to fulfill the required period of obligated service be liable to the United States for any amount that has been paid on the individual's behalf, reduced by the proportion that the number of days served for completion of the period of obligated service bears to the total number of days in the period of obligated service of such individual.

Section 232(h) would require the Secretary to ensure that hiring done under the pilot program is expedited.

Section 232(i) would ensure continued program participation by pilot participants selected because they work in occupations included in the VA OIG staffing shortage determination, in cases where their occupations are no longer included in the determination.

Section 232(j) would require the Secretary to submit to Congress annually a report on the pilot program. The report would be required to include the number of participants, the number of facilities where participants are located, the number of program applicants, and the five most common occupations of participants, other than general practice. The Committee expects that if the Secretary believes modifications should be made to improve the pilot program, that the Secretary recommend such changes in the annual report, if not sooner.

Section 232(k) defines the terms “enrolled veteran” and “underserved facility.”

Staff vacancies in rural and medically underserved areas continue to be a challenge VHA has not been able to address sufficiently. The Committee expects VHA to make a concerted effort to carry out the pilot program required in Section 232 with open-mindedness about if and how such a program could be expanded nationwide.

Sec. 233. Program to furnish mobile deployment teams to underserved facilities.

Section 233 of the Committee, a freestanding original provision, bill would establish a program to provide mobile deployment teams of medical personnel to underserved facilities.

Background. P.L. 113–146 was enacted in response to widely-reported scheduling irregularities at VA. That legislation sought to relieve strain on the VA health care system by allowing some veterans to opt-in to community care. It also sought to bolster VA’s internal capacity to provide care by providing increased funding for the hiring of medical professionals and authorizing clinic leases so that veterans could get care closer to home. Finally, it gave the Secretary improved tools for removing poor-performing employees. Subsequent legislation, such as the Accountability Act, further provided the Secretary with the tools necessary to hold employees accountable. While VA has made great progress in remediating problem areas in health care delivery and improving local facility management, challenges remain.

Committee Bill. The Committee believes that mobile deployment teams, made up of a diversified group of personnel to address urgent and emergent challenges in VHA, would assist VA in addressing problem-areas quickly and succinctly. These teams could investigate, solve, recommend and carry-out actions to address problems at VA medical facilities.

Section 233(a) would establish a program to furnish mobile deployment teams of medical personnel to underserved facilities. It is the Committee’s intent that these mobile deployment teams assist VA facilities with urgent and emergent challenges that prevent or will prevent the furnishing of high-quality and timely health care to veterans. For example, if a local facility is experiencing challenges scheduling consults, the Committee believes that a multidisciplinary team dispatched to address consult challenges would help mitigate scheduling problems before patient care is affected. In this instance, team members might include: information technology personnel, training personnel, scheduling personnel, quality personnel, human resources personnel, and public affairs personnel to address veterans’ concerns. It is the Committee’s intent that the use of a mobile deployment team not be considered punitive, but rather a tool to supplement existing VA resources at any given facility. The Committee also believes that better communication between the Central Office of the Department, VISN and local facilities would assist in mitigating problems before they become a crisis.

Section 233(b) would establish elements that the Secretary must consider when determining whether to furnish mobile deployment teams, including: the medical positions of greatest need at under-

served facilities; the size and composition of teams to be deployed; and any other elements the Secretary considers necessary for effective oversight of the mobile deployment program.

Section 233(c) would require the annual analysis conducted under section 231(c) of the Committee bill to form mobile deployment teams that are composed of the most needed medical personnel for underserved facilities.

Section 233(d) would define “underserved facility” that meets the criteria established under Section 231 of the Committee bill.

Sec. 234. Inclusion of Vet Center employees in education debt reduction program of Department of Veterans Affairs.

Section 234 of the Committee bill, a freestanding original provision, would direct the Secretary to ensure clinical staff working at Vet Centers are eligible to participate in EDRP under chapter 76 of title 38, U.S.C.

Background. Section 7682, title 38, U.S.C. establishes eligibility for EDRP. Employees must be serving in a direct-patient care service or a service incident to a direct-patient care position for which retention or recruitment is difficult and the principal or interest balance on their loan must be for paying the costs related to a course of education or training related to that position.

Committee Bill. Section 234(a) of the Committee bill would direct the Secretary to ensure that Vet Center employees are eligible for EDRP. Section 234(b) also directs the Secretary to submit a report to Congress on the number of participants in the program, who work at Vet Centers, no later than 1 year after the enactment of the bill. Section 234(c) would define the term “Vet Center” as having the same meaning of the term in section 1712A(h) of title 38, U.S.C. Vet Centers address a critical clinical need for veterans with a high risk for mental health issues. Therefore, the Committee believes this provision reflects that the same recruitment and retention tools should be made available and a priority for clinical staff at these facilities.

SUBTITLE C—CONSTRUCTION AND LEASES

Sec. 241. Definition of major medical facility project and major medical facility lease.

Section 241 of the Committee bill, an original provision, would amend section 8101 of title 38, U.S.C., to redefine the term “medical facility” and would amend section 8104 of title 38, U.S.C., to redefine the terms “major medical facility project” and “major medical facility lease.”

Background. Section 8101(3) of title 38, U.S.C., defines “medical facility” as “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, or domiciliary care or medical services), including any necessary building and auxiliary structure, garage, parking facility, mechanical equipment, trackage facilities leading thereto, abutting sidewalks, accommodations for attending personnel, and recreation facilities associated therewith.” Section 8101(3) has never been amended.

Section 8104(a)(3)(A) of title 38, U.S.C., defines “major medical facility project” as “a project for the construction, alteration, or ac-

quisition of a medical facility involving a total expenditure of more than \$10,000,000.” Section 8104(a)(3)(A) was last amended in P.L. 109–461, the Veterans Benefits, Health Care, and Information Technology Act of 2006, when the limit was increased from \$7 million to \$10 million.

Section 8104(a)(3)(B) of title 38, U.S.C., currently defines a “major medical facility lease” as a lease for space at an average annual rent of more than \$1 million. Section 8104(a)(3)(B) was last amended in P.L. 110–387, the Veterans’ Mental Health and Other Care Improvements Act of 2008, when the annual rent amount was increased from \$600,000 to \$1 million.

Committee Bill. Section 241(a) would amend section 8101(3) of title 38, U.S.C., to expand the term “medical facility” to include any facility or part thereof which is, or will be, under the jurisdiction of the Secretary, or as otherwise authorized by law, for the provision of health care services and includes an outpatient clinic under the definition.

Section 241(b) would amend section 8104(a)(3)(A) of title 38, U.S.C., to increase the limit above which a project is considered a major medical facility project requiring Congressional authorization from \$10 million to \$20 million. The definition would exclude an acquisition by exchange, non-recurring maintenance projects, or a shared Federal medical facility for which VA’s estimated share does not exceed \$20 million.

Section 241(c) would amend section 8104(a)(3)(B) of title 38, U.S.C., to define the term “major medical facility lease” to align with the rental value used by the General Services Administration under section 3307(a)(2) of title 40, U.S.C., and is subject to annual adjustment in accordance with section 3307(h) of title 40, U.S.C. The FY 2017 General Services Administration annual prospectus threshold is \$2,850,000,000.

Sec. 242. Facilitating sharing of medical facilities with other Federal agencies.

Section 242 of the Committee bill, an original provision, would create a new section 8111B of title 38, U.S.C., to authorize the Secretary to enter into agreements with other Federal agencies for planning, designing, constructing, or leasing shared medical facilities. It would authorize the Secretary to transfer to another Federal agency amounts appropriated for minor construction projects, major construction projects, and leased projects. Funds transferred to VA from other Federal agencies could be used for planning, designing, or constructing a shared medical facility for minor construction projects, major construction projects, and leased projects.

Background. Established by section 583 of P.L. 108–136, National Defense Authorization Act for Fiscal Year 2004, the VA/DOD Joint Executive Committee (hereinafter, “JEC”) recommends to the Secretaries of the Departments a strategic direction for the joint coordination and sharing efforts between and within the two Departments. The VA/DOD Construction Planning Committee established under the JEC provides a formalized structure to facilitate cooperation and collaboration for shared medical facilities that are mutually beneficial to both Departments. Even with this collaborative structure in place, VA and DOD continue to encounter challenges when attempting to plan and construct joint medical facility pro-

jects. Differing definitions and thresholds for construction project accounts and differing authorization and appropriations requirements for each Department create significant barriers to planning future joint medical facility projects.

Committee Bill. Section 242(a) would amend subchapter I of chapter 81 of title 38, U.S.C., by creating a new section 8111B. Section 8111B(a) authorizes the Secretary to enter into agreements with other Federal agencies for planning, designing, constructing, or leasing shared medical facilities with the goal of improving access to, and quality and cost effectiveness of, health care provided by VA and other Federal agencies. These facilities will be managed by the Under Secretary for Health.

Section 8111B(b) would authorize the Secretary to transfer to another Federal agency amounts appropriated for minor construction projects, major construction projects, and leased projects.

Section 8111B(c) would allow funds transferred to VA from other Federal agencies to be used for planning, designing, or constructing a shared medical facility for minor construction projects, major construction projects, and leased projects. Amounts transferred into VA will be available for the same time period as amounts in the account to which those amounts are transferred.

Section 242(b) would provide a clerical amendment to the table of sections at the beginning of chapter 81 of title 38, U.S.C.

The Committee understands the challenges inherent in joint medical facility projects and anticipates this new authority would lead to an increase in collaboration between DOD and VA on eligible physical infrastructure projects.

Sec. 243. Review of enhanced-use leases.

Section 243 of the Committee bill, an original provision, would amend section 8162(b)(6) of title 38, U.S.C., to require the Office of Management and Budget (hereinafter, “OMB”) to review each enhanced-use lease before the lease goes into effect to determine whether the lease is in compliance with section 8162(b)(5) of title 38, U.S.C.

Background. Under section 8162(b)(6) of title 38, U.S.C., the Secretary is prohibited from entering into an enhanced-use lease without certification in advance in writing by the Director of OMB that such lease complies with the requirements of section 8162.

Committee Bill. Section 243 would modify the OMB’s role in enhanced-use leases executed by VA. OMB would review whether the lease is in compliance with enhanced-use lease regulations, not grant approval. The Committee expects this change will reduce the administrative burden of the previous certification requirement and decrease the time required to complete the OMB process.

Sec. 244. Authorization of certain major medical facility projects of the Department of Veterans Affairs.

Section 244 of the Committee bill, a freestanding original provision, would authorize not more than \$117,300,000 for Phases III and V of the realignment of facilities in Livermore, California, and would require a detailed project proposal and accounting of current and future expenditures for the project.

Background. In its FY 2018 budget submission, VA requested \$117,300,000 for the construction of Phases III and V of the re-

alignment and closure project in Livermore, California. Phase III is the construction of a new East Bay Community Based Outpatient Clinic in Fremont, California. The facility will be approximately 80,000 gross square feet and will include site enhancements such as parking, utilities, flood plain mitigation, and landscaping as appropriate. Phase V is the construction of an approximately 20,000 gross square feet Central Valley Engineering and Logistics Support Facility, which will be collocated with the Phase I community living center and Phase II Community Based Outpatient Clinic, and will include site enhancements such as parking, utilities, flood plain mitigation, and landscaping as appropriate. The overall project has been appropriated \$55,430,000 in fiscal year 2010 for design funds and \$139,000,000 in FY 2016 for the Phase II Community Based Outpatient Clinic in New Central Valley, California.

Committee Bill. Section 244(a) would authorize the construction of the new East Bay Community Based Outpatient Clinic and all associated site work, utilities, parking, and landscaping, construction of the Central Valley Engineering and Logistics support facility, and enhanced flood plain mitigation at the Central Valley and East Bay Community Based Outpatient Clinics as part of the realignment of medical facilities in Livermore, California, in an amount not to exceed \$117,300,000.

Section 244(b) would authorize the appropriation of \$117,300,000 for FY 2018 or the year in which funds are appropriated for the Construction, Major Projects account, for the project authorized in section 244(a).

Section 244(c) would require the Secretary to submit to the House and Senate Committees on Veterans' Affairs within 90 days a detailed project proposal, line item accounting of expenditures, any future obligations for the project, a justification for the expenditures, and any agreements with a non-VA Federal entity to provide construction services for the project.

SUBTITLE D—OTHER HEALTH CARE MATTERS

Sec. 251. Program on use of wellness programs as complementary approach to mental health care for veterans and family members of veterans.

Section 251 of the Committee bill would, a freestanding original provision, provides VA with authority to provide grants to public and private nonprofit entities for the purpose of determining whether wellness programs will improve veterans' well-being and quality of life.

Background. This section would require VA to carry out a program to assess the feasibility and advisability of using wellness programs to complement the provision of mental health care to certain veterans and family members of veterans. The section operationalizes this by creating a grant fund for public and private nonprofit entities to study the benefits of complementary wellness programs to better care for veterans and improve their well-being and quality of life. Veterans eligible to participate are those eligible for counseling under section 1712A(a)(1)(c) of title 38, U.S.C. Under current law, VA's Readjustment Counseling Service does not have the ability to provide grants to public or private non-profit entities.

Committee Bill. Section 251(a)(1) would provide authority to carry out a program to assess the feasibility and advisability of using wellness programs to complement the provision of mental health care to certain veterans and family members of veterans. Veterans eligible to participate are those eligible for counseling under section 1712A(a)(1)(c) of title 38, U.S.C.

Section 251(a)(2) bill would establish the matters that the program will assess. Specifically, the program would look at coordination between governmental and community providers in delivering mental health care to eligible veterans and family members; enhancing outreach and coordination of outreach by providers to eligible veterans and family members; use of wellness programs by providers complementary to mental health care from VA; whether such wellness programs are effective in enhancing the quality of life and well-being of veterans and family members; whether the wellness programs increase the adherence of eligible veterans to the primary mental health services they receive from VA; whether the wellness programs have an impact on the veterans' sense of well-being; and whether the wellness programs are effective in encouraging the veterans to adopt a more healthy lifestyle.

Section 251(b) would establish that the Secretary shall carry out the program for 3 years beginning 1 year after the Committee bill is enacted. Section 251(c) would establish that the Secretary shall carry out the program at VA facilities providing mental health care to eligible veterans and family members.

Section 251(d)(1) would establish that public or private nonprofit entities seeking grant awards shall do so by submitting an application to the Secretary as the Secretary sees fit.

Section 251(d)(2) would describe what the grant proposal applications must contain.

Section 251(d)(2)(A) would describe the plan to coordinate activities under the program between providers of services to veterans to enhance veteran care. Specifically, the plan would provide awareness of VA's benefits and health care services; outreach efforts to increase veterans' use of VA services; and educational efforts to inform veterans of the benefits of healthy and active lifestyle.

Section 251(d)(2)(B) would require a statement of understanding that the entity will be required to report to the Secretary on data and performance measures necessary to evaluate individual outcomes and facilitate evaluations among entities participating. Section 251(d)(2)(C) would enable the Secretary to collect other information as required. Section 251(e)(1) would require the entity awarded a grant to use the award for the purposes prescribed by the Secretary. Section 251(e)(2) would require the entity awarded a grant to use the award only to furnish services to the individuals specified in section 1712A(a)(1)(c) of title 38, U.S.C. for such purposes as described in section 251(e)(1).

Section 251(f) would require VA, not later than 180 days after the commencement of the program and every 180 days thereafter, to submit to Congress a report on the Secretary's findings and conclusions on the program for the 180 preceding days and an assessment of the benefits of the program for veterans and their family members during the 180 preceding days. Further, not later than 180 days after the end of the program, the Secretary shall submit

to Congress a report detailing the Secretary's recommendations as to the advisability of continuing or expanding the program.

Section 251(g) defines the term "wellness" as having the meaning as described by the Secretary in such regulations as the Secretary will promulgate.

Sec. 252. Authorization to provide for operations on live donors for purposes of conducting transplant procedures for veterans.

Section 252 of the Committee bill, which is derived from S. 115, would add a new section to Chapter 17 of title 38, U.S.C., to allow VA to provide transplant procedures with live donors at VA facilities or non-VA facilities regardless of whether the live donor is a veteran.

Background. VA has been providing solid organ transplant procedures on veterans since 1962 and bone marrow transplant procedures since 1982. While transplant care and treatment is provided at 1,065 outpatient clinics and 170 VAMCs, 13 VAMCs are designated VA Transplant Centers. In limited circumstances, VA will provide treatment to non-veterans for emergency conditions or some VA facilities may treat dependents covered under the CHAMPVA Program. Under current law, VA cannot perform a transplant procedure on a live donor that is not a veteran because that person is not eligible for care or treatment at VA.

Committee Bill. Section 252 would allow VA to provide transplant procedures with live donors at VA facilities or in the community. Specifically, section 252(a) would add a new section to chapter 17 of title 38, U.S.C., section 1788. Section 1788(a) would allow VA to provide transplant procedures to a veteran with a live donor if the donor is not a veteran or not otherwise eligible for health care in VA. Section 1788(b) would direct VA to provide the care and services to the donor required in connection with the transplant procedure. Section 1788(c) would allow VA to provide the transplant procedures through a VA community care program and would deem the donor an individual eligible for VA's community care program for the purposes of the transplant procedure. Section 252(b) would make a clerical change to add section 1788 to the table of contents for chapter 17 of title 38, U.S.C.

Sec. 253. Sense of the Senate.

Section 253, a freestanding original provision, would express the Senate's concern to preserve VHA's network of care, ensure it is effectively resourced, and oppose any efforts to privatize the system.

Committee Bill. Section 253 would express the Senate's concern to preserve VHA's network of care, ensure it is effectively resourced, and oppose any efforts to privatize the system.

TITLE III—FAMILY CAREGIVERS

Sec. 301. Expansion of family caregiver program of Department of Veterans Affairs

Subsec. 301(a)(1). Expansion of family caregiver program of Department of Veterans Affairs.

Section 301(a)(1) of the Committee bill, which is derived from S. 591, would expand eligibility for VA's Program of Comprehensive Assistance for Family Caregivers.

Background. The Caregivers and Veterans Omnibus Health Services Act of 2010 was signed into law on May 5, 2010. It established the Program of General Caregiver Support Services and the Program of Comprehensive Assistance for Family Caregivers. The Program of Comprehensive Assistance for Family Caregivers (hereinafter, “the Program”) provides additional support services to caregivers beyond what is provided through the Program of General Caregiver Support Services, including a monthly financial stipend, health care coverage through CHAMPVA, counseling and mental health services, respite care, and technical assistance. The Program is only available to veterans who have serious injuries (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.

In September 2014, GAO released a report on the Program titled “Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program.” The report noted, “Caregivers enable those for whom they are caring to live better quality lives and can contribute to faster rehabilitation and recovery.” Supporting caregiving activities not only ensures equity of services and benefits available to the caregivers of our most seriously injured veterans, it may further enable veterans to remain at home rather than admitting them to a potentially more expensive institutional setting, such as a nursing home.

Prior to the Program’s implementation, VA initially estimated that 4,000 caregivers would be approved for the program; however, as of November 2, 2017, 21,990 caregivers had been approved. GAO’s 2014 report on the Program made specific recommendations for improvement. Among its recommendations, GAO recommended that VA “expedite the process for identifying and implementing an [IT] system that fully supports the program and will enable [VHA] program officials to comprehensively monitor the program’s workload, including data on the status of applications, appeals, home visits, and the use of other support services, such as respite care.” GAO also recommended that the VA Secretary direct the Under Secretary for Health “to use data from the IT system, once implemented, as well as other relevant data to formally reassess how key aspects of the program are structured and to identify and implement modifications as needed to ensure that the program is functioning as envisioned so that caregivers can receive the services they need in a timely manner.”

Committee Bill. Section 301(a)(1) would amend section 1720G of title 38, U.S.C., to require VA to expand eligibility for the Program to all eras of veterans in two phases. The first phase of expanded eligibility would begin during the 2-year period beginning on the date on which the VA Secretary submits to Congress a certification that VA has fully implemented an IT system to support the Program. Section 301(a)(1)(B) of the Committee bill would require VA to submit the certification date in the Federal Register within 30 days to ensure public notification. The first phase includes 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. The second phase of eligibility would begin 2 years after the first phase. This includes those injured in the line of duty after May 7, 1975, and before September 11, 2001.

The current eligibility criteria creates an inequity between post-9/11 veterans and pre-9/11 veterans. However, VA has encountered numerous challenges in implementing the program, and it is clear improvements are needed to ensure the program is meeting the needs of those currently enrolled and can sustain an increase in eligible veterans. The Committee bill ensures those improvements are made prior to expansion to pre-9/11 veterans and their caregivers.

For example, the Program's expansion in two phases, as required by this section, is intended to ensure the Program does not get overwhelmed and continues to operate as intended, providing services in a timely manner, while enrolling those who have become newly eligible. The publication of the VA Secretary's certification date in the Federal Register is intended to ensure veterans are notified of the Program's impending expansion.

Subsec. 301(a)(2). Expansion of needed services in eligibility criteria.

Section 301(a)(2) of the Committee bill, which is derived from S. 591, would expand the Program's eligibility criteria for needed services.

Background. Current law, section 1720G of title 38, U.S.C., provides that veterans eligible for the Program must be in need of personal care services because of an inability to perform one or more activities of daily living, a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury, or such other matters as the Secretary considers appropriate.

Committee Bill. Section 301(a)(2) would amend subsection (a)(2)(C) of section 1720G of title 38, U.S.C., to include 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 among the criteria considered for needed personal care services. It is the intent of the Committee to ensure the Program is consistently inclusive of the caregiving needs required by mental health conditions, traumatic brain injuries or other conditions with which eligible veterans may be diagnosed.

Subsec. 301(a)(3). Expansion of services provided.

Section 301(a)(3) of the Committee bill, which is derived from S. 591, would expand the services provided to caregivers under the Program to include legal and financial planning services.

Background. In 2014, the RAND Corporation released a report, "Hidden Heroes: America's Military Caregivers," which examined characteristics of military caregivers and services available to them. The report indicates that, of the military caregiver-specific programs identified by RAND, few provide long-term planning assistance, including legal and financial planning, for military caregivers.

Committee Bill. Section 301(a)(3) would amend subsection (a)(3)(A)(ii) of section 1720G of title 38, U.S.C., to require VA to include financial planning services and legal services related to the needs of injured veterans and their caregivers as among the services provided to caregivers. The section makes clear that VA should provide these services through the use of contracts with or the provision of grants to public or private entities.

While section 301(a)(3) would require that financial planning and legal services be offered to caregivers in the Program, it is the Committee's intent that VA and VA employees not provide these services, but instead partner with public or private entities. It is also the Committee's intent that, to the maximum extent practicable, VA should utilize partnerships that will provide the services pro bono.

Subsec. 301(a)(4). Modification of stipend calculation.

Section 301(a)(4) of the Committee bill, which is derived from S. 591, would expand the number of factors VA should consider when determining the amount and degree of personal care services provided for certain veterans.

Background. Currently, there are three levels of caregiver stipends based on the amount and degree of personal care services provided. This was established pursuant to section 1720G of title 38, U.S.C. According to current regulations, the stipend payment is based on the number of hours of caregiving required by the veteran. The maximum stipend is based on the requirement of 40 hours of caregiving each week, the median stipend is based on the requirement of 25 hours of caregiving each week, and the lowest stipend is based on the requirement of 10 hours of caregiving each week. In order to determine the degree of personal care services required by the veteran, VA evaluates the veteran and establishes a clinical rating based on specific criteria regarding the ability to perform activities of daily living and the need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury.

Committee Bill. Section 301(a)(4) would amend subsection (a)(3)(C) of section 1720G of title 38, U.S.C., to ensure VA is considering the assessment by the family caregiver of the needs and limitations of the veteran; the extent to which the veteran can function safely and independently in the absence of such supervision, protection, or instruction; and the amount of time required for the family caregiver to provide such supervision, protection, or instruction to the veteran when determining the amount and degree of personal care services provided for a veteran whose need for personal care services is based on a need for supervision or protection or regular instruction or supervision under subsection (a)(2)(C) of section 1720G of title 38, U.S.C.

The Committee understands that these determinations are made at the VAMC level and the intent is to ensure consistency by VA in determining the amount of hours of caregiving required by the veteran.

Subsec. 301(a)(5). Periodic evaluation of need for certain services.

Section 301(a)(5) of the Committee bill, which is derived from S. 591, would require VA to periodically evaluate the needs of the veteran and the skills of the family caregiver to determine if additional instruction, preparation, training, or technical support is needed.

Background. Under section 1720G of title 38, U.S.C., VA is required to provide instruction, preparation, and training for family caregivers to provide care to veterans, in addition to ongoing tech-

nical support to address routine, emergency, and specialized caregiving needs of the family caregiver.

Committee Bill. Section 301(a)(5) would amend subsection (a)(3) of section 1720G of title 38, U.S.C., to require that, in providing instruction, preparation, and training under subparagraph (A)(i)(I) of that section and technical support under subparagraph (A)(i)(II) of that section to each approved family caregiver, the Secretary periodically evaluate the needs of the veteran and the skills of the family caregiver to determine if additional instruction, preparation, training, or technical support is necessary.

The requirement for periodic evaluation of this support will ensure that caregivers have ongoing access to resources and support for their unique needs as they care for veterans, especially given that a veteran's needs and caregiving techniques and best practices may change over time.

Subsec. 301(a)(6). Use of primary care teams.

Section 301(a)(6) of the Committee bill, which is derived from S. 591, would require the VA Secretary to collaborate with the veteran's primary care team when evaluating applications for the Program, to the extent practicable.

Background. Under subsection (a)(5) of section 1720G of title 38, U.S.C., when reviewing applications submitted jointly by the veteran and family caregiver, VA is required to evaluate the veteran to identify the personal care services required and to determine whether the requirements could be significantly or substantially satisfied through personal care services from a family member. The determination for a veteran's approval for the Program is a clinical decision; however, there is no statutory requirement that VA include the veteran's primary care team in the evaluation.

Committee Bill. Section 301(a)(6) would amend subsection (a)(5) of section 1720G of title 38, U.S.C., to require that the Secretary evaluate each application submitted jointly by an eligible veteran and family member in collaboration with the veteran's primary care team to the maximum extent practicable.

Though the veteran's primary care team maintains the veteran's treatment once in the Program, it is the intent of the Committee to ensure multidisciplinary input in the initial evaluation process, when possible.

Subsec. 301(a)(7). Assistance for family caregivers.

Section 301(a)(7) of the Committee bill, which is derived from S. 591, would authorize VA, in providing caregiver services required under current law, to partner with Federal agencies, States, and private, non-profit, and other entities to provide the assistance.

Background. There are numerous public and private entities that provide caregiver services. According to VA's FY 2016 annual report to Congress on assistance and support services for caregivers, VA has contracted and collaborated with non-profit organizations to provide the family caregivers' core curriculum training and optional additional training opportunities. VA has also indicated that it works with respite care providers in communities to provide that service to veterans in the Program.

Committee Bill. Section 301(a)(7) would amend subsection (a) of section 1720G of title 38, U.S.C., to authorize VA to enter into con-

tracts, provider agreements, and memoranda of understanding with Federal agencies, States, and private, non-profit, and other entities to provide family caregiver services required by section 1720G of title 38, U.S.C. The VA Secretary may provide assistance under this authority only if it is reasonably accessible to the family caregiver and is substantially equivalent or better in quality to similar services provided by VA. In addition, the Secretary could provide fair compensation to entities that provide assistance under this authority.

The Committee recognizes that other entities provide services the Program is required to provide, including respite care, and that VA in some cases is already partnering with these other entities to provide services. It is the Committee's intent that, if appropriate in order to provide the services and they are equivalent or better in quality to similar services provided by VA, VA continues to utilize its authority to partner with entities. This could ensure availability of services and could reduce any duplication.

Subsec. 301(b). Modification of definition of personal care services.

Section 301(b) of the Committee bill, which is derived from S. 591, would modify the definition of personal care services.

Background. Subsection (d)(4) of section 1720G of title 38, U.S.C., defines "personal care services" as services that provide the veteran assistance with one or more independent activities of daily living (subsection (d)(4)(A) of section 1720G of title 38, U.S.C.) and any other non-institutional extended care (subsection (d)(4)(B) of section 1720G of title 38, U.S.C.).

Committee Bill. Section 301(b)(1) would strike "independent" in subsection (d)(4)(A) of section 1720G of title 38, U.S.C., and amend subsection (d)(4) to include supervision or protection based on symptoms or residuals of neurological or other impairment or injury and regular or extensive instruction or supervision without which the ability of the veteran to function in daily life would be seriously impaired.

This section is consistent with changes made by sections 301(a)(2) and 301(a)(4) of the Committee bill, which recognize the need for regular or extensive instruction or supervision within the definition of personal care services and ensure the consideration of these personal care needs when determining the caregiver stipend.

Sec. 302. Implementation of information technology system of Department of Veterans Affairs to assess and improve the family caregiver program.

Section 302 of the Committee bill, a freestanding provision derived from S. 591, would require VA to implement a new IT system and conduct ongoing monitoring and modifications after the system is implemented.

Background. The requirement that VA implement a new IT system that can easily retrieve data that will allow all aspects of the Program to be assessed and comprehensively monitored, that can manage data, and that has the ability to integrate with other relevant VHA IT systems, is consistent with recommendations made by GAO in its September 2014 report. The report indicated that the IT system currently utilized, the Caregiver Application Tracker,

was developed quickly due to time constraints on implementing the Program. VA initially expected the Program to be much smaller, and the Caregiver Application Tracker was not designed to manage a high volume of information. As a result, VA is not able to effectively monitor and assess the Program.

Committee Bill. Section 302 would outline requirements for implementing an IT system. Section 302(a) of the Committee bill would require VA to implement an IT system that fully supports the Program and allows for data assessment and comprehensive monitoring of the Program not later than June 1, 2018. The IT system would also be required to include the ability to easily retrieve data that will allow for comprehensive monitoring of all aspects of the Program and workload trends, in addition to the ability to manage data with respect to a number of caregivers that is greater than the number of caregivers expected to apply for the Program, and the ability to integrate the system with other relevant VHA IT systems. These requirements are consistent with the GAO recommendations, and it is the Committee's understanding that the process for developing the new IT system to support the Program is already underway.

Section 302(b) of the Committee bill would require VA to use the IT system to assess key aspects of the Program within 180 days of implementation. Section 302(c) of the Committee bill would require VA to also use the IT system for ongoing monitoring and assessment, including data on the status of applications and the use by caregivers of support services such as respite care. In addition, VA would be required to identify and implement necessary modifications to ensure the Program is functioning as intended and providing veterans and caregivers with services in a timely manner. These requirements are also consistent with the recommendations made by GAO. In order for expansion of the Program to begin, the Secretary must certify to the Committee on Veterans' Affairs of the Senate and House of Representatives and the Comptroller General that the IT system has been implemented. Section 302(d)(3) of the Committee bill would require VA to submit the certification, along with a description of its implementation and utilization for program monitoring not later than June 1, 2019.

Section 302(d)(1) of the Committee bill would require VA, within 90 days of enactment, to submit a report to the Committee on Veterans' Affairs of the Senate and House of Representatives and the Comptroller General, providing an update on the status of the planning, development, and deployment of the IT system. The section would also require that the report include an assessment of the needs of family caregivers and veterans who would be eligible for the Program, as expanded, as well as resources needed for their inclusion.

The intent of this requirement is to ensure proper preparation for the expansion. The Committee expects to be kept up to date on the progress of the IT system implementation and deployment and be informed of any changes to the timeline. By including GAO as a recipient of the report, GAO will have the opportunity to review VA's progress in implementing its recommendations, as required by section 302(d)(2) of the Committee bill. The Committee understands that GAO's audit quality control processes require GAO to at least annually follow up on, track, and record the extent to

which GAO's recommendations have been implemented. The Committee expects GAO to follow up on its recommendations for the Program more often than annually and to periodically inform the Committees on VA's implementation status until VA has taken the appropriate corrective actions to address GAO's findings and recommendations. The Committee also directs the Comptroller General to notify the Committee on Veterans' Affairs of the Senate and the House of Representatives once it has verified that the recommended actions have been implemented and, to the extent possible, that the desired outcomes are being achieved, within 45 days of that determination.

Sec. 303. Modifications to annual evaluation report on caregiver program of Department of Veterans Affairs.

Section 303 of the Committee bill, which is derived from S. 591, would amend requirements for VA's annual evaluation report on VA's caregiver programs.

Background. P.L. 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, requires VA to submit an annual report to the Committees on Veterans' Affairs of the Senate and House of Representatives. Currently, VA is required to report on both the Program of Comprehensive Assistance for Family Caregivers and the Program of General Caregiver Support and include information regarding the number of caregivers receiving assistance, the cost to VA to provide such assistance, a description of outcomes achieved by the program, an assessment of their effectiveness and efficiency, and recommendations for legislative or administrative action. For the Program of Comprehensive Assistance for Family Caregivers, VA is also required to report on outreach activities carried out, in addition to an assessment of the manner in which resources are expended.

Committee Bill. Section 303 would amend subparagraph (A)(iv) of section 101(c)(2) of the Caregivers and Veterans Omnibus Health Services Act of 2010 to require that VA's annual evaluation report on the Program of Comprehensive Assistance for Family Caregivers and the Program of General Caregiver Support include a description of any barriers veterans or caregivers experience in accessing and receiving care and services. It would also amend subparagraph (B) of such section to require that the report on the Program of Comprehensive Assistance for Family Caregivers also include an evaluation of the sufficiency and consistency of the training provided to family caregivers. The additional information on barriers to care and services and the sufficiency and consistency of training will help further inform the Committee on the effectiveness of the Program and potential issues that may need to be addressed.

TITLE IV—APPROPRIATIONS OF AMOUNTS

Sec. 401. Appropriation of amounts for health care from Department of Veterans Affairs.

Section 401 of the Committee bill, a freestanding original provision, would provide \$1 billion for the Secretary to administer EDRP, increase the number of GME residency positions, and allow for recruitment, retention and relocation incentives as authorized under section 221 of the Committee bill.

Background. Section 801 of P.L. 113–146, authorized and appropriated \$5 billion in funding to increase access to care at VA facilities and improve the physical infrastructure of VA facilities.

Committee Bill. Section 401(a) would provide \$1 billion in funding for the Secretary to administer EDRP, increase the number of graduate medical education residency positions, and implement section 221 of the Committee bill.

Section 401(b) would provide that the funds would be available without fiscal year limitation. Section 401(c) would direct that the funds be used to increase the number of graduate medical education residency positions, and allow for recruitment, retention and relocation incentives as authorized under section 221 of the Committee bill. Section 401(d) would direct that the Secretary provide the appropriate committees of Congress with a funding plan describing how the Secretary would intend to use the amounts appropriated in subsection 401(a). Section 401(e) would make explicit that the funds provided in subsection 401(a) are to supplement and not supplant other funding provided to EDRP. Section 401(f) would direct the Secretary to provide the appropriate committees of Congress with a report describing how the Secretary has obligated the amounts appropriated in subsection 401(a) as of the date of the submission of the report. Section 401(g) would define the appropriate committees of Congress.

Sec. 402. Appropriation of Amounts for the Veterans Choice Program.

Section 402 of the Committee bill, a freestanding original provision, would provide an additional \$4 billion for the Veterans Choice Program.

Background. Section 101 of P.L. 113–146 authorized veterans to receive care in the community if they would wait more than 30 days for care in a VA facility or lived more than 40 miles from a VA facility. However, funding for care provided under the Veterans Choice Program was tied to \$10 billion in funding provided in the Veterans Choice Fund as created by section 802 of P.L. 113–146. In July 2017, when VA indicated that the funds for Veterans Choice Program were close to being depleted, Congress provided an additional \$2.1 billion in funding for the Veterans Choice Program. In December 2017, after VA indicated funds for the Veterans Choice Program would be depleted in January 2018, Congress appropriated an additional \$2.1 billion.

Committee Bill. Section 402(a) would provide an additional \$4 billion in funding for the Veterans Choice Program. Section 402(b) would direct that the funds would be available until expended or the date specified in section 802(c)(4), December 31, 2018, as amended by section 142 of the Committee bill.

COMMITTEE BILL COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (hereinafter, “CBO”), estimates that enactment of the Committee bill would, relative to current law, increase discretionary spending by \$43.3 billion over 5 years and increase mandatory spending by \$5.6 billion over 10 years. Enactment of the Committee bill would impose a governmental man-

date, as defined by the Unfunded Mandates Reform Act, that would limit the application of State laws but would not result in additional spending or any significant loss in revenue.

The cost estimate provided by CBO, setting forth a detailed breakdown of costs, follows:

CONGRESSIONAL BUDGET OFFICE,
Washington, DC, January 17, 2018.

Hon. JOHNNY ISAKSON,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 2193, the Caring for Our Veterans Act of 2017.

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

Sincerely,

KEITH HALL,
Director.

Enclosure.

S. 2193—Caring for Our Veterans Act of 2017

Summary: S. 2193 would increase the use of community health care and long-term care by the Department of Veterans Affairs (VA) by broadening eligibility for such care and allowing VA to enter into agreements with health care providers in the private sector without complying with the Federal Acquisition Regulation (FAR). The bill also would make changes to VA's health care programs and compensation of employees, including expanding the caregivers program, increasing pay for employees, and reimbursing medical staff for professional training. In total, CBO estimates that implementing the bill would cost \$43.3 billion over the 2018–2022 period, assuming appropriation of the necessary amounts.

In addition, S. 2193 would directly appropriate \$4 billion for the Veterans Choice Program (VCP) and \$1 billion to provide educational assistance for health professionals at VA. The bill also would expand VA's authority to enter into leases for medical facilities. In total, CBO estimates that enacting the bill would increase direct spending by \$5.6 billion over the 2018–2027 period.

Pay-as-you-go procedures apply because enacting S. 2193 would affect direct spending. Enacting the bill would not affect revenues.

CBO estimates that enacting S. 2193 would not increase net direct spending or on-budget deficits by more than \$2.5 billion in any of the four consecutive 10-year periods beginning in 2028.

S. 2193 would impose an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) by preempting state laws that prohibit VA physicians from practicing telemedicine to treat veterans across state lines. Although it would limit the application of state regulations, the bill would impose no duty on state governments that would result in additional spending or any significant loss of revenues.

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

Estimated cost to the Federal Government: The estimated budgetary effects of S. 2193 are shown in Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

Table 1.—Estimated Budgetary Effects of S. 2193,
The Caring for Our Veterans Act of 2017

	By fiscal year, in millions of dollars—											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018–2022	2018–2027
INCREASES IN SPENDING SUBJECT TO APPROPRIATION												
Estimated Authorization Level	811	7,300	9,880	12,966	15,642	N/A	N/A	N/A	N/A	N/A	46,599	N/A
Estimated Outlays	638	6,342	9,213	12,249	14,895	N/A	N/A	N/A	N/A	N/A	43,337	N/A
INCREASES IN DIRECT SPENDING												
Estimated Budget Authority	5,000	0	0	140	140	140	140	140	140	140	5,280	5,980
Estimated Outlays	558	3,599	145	169	197	247	284	118	132	132	4,668	5,581

N/A = not applicable.

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

Spending subject to appropriation

CBO estimates that implementing S. 2193 would cost \$43.3 billion over the 2018–2022 period, subject to appropriation of the necessary amounts (see Table 2). Most of the bill’s estimated costs stem from provisions that would expand community health care for veterans, increase eligibility and benefits for caregivers, and increase pay for medical staff.

Veterans Community Care Program. Section 101 would establish the Veterans Community Care Program (VCCP) under which VA would be required to enter into contracts to establish networks of health care providers outside of VA to furnish hospital care, medical services, and extended-care services to veterans enrolled in the VA health care system.

Table 2.—Estimate of the Effects on Spending Subject to Appropriation of S. 2193,
The Caring for Our Veterans Act of 2017

	By fiscal year, in millions of dollars—					
	2018	2019	2020	2021	2022	2018–2022
INCREASES IN SPENDING SUBJECT TO APPROPRIATION						
Veterans Community Care Program						
Estimated Authorization Level	200	1,900	3,800	5,600	7,000	18,500
Estimated Outlays	200	1,700	3,500	5,300	6,600	17,300
Veterans Care Agreements						
Estimated Authorization Level	*	4,400	4,500	4,700	4,800	18,400
Estimated Outlays	*	3,800	4,300	4,500	4,700	17,300
Expansion of Family Caregivers Program						
Estimated Authorization Level	11	12	341	1,069	1,968	3,401
Estimated Outlays	10	11	298	962	1,815	3,096
Pay Caps for Nurses						
Estimated Authorization Level	400	480	580	680	790	2,930
Estimated Outlays	350	460	550	650	760	2,770
Walk-In Clinics						
Estimated Authorization Level	*	82	170	333	438	1,023

Table 2.—Estimate of the Effects on Spending Subject to Appropriation of S. 2193,
The Caring for Our Veterans Act of 2017—Continued

	By fiscal year, in millions of dollars—					
	2018	2019	2020	2021	2022	2018– 2022
Estimated Outlays	*	71	156	306	414	947
Agreements for State Veterans Homes						
Estimated Authorization Level	0	80	110	130	160	480
Estimated Outlays	0	70	100	130	150	450
Prompt Payment to Providers						
Estimated Authorization Level	3	55	68	89	111	326
Estimated Outlays	3	48	64	84	106	305
Shared Medical Facilities						
Estimated Authorization Level	100	100	100	107	107	514
Estimated Outlays	4	19	49	75	91	238
Staffing Vacant Medical Positions						
Estimated Authorization Level	15	59	54	56	58	242
Estimated Outlays	13	53	53	54	57	230
Reimbursement for Education of Nurses						
Estimated Authorization Level	34	34	34	34	34	170
Estimated Outlays	30	33	33	33	33	162
Transplant Donors						
Estimated Authorization Level	2	17	35	47	49	150
Estimated Outlays	2	15	32	44	47	140
Compensation for Medical Directors						
Estimated Authorization Level	0	16	21	26	29	92
Estimated Outlays	0	14	20	25	28	87
Modify Threshold for Major Medical Facilities						
Estimated Authorization Level	16	16	16	36	36	120
Estimated Outlays	1	3	8	28	32	72
Mobile Deployment Teams						
Estimated Authorization Level	6	10	15	20	26	77
Estimated Outlays	5	9	14	19	25	72
Podiatrists						
Estimated Authorization Level	9	10	10	12	13	54
Estimated Outlays	8	10	10	12	13	53
Peer Specialist Program						
Estimated Authorization Level	4	9	9	10	10	42
Estimated Outlays	3	8	9	10	10	40
Demonstration Program on Dental Care						
Estimated Authorization Level	4	5	5	5	6	25
Estimated Outlays	3	5	5	5	6	24
Pilot Program for Tuition Reimbursement						
Estimated Authorization Level	4	4	4	5	5	22
Estimated Outlays	3	4	4	5	5	21
Coordinated-Care Program						
Estimated Authorization Level	0	5	5	5	0	15
Estimated Outlays	0	4	5	5	1	15
Pay for Perfusionists						
Estimated Authorization Level	1	1	1	1	1	5
Estimated Outlays	1	1	1	1	1	5
Studies, Reports, and Training						
Estimated Authorization Level	2	5	2	1	1	11
Estimated Outlays	2	4	2	1	1	10
Total Changes in Spending Subject to Appropriation						
Estimated Authorization	811	7,300	9,880	12,966	15,642	46,599
Estimated Outlays	638	6,342	9,213	12,249	14,895	43,337

* = less than \$500,000.

Under this program, subject to appropriations, VA would be required to provide care through those networks, at the veteran's discretion, in the following situations:

- VA does not offer the care needed,
- The veteran resides in New Hampshire, or

- The veteran, as of the day before enactment, lives 40 miles away from a VA medical facility.

VA also would be required to provide such community care if the veteran's primary care provider and the veteran agree it is in the best medical interest of the veteran to do so, based on criteria to be developed by VA that consider the nature and frequency of the needed care and how accessible that care is to the veteran. In addition, VA would be authorized to offer community care if it determines that a VA medical center is not meeting the standards for timeliness and quality that would be developed by the department for different types of care. Section 101 would require VA to promulgate regulations to implement the program within 1 year.

The VCCP would replace an existing program that authorizes VA to provide community care to veterans with service-connected disabilities (SCDs) when VA does not offer the needed care or when that care is geographically inaccessible to the veteran and to women veterans who need hospital care. Under its existing program, VA currently spends roughly \$9 billion a year for community care (excluding emergency care). CBO expects the VCCP could cost several times more than the existing program although several factors would limit the rate and ultimate extent of cost growth. Cost would be higher because:

- VA would be required, subject to appropriations, rather than authorized to provide community care,
- The number of eligible veterans would be several times larger than the number eligible for the current program,
- The criteria for offering community care would be broader, and
- The convenience of community care could encourage more veterans to enroll in the VA health care system.

However, CBO expects these factors would limit the rate and ultimate extent of cost growth:

- A greater number of enrolled veterans receiving community care could shorten wait times for care provided in VA facilities, and thus reduce the number of veterans that need to be referred to community care because VA care is not available in a timely fashion.
- Many of the regulations that need to be written to implement the program could curtail use. For instance, VA would probably require all veterans to be seen by a VA caregiver before being referred for community care.
- The community care networks could be limited in size and scope, particularly in more rural areas, reducing the accessibility of such care.
- VA might implement the program slowly, as happened with the VCP.

To estimate the cost of this program over the next 5 years, CBO focused primarily on the extent to which the number of veterans eligible for VCCP would be larger than those eligible for the existing community care program. The currently eligible population—veterans with SCDs and women veterans needing hospital care—represents about 30 percent of enrolled veterans. Under VCCP, the eligible population would more than triple because all enrolled veterans would be eligible.

After accounting for the factors that might restrict use, CBO estimates that in the early years of the program, the newly eligible population would use community care at about half the rate of veterans in the current community care program. In addition, CBO expects that the program would be implemented gradually. On that basis, CBO estimates that implementing section 101 would cost \$17.3 billion over the 2018–2022 period.

Veterans Care Agreements. Section 102 would allow VA to enter into Veterans Care Agreements with health care providers in the community to provide hospital care, medical services, or extended care to eligible veterans. Such agreements would:

- Exempt VA from using the competitive bidding procedures as required under the FAR,
- Require VA to verify that those community providers meet the conditions for certification, and
- Require VA to periodically review the necessity of the agreements.

Under current law, VA must comply with the FAR for agreements and contracts with community health care and extended-care providers. The FAR is an extensive and complex set of rules governing the federal government’s purchasing processes. According to VA, the FAR’s requirements are appropriate for large and long-term agreements for contracted health care services but may not be practical for case-by-case arrangements in all regions of the United States. This bill would allow VA to use other agreements for certain health care services and extended care provided outside the VA system.

For 2018, the Congress has provided roughly \$10 billion for community health care at VA (excluding the VCP). Using information from VA, CBO estimates that implementing section 102 would give VA the legal authority to continue to provide about 40 percent (or \$4 billion annually) of that community health care. After adjusting for inflation and accounting for existing appropriations, CBO estimates that implementing this section would cost \$17.3 billion over the 2018–2022 period.

Expansion of the Family Caregivers Program. Section 301 would expand access to the Family Caregivers Program, which provides stipends, health insurance, respite care, training, and other forms of support to caregivers of eligible veterans enrolled in the program. Veterans are eligible for the program if they require assistance in activities of daily living, such as bathing, eating, or grooming, as a result of injuries incurred during military service on or after September 11, 2001. Section 301 would open that program in two stages to eligible veterans of any era and would expand its benefits to include legal and financial-planning services. In total, CBO estimates that implementing section 301 would cost \$3.1 billion over the 2018–2022 period.

Under stage one, eligible veterans who were injured during service on or before May 7, 1975, could enter the Family Caregivers Program. That stage would begin within 2 years of enactment (after VA develops and certifies a new information technology [IT] system to track benefits, as required under section 302). Stage two would begin 2 years after stage one and would open the program to the remaining eligible veterans—those injured during service after May 7, 1975, and before September 11, 2001. For the pur-

poses of this estimate, CBO assumes that the bill will be enacted near the beginning of calendar year 2018, that stage one of the proposal will begin early in 2020, and that stage two will begin early in 2022.

In 2016, costs for the Family Caregivers Program totaled \$493 million, about \$19,000 per participating veteran. Most of that cost resulted from monthly stipends paid to caregivers. Stipends are based on the hours of daily care the veteran requires and the prevailing wage for home health aides. In 2016, the annual stipends paid under the program ranged from \$7,800 to \$30,000 and averaged roughly \$20,000. Caregivers also are eligible to participate in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), a program run by VA that provides health insurance for dependents and survivors of certain disabled veterans. In addition, the Family Caregivers Program provides up to 30 days of respite care each year as well as training and 15 other support services. In 2016, costs under the Family Caregivers Program for CHAMPVA and the remaining services averaged about \$2,600 per veteran.

CBO's estimate of the cost of expanding the caregivers program is based on the patterns of use and the average costs of the existing program and the number of veterans with significant, service-connected disabilities in the cohorts that would be newly eligible. Furthermore, to account for the advanced age of the newly eligible veterans, the estimate reflects the following findings from a 2014 RAND study:¹

- Disabled veterans rely more heavily on assistance for daily activities as they age,
- Older veterans tend to rely on older caregivers, and
- Health care costs for caregivers increase with age.

For stage one, CBO estimates that about 22,000 additional veterans would participate in the program in 2020, increasing to roughly 46,000 by 2022. CBO expects that the youngest would be in their late 60s. After factoring in a heavier reliance on caregiver assistance for activities of daily living and higher health care costs for an older group of caregivers, CBO estimates that the average cost per participant in 2020 would be about \$30,500. However, VA already provides respite care to assist some caregivers through its General Caregiver Program, which provides limited support services to caregivers of eligible veterans from all eras. Accounting for those current benefits in the estimate reduces the average added cost per participant to \$30,000. After accounting for gradual implementation and incorporating annual inflation, CBO estimates that stage one of the proposal would cost \$2.6 billion over the 2020–2022 period.

For stage two, CBO estimates that about 30,000 additional veterans would use the Family Caregivers Program in 2022. Because those veterans would be younger than the group under the initial expansion, they would have less need for caregiver assistance (with a correspondingly lower stipend amount) and the caregivers would be younger (and have lower CHAMPVA costs). After accounting for existing benefits under the General Caregiver Program, the aver-

¹Rajeev Ramchand and others, Hidden Heroes: America's Military Caregivers (RAND Corporation, 2014), www.rand.org/pubs/research_reports/RR499.html.

age incremental cost per participant in 2022 would be \$29,000, about 12 percent lower than the cost for participants under stage one in that year. After factoring in a gradual implementation for the second stage of expansion and incorporating annual inflation, CBO estimates that the additional costs for stage two of the Family Caregivers Program would be \$417 million in 2022. Those costs would rise to billions of dollars a year by the end of the 10-year window, CBO estimates.

In addition, CBO estimates that roughly 30,000 caregivers in the current Family Caregivers Program (for veterans injured during service on or after September 11, 2001) would receive legal and financial support services. On the basis of the resources necessary to provide counseling under the existing program, CBO estimates an average annual cost of \$130 per beneficiary for legal and financial services. CBO estimates a cost of \$15 million over the 2018–2022 period to provide those benefits to individuals eligible for the Family Caregivers Program under current law. The costs of providing that additional benefit for newly eligible enrollees in the Family Caregivers Program under this provision are included in the estimates above for adding those people to the program.

Furthermore, in anticipation of the surge of new applications upon expansion of the Family Caregivers Program, VA would need to hire and train additional staff to manage the program (to staff a caregiver support line, provide outreach, and monitor the program). On the basis of program data from 2014 and adjusting for inflation, CBO estimates overhead costs of about \$400 per participant to process 22,000 new applications starting in 2020. As a result, CBO estimates the additional overhead costs would be \$17 million over the 2018–2022 period.

Pay Caps for Nurses. Section 224 would increase the maximum rate of pay for registered nurses at VA to executive level III (\$172,100 in 2017) from the current maximum of executive level IV (\$161,900 in 2017)—an increase of 6.3 percent. VA employs roughly 68,000 registered nurses. CBO expects that such a change would result in average pay for registered nurses increasing by that same percentage, from \$89,000 to \$94,600 in 2017. In addition, the higher pay level could help ameliorate VA’s current difficulties in recruiting and retaining registered nurses and would thus increase the total number of nurses employed by VA. Using data from VA on hiring and retaining nurses, CBO estimates that, under section 224, VA would employ roughly 71,000 registered nurses by 2022 (or a 4 percent increase above current staffing). On that basis, CBO estimates that implementing section 224 would cost \$2.8 billion over the 2018–2022 period for increased compensation for registered nurses.

Section 224 also would increase the maximum rate of pay for nurse executives at VA to executive level I (\$207,800 in 2017) from the current maximum of executive level IV (\$161,900 in 2017)—an increase of 28 percent. VA employs about 160 nurse executives at average salaries of \$136,995. CBO expects that VA would gradually increase the salaries of the nurse executives to reach a 28 percent increase, on average, by 2022. As a result, CBO estimates that increasing the cap for nurse executives would cost \$16 million over the 2018–2022 period. In total, CBO estimates that implementing section 224 would cost \$2.8 billion over the 2018–2022 period.

Walk-In Clinics. Within a year of enactment, section 105 would require VA to provide access to walk-in clinics operated by non-VA entities for veterans actively using the VA health care system. For their first two visits to a private clinic in any year, veterans' copayments would be limited to the amount, if any, required at VA facilities, as determined by the department. For subsequent visits, the veterans would be required to make copayments in an amount set by the department.

Using information from VA, CBO estimates that the department would reimburse about 2.7 million claims for visits to walk-in clinics each year, at an average of \$200 per visit. After adjusting for time to prepare the regulations and a gradual implementation, CBO estimates that implementing section 105 would cost \$947 million over the 2018–2022 period.

Agreements for State Veterans Homes. Section 103 would waive the requirements of the FAR for contracts and agreements that VA enters into with state-run nursing homes for veterans. Under current law, the state veterans' homes (SVHs) must fill 75 percent of their beds with veterans. VA pays SVHs the full cost of care for veterans with an SCD rating of 70 percent or more, under a contract or agreement. For all other veterans, VA pays SVHs a grant based on a fixed daily allowance.

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

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

Prompt Payment to Providers. Section 111 would establish standards for prompt payment of claims for reimbursement for health care provided to veterans in the community, and it would require VA to enter into a contract or agreement with a nondepartment entity to process those claims. In total, CBO estimates, implementing this section would cost \$305 million over the 2018–2022 period.

Expedited Processing of Claims. Currently, department standards require VA to process 90 percent of claims for reimbursement of non-VA health care within 30 days. However, VA has been unable to meet such standards. Under section 111, VA would be required to reimburse non-VA providers within 30 to 45 days of re-

ceiving a completed claim form. On the basis of a report by the Government Accountability Office and information from VA, CBO estimates that the department would need 340 additional claims processors at an average annual compensation of \$51,000 to meet the expedited time frame for reimbursing existing non-VA health care. After factoring in the period for VA to prepare regulations in 2018, CBO estimates that expediting the processing of claims for such health care would cost \$62 million over the 2018–2022 period.

Contracted Claims Processors. Section 111 also would require VA to outsource the processing of claims for non-VA health care. Currently, VA employs about 2,000 claims processors for that purpose at an average compensation of \$51,000. CBO expects that the costs for using contractors rather than VA employees would be the same; therefore, no additional costs are estimated for replacing existing VA claims processors with contractors.

Upon entering into contracts for claims processors, CBO expects that VA would offer current existing claims processors the following options:

- Accept placement in another vacant local position at VA,
- Relocate to a position that already exists in another VA location, or
- Voluntarily separate from VA employment.

CBO estimates that placing one-third (or about 600) of the claims processors in other local positions would present minimal costs for administrative duties to select and train the staff. CBO expects that the other two-thirds (about 1,100 claims processors) would relocate or voluntarily end their employment at VA. Using information from VA, CBO estimates that the average cost for relocation or incentive payments for voluntary separation would be \$20,000 per employee. As a result, CBO estimates that relocating or ending employment for VA claims processors would cost \$24 million over the 2019–2020 period.

Processing New Claims. In order to handle the additional claims of the VCCP established under section 101 of the legislation, CBO estimates that VA would gradually expand the contract discussed above to account for the more than doubling of non-VA health care. By 2022, an additional 2,230 processors would be needed at an average annual compensation of \$51,000. After factoring in a gradual implementation of the program, adding those claims processors would cost about \$220 million over the 2018–2022 period.

Shared Medical Facilities. Section 242 would allow VA to enter into agreements with other federal departments to construct shared medical facilities.

Implementing this section could reduce VA’s share of the cost of some construction projects and some projects would no longer require legislative authorization. Using information from VA, CBO estimates that the total cost for such major construction projects would average about \$100 million each year. On that basis, CBO estimates costs of \$225 million over the 2018–2022 period for additional construction projects.

Section 242 also would expand VA’s authority to enter into leases for medical facilities. CBO estimates that VA would enter into one additional lease each year, with a total annual rent payment of \$3 million. For those leases, VA would record obligations of \$7 million each year as it enters those contracts at a cost of \$13 million over

the 2021–2022 period for additional leases. Entering into those leases also would increase direct spending; which is discussed below under the heading “Direct Spending.”

In total, CBO estimates section 242 would cost \$238 million over the 2018–2022 period.

Staffing Vacant Medical Positions. Within 180 days of enactment, section 206 would require VA to identify and fill vacant positions in the areas of mental health care (such as psychologists, psychiatrists, and additional therapists and counselors) and staff on Patient Aligned Care Teams or PACTs (such as mental health professionals and primary care physicians). PACTs use a team-based model of care to address the comprehensive needs of patients receiving health care at VA medical centers.

VA has advertised vacant positions for mental health professionals and primary care physicians. CBO estimates about 130 vacant positions for mental health professionals and 130 positions for primary care physicians in PACTs would be filled under this section. Using information from VA, CBO expects an average compensation of \$120,000 for a mental health care provider and \$220,000 for a primary care physician in 2018. VA would probably need to offer special recruitment incentives (such as hiring bonuses) to meet the hiring deadline under this proposal. Under current law, VA offers up to 25 percent of the rate of basic pay as a recruitment bonus. Such onetime bonuses would amount to roughly \$23,000 for mental health providers and \$43,000 for physicians. After accounting for the expected growth in wages, CBO estimates that implementing this section would cost \$230 million over the 2018–2022 period.

Reimbursement for Education of Nurses. Section 213 would require VA to reimburse nurses for up to \$1,000 of the cost of continuing professional education. Under current law, VA is only required to reimburse physicians and dentists for such costs. However, the department currently reimburses registered nurses an average of \$500 per year. VA employs roughly 68,000 registered nurses. CBO estimates that this provision would increase reimbursement for continuing professional education by \$500 per nurse, on average. As a result, CBO estimates that implementing this section would cost \$162 million over the 2018–2022 period.

Transplant Donors. Section 252 would allow VA to cover costs related to organ transplant procedures for veterans and their living donors at nondepartment facilities. Currently, VA covers the medical and service expenses (such as transportation and lodging) for veterans and their living donors only for procedures performed at the Department of Veterans Affairs Transplant Centers (VATCs). For procedures that take place at nondepartment facilities, VA reimburses donors only for transportation and lodging. In 2017, VA provided 560 organ transplants, most of which occurred at VATCs. Of those operations, about 200 were for kidney transplants and about 20 were with living donors.

Section 252 would authorize VA to pay for transplant procedures at various locations nationwide with minimal out-of-pocket expenses for veterans and their living donors. As a result, CBO expects more veterans would use VA for such procedures and more people would be willing to donate organs. In determining the additional number of transplant procedures, CBO considered the other

sources of health care coverage carried by enrolled veterans and the likelihood, under this proposal, that those veterans would instead use VA for their transplant procedures.

Using information from the Census Bureau, VA, and the Department of Health and Human Services (HHS), CBO estimates that under this section roughly 60 additional veterans would undergo transplants at nondepartment facilities each year, at an average cost of \$750,000 per patient. CBO estimates that VA would cover the medical expenses of an additional 50 living donors (some for procedures that will occur under current law but for which VA would not pay medical expenses) each year, at an average cost of \$80,000 per donor. In addition, CBO believes that implementing this section would allow veterans to undergo transplants closer to home. As a result, CBO estimates a reduction in costs for transportation reimbursements of about \$4 million each year. Based on the expectation that VA would implement the bill gradually, CBO estimates that implementing section 252 would have a net cost of \$140 million over the 2018–2022 period.

Compensation for Medical Directors. Section 205 would remove the cap on basic pay for directors of regional and medical facilities at the department. Under current law, the salary for those positions is capped at level V of the executive schedule. CBO expects that this section would allow VA to offer competitive pay (based on compensation in the private market) for those positions. VA employs about 130 directors at an average compensation amount of \$282,000 in 2017. On average, compensation for medical directors in the private sector is about \$320,000. As a result of the increase in salary, CBO estimates that VA would be able to fully staff the 140 medical director positions by 2021. After factoring in a 1-year delay and additional hiring, CBO estimates that implementing this provision would cost \$87 million over the 2018–2022 period.

Modify Threshold for Major Medical Facilities. Section 241 would expand the authority of VA to construct and lease medical facilities.

Section 241 would allow VA to construct medical facilities with total costs of up to \$20 million without legislative authorization. Under current law, VA must receive legislative authorization to construct medical facilities with total expenses above \$10 million.

Using information on planned construction projects in VA's 2018 budget submission, CBO estimates that implementing this section would authorize one additional construction project each year with an average cost of \$16 million. On that basis, CBO estimates costs of \$36 million over the 2018–2022 period for construction of new facilities.

In addition, this section would expand VA's authority to enter into leases for medical facilities. CBO estimates that VA would enter into six additional leases each year with a total annual rent payment of \$7 million. In that case, VA would record obligations of \$20 million each year as it enters those contracts at a cost of \$36 million over the 2021–2022 period for additional leases. CBO estimates that this authority also would increase direct spending, which is discussed below under the heading "Direct Spending."

In total, CBO estimates implementing section 241 would cost \$72 million over the 2018–2022 period.

Mobile Deployment Teams. Section 233 would require VA to establish a program to provide mobile deployment teams of medical personnel to provide health care at underserved VA facilities. On the basis of costs in the private-sector to operate mobile clinics, CBO estimates start-up costs of \$300,000 per team and annual costs to operate each mobile clinic of \$375,000. In addition, CBO estimates a medical team of three physicians would cost \$450,000 per clinic. CBO expects that VA would implement this program gradually, starting with five mobile deployment teams in 2018 and growing to 25 by 2022. As a result, CBO estimates that implementing this section would cost \$72 million over the 2018–2022 period.

Podiatrists. Section 202 would add podiatrists to the same pay schedule as physicians and dentists and thereby increase their pay. Currently, VA employs about 400 podiatrists nationwide at an average annual salary of about \$130,000. On the basis of information from VA about the average increase necessary for podiatrists to move to a pay schedule comparable to that of physicians and dentists, CBO estimates that the base salary for podiatrists would increase by about 15 percent to \$150,000 in 2018. In addition, using data on hiring from VA, CBO estimates that VA would be able to hire an additional 30 podiatrists because the increased pay would make working at VA more attractive. After accounting for projected pay raises, CBO estimates that implementing the provision would cost \$53 million over the 2018–2022 period.

Peer Specialist Program. Section 208 would require that VA establish a program to include at least two peer specialists in PACTs to promote services for mental health, substance use disorders, and behavioral health in primary care. The program would require a rapid rollout, being implemented in at least 25 medical centers in 2018 and in at least 50 medical centers in 2019. CBO expects the department would implement the program in two PACTs per medical center. Using information from VA, CBO estimates that the 200 additional peer specialists by 2019 would receive an average salary of \$41,000. After adjusting for wage growth, CBO estimates that implementing this section would cost \$40 million over the 2018–2022 period.

Demonstration Program on Dental Care. Section 215 would require VA to establish a demonstration program to increase veterans' access to dental care that would require hiring and training alternative dental health providers. Those employees would include community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professionals that the Secretary determines appropriate.

Based on the scope of a similar demonstration program operated by HHS, CBO expects that developing and operating the program would require two additional full-time employees at each facility to engage in research, training, and assessment of the program. Based on the costs of similar proposals, CBO expects this program would operate within 10 medical facilities and that the annual cost per staff person would be \$100,000 in 2018 and \$11 million over the 2018–2022 period.

CBO expects that the use of alternative dental care providers would increase VA's delivery of dental care to veterans. CBO estimates VA would hire two additional dental health providers at each of the 10 medical facilities at an average compensation of \$150,000. As a result, CBO estimates that hiring additional dental health providers would cost \$14 million over the 2018–2022 period.

In total, implementing section 215 would cost \$24 million over the 2018–2022 period.

Pilot Program for Tuition Reimbursement. Section 232 would require VA to carry out a 6-year pilot program to repay the education loans of certain physicians. Eligible physicians would include those who are licensed as well as those in their last year of residency who agree to work at VA for a certain period in rural locations. The department would be required to select employees in at least three medical centers and seven ambulatory care facilities.

The program would pay up to the full amount of the medical loans for newly licensed physicians and up to \$50,000 of loans for current physicians at VA. For this estimate, CBO expects that VA would repay the loans of 50 physicians in each year of the pilot program, and that one-third of the participants would be newly licensed physicians and two-thirds would be established physicians at VA. Based on information from the National Center for Education Statistics and the Association of American Medical Colleges, newly licensed physicians would have an estimated average education loan debt of \$170,000 in 2017. For established physicians, CBO expects that VA would reimburse about \$40,000 of their student loan debt. After factoring in the growth in costs for higher education, CBO estimates that implementing the pilot program would cost \$21 million over the 2018–2022 period.

Coordinated-Care Program. Section 251 would require VA to provide grants to certain public or nonprofit entities. Grant recipients would coordinate wellness care for veterans receiving mental health care from VA. The grantees also would assess the usefulness of coordinating such care and report on that assessment. That program would begin a year after enactment and continue for 3 years.

Based on VA's implementation of other programs of similar scope (such as using meditation for veterans with Post Traumatic Stress Disorder), CBO expects that VA would award grants to coordinate care at 10 VA medical facilities and that each grant would cover the costs of about four employees to deliver services and analyze and report to the Congress on the results of their efforts. CBO estimates that the average compensation for those employees would be about \$120,000 in 2018. In total, after accounting for inflation, CBO estimates the cost to implement the program would be \$15 million over the 2018–2022 period.

Pay for Perfusionists. Section 203 would increase the maximum salary for perfusionists employed by VA by exempting them from certain salary limitations. (Perfusionists are medical professionals responsible for operating heart-lung machines during cardiac surgery.) Currently VA employs 28 perfusionists (in the 41 VA medical facilities offering the type of cardiac surgery requiring such services) at an average salary of \$101,000. On the basis of information from VA, CBO estimates that implementing this proposal would increase the salary of perfusionists at the department by 18 percent. As a result, CBO also expects that VA would see higher retention

and recruitment for this position, resulting in a 20 percent increase in staff—an additional 6 perfusionists by 2022. In total, CBO estimates that implementing this section would cost \$5 million over the 2018–2022 period.

Studies, Reports, and Training. S. 2193 would require VA to conduct studies, issue reports, and provide training for staff. Based on the costs of similar activities, CBO estimates that meeting those requirements would cost \$10 million over the 2018–2022 period.

- By December 31, 2018, section 302 would require VA to develop and implement an IT system to track and assess data from the Family Caregiver Program. VA reports that it is currently working to enhance its existing IT system for tracking caregivers to allow for an easier application process and for tracking stipend awards and other benefits. As a result, CBO estimates that this requirement would mostly codify existing practice and would have no budgetary effect. However, the provision also includes assessment and reporting requirements that CBO estimates would cost \$2 million over the 2018–2022 period.

- Section 104 would require that VA establish benchmark guidelines for access to health care at VA medical facilities. Such guidelines would assist medical providers on whether to refer veterans into the community for health care. The section also would establish quality standards for health care at the department. CBO estimates that this section would cost \$1 million over the 2018–2022 period.

- Starting in 2019 and every 2 years thereafter, section 106 would require that VA conduct market area assessments on the health care services provided by the department. Every 4 years, this section also would require VA to develop a strategic plan to meet the demand for health care provided by the department. CBO estimates that implementing this section would cost \$1 million over the 2018–2022 period.

- Other provisions, including sections 108, 121, 122, 123, 201, 207, and 222 would require periodic reports on education and training programs, personnel, telemedicine, and performance awards and bonuses for employees at VA. Furthermore, section 231 would require VA to develop criteria to assess underserved facilities. In total, CBO estimates that those reports and criteria would cost \$6 million over the 2018–2021 period.

Direct spending

S. 2193 would appropriate funds for the Veterans Choice Program and for health care at VA. In addition, the bill would increase VA's ability to lease medical facilities without subsequent legislative authorization. On that basis, CBO estimates that the legislation would increase direct spending by \$5.6 billion over the 2018–2027 period (see Table 3).

Veterans Choice Program. Section 402 would appropriate \$4 billion for VCP, which pays for certain veterans to receive health care from participating providers in the private sector. For fiscal year 2018, VCP has about \$4 billion in available funds, which CBO estimates will be completely committed in 2018. Under current law, the program will terminate once its funding is exhausted. CBO expects that enacting this provision would extend the life of VCP through most of 2019. On that basis, CBO estimates that section

402 would increase direct spending by \$4 billion over the 2018–2027 period.

Table 3.—Estimate of the Effects on Direct Spending of S. 2193, The Caring for Our Veterans Act of 2017

	By fiscal year, in millions of dollars—											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018–2022	2018–2027
INCREASES IN DIRECT SPENDING												
Veterans Choice Program												
Budget Authority	4,000	0	0	0	0	0	0	0	0	0	4,000	4,000
Estimated Outlays	500	3,500	0	0	0	0	0	0	0	0	4,000	4,000
Health Professionals Education Assistance Program												
Budget Authority	1,000	0	0	0	0	0	0	0	0	0	1,000	1,000
Estimated Outlays	58	99	145	163	170	178	187	0	0	0	635	1,000
Major Medical Facilities												
Estimated Budget Authority	0	0	0	100	100	100	100	100	100	100	200	700
Estimated Outlays	0	0	0	4	19	49	69	84	94	94	23	413
Shared Medical Facilities												
Estimated Budget Authority	0	0	0	40	40	40	40	40	40	40	80	280
Estimated Outlays	0	0	0	2	8	20	28	34	38	38	10	168
Total Changes in Direct Spending												
Estimated Budget Authority	5,000	0	0	140	140	140	140	140	140	140	5,280	5,980
Estimated Outlays	558	3,599	145	169	197	247	284	118	132	132	4,668	5,581

Health Professionals Education Assistance Program. Section 401 would appropriate \$1 billion for reimbursing employees at VA for their professional education. Specifically, the appropriations would be used to increase the number of graduate medical residents at VA (under sections 202 and 203 of this bill), increase bonuses and awards for VA employees (under section 204), and increase the payments for reducing student loan debt for certain VA staff (under section 213). CBO estimates that the appropriated amounts would be sufficient to fund those programs through 2024. Beyond that year, CBO estimates that the increased program costs would continue, subject to appropriation of the necessary amounts. CBO estimates section 401 would increase direct spending by \$1 billion over the 2018–2027 period.

Major Medical Facilities. Sections 241 would expand VA’s authority to enter into leases for medical facilities. (Provisions also would expand the authority to construct medical facilities, discussed above under the heading “Spending Subject to Appropriation.”) In total, CBO estimates that enacting this section would increase direct spending by \$413 million over the 2018–2027 period.

VA classifies its contracts for acquiring such facilities as operating leases and thus records its obligations for lease payments on an annual basis over the term of each lease. However, CBO has reviewed several contracts and has concluded that they are akin to government purchases of facilities built specifically for VA’s use—but instead of being financed by the Treasury, they rely on third-party financing (that is, funds raised by a nonfederal entity), which

is generally more expensive.² That conclusion is based on those leases having many of the following key features:

- The facilities are designed and constructed to the unique specifications of the government;
- The facilities are constructed at the request of the federal government;
- The leases on the newly constructed facilities are long term—usually 20 years;
- Payments from the federal government are the only or the primary source of income for the facilities;
- The term of the contractual agreements coincides with the term of the private partner’s financing instrument for developing and constructing the facility (that is, a facility financed with a 20-year bond will have a 20-year lease term);
- The federal government commits to make fixed annual payments that are sufficient to service the debt incurred to develop and construct the facility, regardless of whether the agency continues to occupy the facility during the guaranteed term of the lease; and
- The fixed payments over the life of the lease are sufficient to retire the debt for the facility.³

Thus, although those transactions are structured as leases, they are essentially government purchases. Under the normal procedures governing the budgetary treatment of the purchase of capital assets, budget authority should be available and obligations should be recorded at the time the acquisitions are initiated, and amounts recorded should equal the full development and construction costs of the medical facilities. Instead, VA records a small fraction of those costs as obligations when it awards the contracts for such transactions.

To the extent that the full costs of developing and constructing the facilities exceeds the relatively small amount that VA would initially record as obligations against its appropriation, CBO treats the legislative authorization for those transactions as contract authority—a type of budget authority that allows an agency to enter into a contract and incur an obligation before receiving an appropriation for those activities. Because the contract authority would be provided in an authorizing bill, rather than in an appropriation act, the resulting spending is categorized as direct spending (as distinguished from discretionary spending, which results from appropriation acts).

In addition, at the time the contracts are signed, VA typically obligates some amounts from available appropriations; those costs are considered discretionary.

Section 241 would allow VA to enter into leases without legislative authorization for medical facilities with annual lease payments of up to \$1.5 million. Under current law, VA must receive legislative authorization to lease medical facilities with annual rent payments in excess of \$1 million.

²For more information on the budgetary treatment of third-party financing, see Congressional Budget Office, *Third-Party Financing of Federal Projects* (June 2005), www.cbo.gov/publication/16554.

³See testimony of Robert A. Sunshine, Deputy Director, Congressional Budget Office, before the House Committee on Veterans’ Affairs, *The Budgetary Treatment of Medical Facility Leases* by the Department of Veterans Affairs (June 27, 2013), www.cbo.gov/publication/44368.

After reviewing VA's 2018 budget request for leases of medical facilities, CBO estimates that enacting this provision would allow VA to enter into six additional leases, on average, each year. In total, the annual rent payments for those leases would be about \$7 million. CBO expects that the initial contracts for those facilities would be entered into starting in 2021 and that similar contracts would be signed each year thereafter.

When the government leases a facility the lessor charges the government for the cost to construct the facility plus interest on those costs over the period it takes to recover them through the lease payments. CBO's estimate of direct spending reflects an amount equal to the cost of constructing the facilities, plus the net present value of the portion of lease costs attributable to interest rates that would exceed U.S. Treasury interest rates. (Borrowing costs equivalent to the amount of Treasury interest that would be paid if the equipment was financed with appropriated funds are not included in our estimate because, for the enforcement of Congressional budget rules, changes in Treasury interest costs are not counted as a cost or savings related to any particular legislative provision.) CBO's estimate of outlays reflects its judgment as to when the facilities would be provided—typically over a 6-year period.

On that present value basis for each lease over the term of the lease agreement, CBO estimates that enacting this provision would increase direct spending by \$413 million over the 2021–2027 period.⁴

Shared Medical Facilities. Section 242 would allow VA to enter into sharing agreements with other federal agencies to lease medical facilities. VA's portion of the annual rent payments for leased medical facilities could be lowered by enough that some leases would no longer require legislative authorization. Using information from VA, CBO estimates that, on average, this section would allow construction of one medical facility each year with an average annual rent payment of \$3 million. CBO expects that VA would enter into the first such contract in 2021 and that similar contracts would take effect each year thereafter. On a present value basis for each lease over the term of the lease agreement, CBO estimates that enacting this section would increase direct spending by \$168 million over the 2021–2027 period.

Pay-As-You-Go Considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in Table 4.

⁴A present value is a single number that expresses a flow of past and future income or payments in terms of an equivalent lump sum received or paid today. The value depends on the rate of interest, known as the discount rate, used to translate past and future cash flows into current dollars. CBO calculated costs for the 20-year leases by discounting the expected annual rent payments using the rate on Treasury securities of comparable maturity.

Table 4.—CBO Estimate of Pay-As-You-Go Effects of S. 2193, The Caring for Our Veterans Act of 2017, as Ordered Reported by the Senate Committee on Veterans' Affairs on November 29, 2017

	By fiscal year, in millions of dollars—													2018– 2022	2018– 2027	
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027						
	NET INCREASE IN THE ON-BUDGET DEFICIT															
Statutory Pay-As-You-Go Impact	558	3,599	145	169	197	247	284	118	132	132		4,668	5,581			

Increase in long-term direct spending and deficits

CBO estimates that enacting the draft bill would not increase net direct spending or on-budget deficits by more than \$2.5 billion in any of the four consecutive 10-year periods beginning in 2028.

Mandates

S. 2193 would impose an intergovernmental mandate as defined in UMRA by preempting state laws that prohibit VA physicians from practicing telemedicine to treat veterans across state lines. Although it would limit the application of state regulations, the bill would impose no duty on state governments that would result in additional spending or any significant loss of revenues.

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

Previous CBO estimates: On November 13, 2017, CBO transmitted a cost estimate for H.R. 4243, the VA Asset and Infrastructure Review Act of 2017, as ordered reported by the House Committee on Veterans' Affairs on November 8, 2017. Sections 201 and 204 in H.R. 4243 are similar to sections 241 and 242 of S. 2193 and the estimated costs for both sections are the same.

On November 8, 2017, CBO transmitted a cost estimate for H.R. 1133, the Veterans Transplant Coverage Act of 2017, as ordered reported by the House Committee on Veterans' Affairs on July 19, 2017. H.R. 1133 is similar to section 252 of S. 2193 and the estimated costs are the same.

On July 24, 2017, CBO transmitted a cost estimate for H.R. 1058, the VA Provider Equity Act, as ordered reported by the House Committee on Veterans' Affairs on July 19, 2017. The language in H.R. 1058 that affects podiatrists is similar to section 202 of S. 2193 and the estimated costs are the same.

Estimate prepared by: Federal Costs: Ann E. Futrell; Mandates: Zachary Byrum.

Estimate approved by: H. Samuel Papenfuss, Deputy Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7(b) of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at its November 29, 2017, meeting. Twenty-two amendments to the Committee Bill were voted on by members.

Chairman Isakson called up nineteen amendments to be considered en bloc. The amendments were sponsored by Senators Sullivan, Heller, Cassidy, Rounds, Sanders, Blumenthal, Moran, Tillis, and Brown. The amendments were agreed to by voice vote.

An amendment by Senator Moran would have replaced sections of the Committee Bill regarding community care, access and quality standards, prompt pay, access to walk-in care, a strategy for care provided by VHA, authorization of appropriations for care provided in VHA, and the appropriation of \$4 billion for the Veterans Choice Program. In addition, the amendment would have added provisions to the Committee Bill relating to continuity of care, payment rates for care in the community, and a center of innovation for care and payments. This amendment was not agreed to by voice vote and Senator Moran requested that he be recorded as voting aye.

An amendment by Senator Cassidy would have removed a section of the Committee Bill that allowed veterans to file a disability compensation claim for adverse medical events for care received in the community. This amendment was not agreed to by voice vote.

The Committee also discussed amendments sponsored by Senator Sanders but did not vote on those amendments because they were withdrawn.

The Committee Bill, as amended during the Committee meeting, was agreed to by a roll call vote.

Nays	Senator	Yeas
X	Mr. Moran	
	Mr. Boozman	X
	Mr. Heller	X
	Mr. Cassidy	X
	Mr. Rounds	X
	Mr. Tillis	X
	Mr. Sullivan	X
	Mr. Tester	X
	Mrs. Murray	X
	Mr. Sanders	X
	Mr. Brown	X
	Mr. Blumenthal	X
	Ms. Hirono	X (by proxy)
	Mr. Manchin	X
	Mr. Isakson, Chairman	X
1	TALLY	14

AGENCY REPORTS

On May 17, 2017, Jennifer S. Lee, M.D., Deputy Under Secretary for Health for Policy and Services, Veterans Health Administration; on July 11, 2017, Baligh Yehia, M.D., Deputy Under Secretary for Health for Community Care, Veterans Health Administration from the Department of Veterans Affairs appeared before the Committee

on Veterans' Affairs and submitted testimony on various bills incorporated into the Committee bill. Excerpts from those statements are below:

STATEMENT OF DR. JENNIFER S. LEE, DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND SERVICES VETERANS HEALTH ADMINISTRATION DEPARTMENT OF VETERANS AFFAIRS

Good morning, Chairman Isakson, Ranking Member Tester, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect the Department of Veterans Affairs' (VA) programs and services. Joining me today is Ms. Margaret Kabat, National Director, Caregiver Support Program, Veterans Health Administration (VHA); Phil Parker, Acting Associate Deputy Assistant Secretary, Office of Acquisition and Logistics, Office of Acquisition, Logistics, and Construction (OALC); Mr. James Ruhlman, Assistant Director for Policy & Procedures, Veterans Benefits Administration (VBA); Ms. Meghan Flanz, Interim General Counsel; Dave McLenachen, Director, Appeals Management Office, VBA; and Donnie Hachey, Chief Counsel for Operations, Board of Veterans Appeals (BVA).

There are a number of bills on the agenda today, and we are unable at this time to provide views and cost estimates on a few of these provisions. Specifically, we do not have cost estimates on S. 543 and S. 764.

S. 591—MILITARY AND VETERAN CAREGIVERS SERVICE IMPROVEMENT ACT OF 2017

S. 591 would expand eligibility for VA's Program of Comprehensive Assistance for Family Caregivers, expand benefits available to participants under such program, enhance special compensation for certain members of the uniformed services who require assistance, and make other amendments to increase the provision of benefits.

The Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163, signed into law on May 5, 2010, provided expanded support and benefits for caregivers of eligible and covered Veterans. While the law authorized certain support services for caregivers of covered Veterans of all eras, other benefits were authorized only for qualified family caregivers of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. These new benefits for approved family caregivers, provided under the Program of Comprehensive Assistance for Family Caregivers, include a monthly stipend paid directly to designated primary family caregivers and medical care under CHAMPVA for designated primary family caregivers who are not eligible for TRICARE and not entitled to care or services under a health-plan contract.

Section 2 of S. 591, the Military and Veteran Caregiver Services Improvement Act of 2017, would remove "on or after September 11, 2001" from the statutory eligibility criteria for the Program of Comprehensive Assistance for Family Caregivers, and thereby expand

eligibility under the program to Veterans of all eras who otherwise meet the applicable eligibility criteria. Family caregivers could not receive assistance under this expanded eligibility until FYs 2018, 2020, or 2022 depending on the monthly stipend tier for which their eligible Veteran qualifies. Section 2 would also add “or illness” to the statutory eligibility criteria, and thereby expand eligibility to include those Veterans who require a caregiver because of an illness incurred or aggravated in the line of duty. In addition, the bill would expand the bases upon which a Veteran could be deemed to be in need of personal care services, to include “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.”

This section would also expand the assistance available to primary family caregivers under the Program of Comprehensive Assistance for Family Caregivers to include child care services, financial planning and legal services “relating to the needs of injured and ill Veterans and their caregivers,” and respite care that includes peer-oriented group activities. The bill would ensure that in certain circumstances VA accounts for the family caregiver’s assessment and other specified factors in determining the primary family caregiver’s monthly stipend amount. In addition, the bill would require VA to periodically evaluate the needs of the eligible Veteran and the skills of the family caregiver to determine if additional instruction, preparation, training, or technical support is needed, and it would require certain evaluation be done in collaboration with the Veteran’s primary care team to the maximum extent practicable.

Section 2 would also authorize VA, in providing assistance under the Program of Comprehensive Assistance for Family Caregivers, to “enter into contracts, provider agreements, and memoranda of understanding with Federal agencies, states, and private, non-profit, and other entities” in certain circumstances. It would expand the definition of family member to include a non-family member who does not provide care to the Veteran on a professional basis, and it would amend the definition of “personal care services.” The bill would also end the Program of General Caregiver Support Services on October 1, 2022, but would ensure that all of its activities are carried out under the Program of Comprehensive Assistance for Family Caregivers. Finally, the bill would amend the annual reporting requirements for the Program of Comprehensive Assistance for Family Caregivers.

In September 2013, VA sent a report to the Committees on Veterans’ Affairs of the Senate and House of Representatives (as required by Section 101(d) of Public Law 111–163) on the feasibility and advisability of expanding the Program of Comprehensive Assistance for Family Caregivers to family caregivers of Veterans who incurred or aggravated a serious injury in the line of duty before September 11, 2001. In that report, VA noted that expanding the Program of Comprehensive Assistance for Family Caregivers would allow equitable access to seriously injured Veterans from all eras (who otherwise meet the program’s eligibility criteria) and their approved family caregivers.

In the report, however, VA noted difficulties with making reliable projections of the cost effect of opening the Program of Comprehensive Assistance for Family Caregivers to eligible Veterans of all eras, but estimated a population range of 32,000 to 88,000 additional Veterans in the first year (estimated for FY 2014), at a cost of \$1.8 billion to \$3.8 billion in the first year (estimated for FY 2014). After VA provided this report to Congress, the RAND Corporation published a report titled, "Hidden Heroes: America's Military Caregivers," which estimates a significantly larger eligible population (1.5 million) that may be eligible if the program were expanded to caregivers of pre-9/11 Veterans and those qualifying due to illness. VA's estimates in its 2013 report did not account for expansion to eligible Veterans with an illness incurred or aggravated in the line of duty, other Veterans who would become eligible for the program based on the amendments in section 2, or the additional assistance that would become available to primary family caregivers under the bill. This estimate also did not factor in a phased implementation of stipend expansion, as contemplated by the bill.

VA cannot responsibly provide a position in support of expanding the Program of Comprehensive Assistance for Family Caregivers without a realistic consideration of the resources necessary to carry out such an expansion, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care services. This is especially true as VA presses to strengthen mental health services and ensure the fullest possible access to care across the system.

We wish to make it very clear that VA believes an expansion of those benefits that are currently limited by era of service would result in equitable access to the Program of Comprehensive Assistance for Family Caregivers for long-deserving caregivers of those who have sacrificed greatly for our Nation. However, VA cannot endorse this measure before further engaging with Congress on these fiscal constraints, within the context of all of VA health care programs.

Additionally, before expanding eligibility under the Program, we believe it prudent for VA to ensure that the current eligibility criteria are applied in a consistent manner across the program. For example, the National Caregiver Support Program is undergoing an internal review to evaluate consistency in revocations and reductions from the Program and standardize communication with Veterans and Caregivers. On April 17, 2017, VA suspended certain VA-initiated revocations in order to carry out this review.

VA welcomes further discussion of these issues with the Committee.

Section 3 of this bill proposes to add a new section 3319A to title 38 to authorize individuals who are eligible for and participating in a program of comprehensive assistance for family caregivers under 38 U.S.C. § 1720G(a) the opportunity to transfer their unused Post-9/11 GI Bill education benefits to their dependents. Veterans may complete the transfer of entitlement any time during the 15-year period beginning on the date of their last discharge or release from active duty. There is no length of service requirement, and the monthly rate of educational assistance would be the same

rate payable to the individual making the transfer. The Secretary would be authorized to prescribe regulations to carry out this section. We note that the Survivors' and Dependents' Educational Assistance (DEA) program, or chapter 35, currently offers education and training benefits to eligible dependents of members of the Armed Forces and Veterans who have a service-connected disability rated as permanently and totally disabling, including individuals who are eligible for a program of comprehensive assistance for family caregivers. Assistance includes up to 45 months of full-time benefits.

VA supports the intent of section 3 to take care of caregivers; however, VA cannot support this section as written. The transfer of entitlement provisions of the Post-9/11 GI Bill were established as a recruitment and retention tool for the uniformed services. As such, the Department of Defense (DOD) determines eligibility for transfer of entitlement. If enacted, the proposed legislation would require VA to develop procedures to receive requests to transfer entitlement for certain individuals, determine eligibility, and award benefits for the transfer of entitlement program. However, VA notes that Congress would need to identify appropriate offsets for the cost of this legislation

Additionally, under the proposed section 3319A, dependents would receive the same rate of payment as otherwise payable to the individual making the transfer. This is different than the rate payable for a dependent child using transferred entitlement under section 3319. Currently, a dependent child is awarded benefits as if the individual making the transfer were not on active duty. As such, a child is entitled to the monthly housing allowance stipend even though the individual transferring benefits is still on active duty. Under the proposed legislation, a child would not be eligible for the housing allowance while the individual described in 38 U.S.C. § 1720G(a)(2) is on active duty. This change would impact the Long-Term Solution for processing Post-9/11 GI Bill claims, as VA would have to make system modifications in order to apply a blended set of rules for claims involving transferred education benefits.

Section 4(a) would amend 37 U.S.C. 439, providing for special compensation for members of the uniformed services with catastrophic injuries or illnesses requiring assistance in everyday living, by amending the definition of covered members to include those Servicemembers who have a serious injury or illness that was incurred or aggravated in the line of duty and are in need of personal care services as a result of such injury or illness. Section 4(b) would further amend section 439 by requiring VA to provide family caregivers of a Servicemember in receipt of monthly special compensation the assistance available to family caregivers of eligible Veterans under 38 U.S.C. § 1720G(a)(3)(A), other than the monthly caregiver stipend. VA would provide assistance under this subsection in accordance with a memorandum of understanding (MOU) between VA and DOD, and an MOU between VA and the Secretary of Homeland Security. VA would be required to ensure that a family caregiver in receipt of assistance under this subsection is able to transition seamlessly to the receipt of assistance under 38 U.S.C. § 1720G. Section 4(c) would require DOD, in collaboration with VA,

to ensure that members of the uniformed services in receipt of monthly special compensation are aware of the eligibility of such members for family caregiver assistance. Section 4(d) would define the term “serious injury or illness,” which would replace the term “catastrophic injury or illness,” to mean an injury, disorder, or illness that (1) renders the afflicted person unable to carry out one or more activities of daily living; (2) renders the afflicted person in need of supervision or protection due to the manifestation by such person of symptoms or residuals of neurological or other impairment or injury; (3) renders the afflicted person in need of regular or extensive instruction or supervision in completing two or more instrumental activities of daily living; or (4) otherwise impairs the afflicted person in such manner as the Secretary of Defense or Homeland Security prescribes.

Regarding section 4 of the bill, VA defers to DOD and the Department of Homeland Security regarding sections 4(a), 4(c), and 4(d). VA does not support section 4(b) because DOD already provides many of the services and supports available under VA’s Program of Comprehensive Assistance for Family Caregivers including health care coverage, mental health services, and respite care. Requiring VA to provide services under its program would result in a duplication of efforts.

Section 5 would authorize the Office of Personnel Management (OPM) to promulgate regulations under which a covered employee, which would include a caregiver defined in 38 U.S.C. § 1720G or a caregiver of an individual receiving compensation under 37 U.S.C. § 439, to use a flexible schedule or compressed schedule or to telework. VA defers to OPM on this section.

Section 6 would amend the Public Health Service Act (42 U.S.C. § 300ii), which governs lifespan respite care, to amend the definition of “adult with a special need” to include a Veteran participating in the family caregiver program under 38 U.S.C. § 1720G(a). It would also amend the definition of “family caregiver” to include family caregivers under 38 U.S.C. § 1720G. Furthermore, in awarding grants or cooperative agreements to eligible state agencies to furnish lifespan respite care, HHS would be required to work in cooperation with the interagency working group on policies relating to caregivers of Veterans established under section 7 of this bill. Section 6 would also authorize appropriations of \$15 million for FYs 2017 through 2022 for these grants. VA defers to HHS on this section.

Section 7 would establish an interagency working group on policies relating to caregivers of Veterans and Servicemembers. The working group would be composed of a chairperson selected by the President, and representatives from VA, DOD, HHS (including the Centers for Medicare & Medicaid Service), and the Department of Labor. The working group would be authorized to consult with other advisors as well. The working group’s duties would include regularly reviewing policies relating to caregivers of Veterans and Servicemembers, coordinating and overseeing the implementation of policies relating to these caregivers, evaluating the effectiveness of such policies, developing standards of care for caregiver and respite services, and others. Not later than December 31, 2017, and annually thereafter, the working group would be required to sub-

mit to Congress a report on policies and services relating to caregivers of Veterans and Servicemembers.

VA generally supports a working group that would provide a forum for analyzing and evaluating different issues that family caregivers of Veterans and Servicemembers face. Such a working group would be ideally suited to considering in depth the types of issues other provisions of this bill are intended to address and would also be able to evaluate emerging issues.

The Department of Justice advises, however, the bill's method for selecting members of the working group raises Appointment Clause concerns, which DOJ will convey in greater detail under separate cover.

We also note several technical concerns with the legislation in terms of the creation of the working group, its role, the potential applicability of the Federal Advisory Committee Act to such a group, and which agency (if any) would be responsible for initiating, managing, and funding the working group. We would be happy to discuss these issues with you upon your request.

Section 8(a) would require VA to conduct a longitudinal study on Servicemembers who began their service after September 11, 2001. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. Within 1 year of the date of the enactment of the Act, VA would be required to submit to the Committees on Veterans' Affairs a plan for the conduct of the study. Not later than October 1, 2021, and not less frequently than once every 4 years thereafter, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of the study. Section 8(b) would require VA to provide for the conduct of a comprehensive study on Veterans who have incurred a serious injury or illness and individuals who are acting as caregivers for Veterans. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. The study would be required to include the health of the Veteran and the impact of the caregiver on the health of the Veteran, the employment status of the Veteran and the impact of the caregiver on that status, the financial status and needs of the Veteran, the use by the Veteran of VA benefits, and any other information VA considers appropriate. No later than 2 years after the date of the enactment of this Act, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of this study.

VA does not support section 8, as it would duplicate research in several ongoing or in-development studies. DOD and VA have a collaboration on the Millennium Cohort Study, a longitudinal cohort study that has and will continue to produce findings on health issues of multiple eras of military service. The Million Veterans Program creates a repository of clinical and genetic information on Veterans, including post-9/11 Veterans, which will provide data for targeted studies on health for years to come. VA's Cooperative Studies Program is developing a study on the respiratory health of Gulf War and post-9/11 Veterans. Finally, a study of the life transitions of military Servicemembers who served in Iraq or Afghanistan is funded and in development.

VA estimates section 8 would cost \$4.3 million in FY 2018, \$17.5 million over 5 years, and \$34 million over 10 years, with additional close out expenses of \$3.3 million in FY 2028 for a total cost of \$37.3 million.

DRAFT—VETERAN PARTNERS’ EFFORTS TO ENHANCE REINTEGRATION
(PEER) ACT

The draft bill would require the Secretary to phase in and conduct a program whereby peer specialists would be included in patient aligned care teams at VAMCs to promote the use and integration of mental health services in a primary care setting. Not later than 180 days after the date of enactment, this program would have to be established at not fewer than 10 VAMCs. By not later than 2 years from the date of enactment, it would have to be in place at not fewer than 25 VAMCs. Under the bill, the Secretary would be directed to consider specified factors when selecting sites for this program, but, not fewer than five would have to be established at VA designated Polytrauma Centers, and not fewer than ten would have to be established at other VAMCs. The draft bill would also require that all peer specialist programs established under this mandate: (1) ensure that the needs of female Veterans are considered and addressed; and (2) include female peer specialists. Finally, this measure would establish initial, periodic, and final Congressional reporting requirements, as detailed in the bill.

VA has no objection to the bill, but notes that it is not necessary because VA already has the authority to execute this program. However, we would require additional funding to implement it. We also note that a few technical changes are needed for clarity. This legislation, if enacted, would complement VA’s ongoing pilot program (commenced in 2014) whereby peer support through peer specialists has been extended beyond traditional mental health sites of care to include Veterans receiving mental health care in primary care settings. Under the pilot program, trained peer specialists work with VA primary care teams to, in general terms, help improve the health and well-being of other Veterans being treated in VA primary care settings. All 25 sites now have assigned one peer specialist to work in Primary Care at least 10 hours per week. The first cohort of eight sites began seeing Veterans in primary care in January 2016, the second cohort of eight began in August 2016, and the final nine sites began April 1, 2017. To date, the peers in this program have provided services to more than 3,000 Veterans. The response from Veterans, peers, and primary care clinicians has been overwhelmingly positive. Sites made a 1- year commitment to participate in the project, and VA will have a formal program evaluation based on clinical and other outcomes in 2018. It is likely that some of the existing sites will not be able to continue the pilot program after FY 2017 without additional funding.

The bill specifies program participation of female peer specialists. I am pleased to report that women peer specialists are already well represented, with 16.2 percent of the national peer specialist workforce being women. While at first glance 16.2 percent may seem a low rate, please bear in mind that this figure is higher than the percentage of Veterans seeking services through VA who are women. We do recognize, however, that the current number of

women Veteran peer specialists in the pilot is unevenly distributed across the country, with some VAMCs having greater difficulty than others in attracting qualified applicants.

Also, it is unclear if the peers will address substance use disorders under the umbrella of their mental health duties. Given the comorbidity of these issues, the need for integration of substance use disorder identification and care, the need for overdose prevention and links as needed to Medication Assisted Treatment for opioid use disorders, and the need to increase the numbers of Veterans achieving long-term recovery, we recommend that this be clarified and, if possible, included.

We estimate this bill would cost \$4.94 million in FY 2018, \$25.99 million over 5 years, and \$55.48 million over 10 years.

DRAFT—SERVING OUR RURAL VETERANS ACT OF 2017

The draft bill would amend 38 U.S.C. §7406(c) to authorize training and supervision of residents at facilities operated by an Indian tribe, a tribal organization, or the Indian Health Service, Federally-qualified health centers, and community health centers. It would also direct VA, in consultation with the Director of the Indian Health Service, to carry out a pilot program to establish graduate medical education residency training programs at such facilities and to affiliate with established programs. VA would be required to carry out the pilot program at not more than four covered facilities and would carry out the pilot program for a period of 8 years beginning on the date that is 180 days after the date of enactment. VA would be required to reimburse certain costs associated with the program and to enter into agreements with individuals participating in the pilot program under which they would agree to serve a period of 1 year at a covered facility (including a VA facility) service for each year in which the individual participates in the pilot program. The bill would provide terms related to breach of the agreement, loan repayment, and concurrent service. VA would be required to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate not later than 3 years before the termination of the pilot program on the feasibility and advisability of expanding the pilot program to additional locations and making the pilot program or any part of it permanent. The draft bill would authorize to be appropriated to VA \$20 million per year to carry out the pilot program and would also authorize appropriations for the Secretary of HHS, acting through the Director of the Indian Health Service, and to VA such sums as may be necessary to cover loan repayments under each agency's respective loan repayment programs.

VA supports the draft bill in principle. VA strongly supports the imperative to build Graduate Medical Education capacity in rural and underserved areas with the strategic intent to address a geographically inequitable distribution of the Nation's physician and clinical workforce.

While we appreciate the purpose of this bill, it is likely that a relatively small proportion of the patients seen by residents in such programs would be Veterans, yet VA would incur much of the burden for program initiation and maintenance including resident sal-

aries, faculty time and development, curriculum development, and recruitment efforts.

Under the draft bill, a medical resident who participates in the pilot program would be eligible for participation in the Indian Health Service Loan Repayment Program under section 108 of the Indian Health Care Improvement Act (section 1616a of title 25, U. S. C.) and the VA Education Debt Reduction Program. The draft bill also would include a period of obligated service (1 year of service at VA for each year of participation in the program). VA supports such a loan repayment and obligated service scheme, but recommends requiring 2 years of service for each year of program participation. Moreover, because residents typically receive a salary and are not obligated, post-residency, to perform services as a result of participating in a residency program, VA requests the authority to concurrently provide educational loan repayment to residents in the program(s) as a tool to recruit highly qualified residents.

VA fundamentally believes that supporting the practice of rural health care in the United States is crucial to fulfilling its mission to provide the highest quality care for Veterans and that we must include within our broad health professions education portfolio a focus on rural health in order to meet our statutory mission to provide medical education for VA and for the Nation. VA endorses educating all physicians regarding the unique health needs of Veterans and providing clinical training opportunities in rural health care delivery systems.

VA estimates the cost of implementation at four sites would be \$20.3 million in FY 2018, \$90.6 million over 5 years, and \$201.8 million over 10 years.

Mr. Chairman and Members of the Committee, this concludes my statement. I would be happy to answer any questions you may have.

STATEMENT OF BALIGH R. YEHIA, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR COMMUNITY CARE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Good morning, Chairman Isakson, Ranking Member Tester, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect the Department of Veterans Affairs' (VA or Department) programs and services. Joining me today is Dr. Tom Lynch, Assistant Deputy Under Secretary for Health Clinical Operations, Veterans Health Administration (VHA); Brad Flohr, Senior Advisor for Compensation Services, Veterans Benefits Administration; and Carin Otero, Assistant Deputy Assistant Secretary for Human Resources Policy and Planning, Human Resources and Administration.

This written statement includes VA's views on eleven significant bills on important topics. Because of the timing of receipt of two of the bills, we are not able to provide formal views in this statement on S. 1279, the Veterans Health Administration Reform Act of 2017 or the draft bill, "The Department of Veterans Affairs Quality Employment Act of 2017." We also will follow up with the Com-

mittee on one section (section 10) of the Veterans Choice Act of 2017. We look forward to providing views at a later time and discussing these bills with you today.

S. 115—VETERANS TRANSPLANT COVERAGE ACT

S. 115 would add section 1788 to Title 38, authorizing the Secretary of Veterans Affairs (Secretary) to provide for an operation on a live donor to carry out a transplant procedure for an eligible Veteran, notwithstanding that the live donor may not be eligible for VA health care. VA would be required to provide to a live donor any care or services before and after conducting the transplant procedure that may be required in connection with the transplant.

VA supports S. 115, contingent on the provision of additional resources to support implementation, although we recommend some clarifications in the bill language. We believe it would be appropriate to limit the duty and responsibility to furnish follow-on care and treatment of a living donor to 2 years after the procedure is performed by a VA facility. This would be consistent with the recommendations of the United Network for Organ Sharing and the Organ Procurement and Transplant Network. We further recommend that the duty to provide follow-on care and treatment should be limited to that which is “directly related to” the living donor procedure (rather than what “may be required in connection with such procedure,” as the bill would provide).

There are other potential issues related to organ transplantation that the bill does not address that we would be pleased to discuss with the Committee in its contemplation of this proposal.

We estimate the bill as written would cost \$1.8 million in Fiscal Year (FY) 2018, \$9.7 million over 5 years, and \$21.5 million over 10 years.

S. 1153—VETERANS ACQUIRING COMMUNITY CARE EXPECT SAFE SERVICES (ACCESS) ACT OF 2017

S. 1153 would require the Secretary of Veterans Affairs to deny or revoke eligibility of certain health care providers to provide non-VA health care services to Veterans. The bill would, in general, require that the Secretary deny or revoke the eligibility of a health care provider to provide non-Department health care services if the Secretary determines that: (1) the provider was removed from employment at VA due to conduct that violated a policy relating to the safe and appropriate delivery of health care; (2) the provider violated the requirements of a medical license; (3) the provider had a Department credential revoked that would impact that provider’s ability to provide safe and appropriate health care; or, (4) the provider violated a law for which a term of imprisonment of more than 1 year may be imposed. The bill would permit, but not require, the denial, revocation, or suspension of the eligibility of a health care provider to furnish non-Department health care when the Secretary has a reasonable belief that such action is necessary to immediately protect the health, safety, or welfare of Veterans and: (1) the provider is under investigation by the medical licensing board of a State in which the provider is licensed or practices; (2) the provider has entered into a settlement agreement for a disciplinary charge related to the practice of medicine; or, (3) the Secretary oth-

erwise determines that such action is appropriate under the circumstances. The bill would require that the Secretary suspend the eligibility of a health care provider to provide non-Department care if that provider is suspended from serving as a health care provider of the Department. The bill also would require that the Secretary review, within 1 year of enactment, each non-Department health care provider to identify whether he or she was an employee of the Department to determine if the provider meets any of the criteria for denial, revocation, or suspension of eligibility. Finally, the bill would require the Comptroller General to submit a report to Congress within 2 years of enactment on the implementation of these authorities and its effects.

VA supports the proposed legislation in principle and would appreciate the opportunity to work with Congress to develop a proposal that builds upon similar requirements already in place without creating the unnecessary administrative burdens we believe the bill would produce, as these burdens could negatively impact Veterans' access to quality care. Currently, VA procures most community care using Third Party Administrators (TPA), under Patient Centered Community Care (PC3)/Choice contracts, which include the development and maintenance of an adequate provider network of high quality, credentialed/certified health care providers. VA monitors adherence by performing quality checks through the use of a Quality Assurance Plan (QASP). As part of the QASP, VA utilizes a "three lines of defense" model to oversee the credentialing and certification process of network health care providers. These lines of defense involve both VA and the TPA performing ongoing reviews to ensure the quality of the providers in the network. Additionally, VA requires the contractor to report to VA, not more than 15 days after being notified, of the loss of or other adverse impact to a network provider's certification, credentialing, privileging, or licensing. Future acquisitions will carry similar criteria as they pertain to review of provider licensure and credentialing, as VA remains committed to developing contracts for high performing networks.

Because of the measures already in place to ensure that VA only utilizes the highest quality providers in the community, VA is concerned that the administrative requirements of this legislation as written would have the potential to adversely impact Veteran access to community care as well as limit current and future contractors' ability to timely recruit and retain qualified providers within their networks.

VA also has concerns relating to due process protections under the bill. To the extent VA relies on any fact that had not been established through a complete and fair process satisfying the requirements of due process (e.g., a criminal conviction, or a full investigation and determination by a State licensing board), the Agency's decision should be appealable. VA does not have an existing process that could accommodate such appeals. Affected providers must be given notice and an opportunity to be heard to contest such determinations or beliefs in order to satisfy due process requirements, but it is unclear how VA would provide for this.

VA is unable to provide a cost estimate for this proposal as currently written because it is unclear what additional administrative

requirements would be needed to ensure appropriate review and protections are in place.

S. 1325—BETTER WORKFORCE FOR VETERANS ACT OF 2017

The draft bill, “Better Workforce for Veterans Act of 2017,” contains a number of provisions intended to improve the authorities of the Secretary to hire, recruit, and train employees of the Department.

Section 101(a) would create a new section 718 that would authorize the Secretary to recruit and appoint qualified recent graduates and post-secondary students to competitive service positions within the Department, notwithstanding certain provisions of Title 5. The Secretary would only be authorized to appoint no more than a number equal to 15 percent of the number of hires made into professional and administrative occupations at the GS–11 level or below (or equivalent) during the previous fiscal year. The Secretary would be required to develop regulations governing this authority. To the extent practicable, the Secretary would be required to publicly advertise positions available under this section within certain constraints.

VA supports the concept of this provision, but also would like to note that the Administration authored a similar proposal that would be applicable to all agencies, and transmitted it for consideration in the FY 2018 National Defense Authorization Act (FY 2018 NDAA). This would provide greater flexibility to hire students and recent college graduates, providing an immediate opportunity for new employees to begin their careers with VA. The Administration would prefer a Government-wide solution that would provide a significant recruitment benefit if all agencies were able to utilize it.

Section 101(b) would create a new section 719 that would require the Secretary to prescribe regulations to allow for excepted service appointments of certain students and recent graduates leading to conversion to career or career conditional employment.

VA defers to OPM on implementation of this provision as an important element to implementing the program authorized by section 101(a) for certain students and interns. OPM would be best suited to provide any necessary technical drafting assistance to align these authorities with OPM’s current Government-wide Pathways Program.

Section 102 would amend section 3304(a)(3)(B) of Title 5 to permit the Secretary to appoint directly for positions for which there is a severe shortage of highly qualified candidates. OPM would have the authority to determine what positions would qualify, as well as having the ability to delegate the authority to make those determinations.

VA supports this provision as this would provide greater flexibility to directly reach applicants when we have a severe shortage of highly qualified candidates. This would help the Department address some of its most critical vacancies.

Section 103 would create a new section 712 to authorize the Secretary to appoint a former Federal employee to a high-demand position within the Department for which the former Federal employee is highly qualified without regard to provisions concerning competitive appointments. The former Federal employee could be

appointed to a position at a higher grade or with more promotion potential than the position the employee previously held. Within 18 months of enactment, the Inspector General of the Department would be required to conduct an audit of the use of this authority by the Secretary and report to Congress on the results of that audit.

VA defers to OPM on this provision. Currently, we could hire someone non-competitively to a position at the same level they previously held, while this provision would allow VA to hire someone to a higher level than they previously held. Therefore, implementation would need to be measured, with appropriate controls in place to prevent misuse.

Section 104 would create a new section 720 to require the Secretary to develop and implement a resume-based application method for applications for appointment to senior executive positions within VA. The application would have to be, to the extent practicable, comparable to the resume-based application method for the Senior Executive Service (SES) developed by the Office of Personnel Management (OPM), and would have to be used for initial applications for a position as a senior executive to the extent such use will be more efficient and effective and less burdensome for all participants. The Secretary would be authorized to make an initial career appointment of an individual to a position as a senior executive if a review board convened by VA certifies the executive and managerial qualifications of the individual.

At this time, VA does not support this provision because we do not believe it is necessary. Resume-based application is allowed under current rules, and VA would like to maintain flexibility in hiring and assessment. VA currently uses a resume-based system for executive recruitment for its medical center Director positions, and with the recently enacted Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 (Public Law 115-41), signed June 23, 2017, VA now has direct hiring authority for these and VISN Director positions. We continuously evaluate our hiring methods, timeframes, and outcomes to identify opportunities for improvement, and we would be happy to share our findings with the Committee.

Section 105 would establish a new section 721 that would require the Secretary to establish and periodically review a single database that lists each vacant position in VA that the Secretary determines is critical to VA's mission, difficult to fill, or both. If the Secretary determines that an applicant for a position listed in the database is qualified for such position, but the Secretary does not select such applicant, the Secretary, at the election of the applicant, would be required to consider the applicant for other, similar vacant positions listed in the database. If the Secretary did not fill a vacant position listed in the database after an appropriate time (as determined by the Secretary), the Secretary would be required to ensure that applicants who were not selected for other positions but who meet the qualification requirements are considered. The Secretary would also be required to use the database to assist in filling such positions. Within 1 year of enactment, the Secretary would be required to submit a report to Congress on the use and efficacy of the database established under this section.

We support the concept of identifying and maintaining a database of vacancies, but do not support this particular provision. VA completed the implementation of a commercial software product as the core foundation to our new enterprise automated human resources system. We will implement an enhancement in FY 2018 to manage positions, which will provide real-time vacancy information. With the systems we currently have in place and in development, we believe we can meet the intent of this provision without legislation, and in a way that is less administratively burdensome.

Section 106 would create a new section 722 that would require the Secretary to measure and collect information on indicators of hiring effectiveness concerning certain identified factors related to recruiting and hiring candidates, as well as the satisfaction of employees, newly hired employees, and applicants. To the extent practicable, and in a manner protecting personally identifiable information, the Secretary would be required to collect and report data disaggregated by facility and VISN to ensure the data is collected from human resources offices throughout VA. The Secretary would be required to submit an annual report to Congress on the information collected, and to make such information publicly available.

As written, we do not support this provision. We are concerned the vagueness of the language could result in application to virtually every aspect of the recruitment process. The terminology in this provision includes subjective terms, and we believe some provisions may be inconsistent internally. In addition, these provisions could be inconsistent with other agencies' recruitment and hiring information. We have a number of technical comments and recommendations and would be glad to share those with the Committee. We also would request that the Committee solicit OPM for technical drafting assistance on this provision.

Section 107 would create a new section 723 requiring the Secretary to develop and carry out a standardized, anonymous, voluntary exit survey for career and non-career employees who voluntarily separate from VA. The survey would have to ask questions regarding the reasons for leaving, any efforts made to retain the individual, the extent of job satisfaction and engagement, the intent of the employee to remain in or leave Federal employment, and other matters considered appropriate by the Secretary. The Secretary would be required to share the results of the survey with the directors and managers VA facilities and VISNs, and the Secretary would be required to report annually on the aggregate results of the exit survey.

We do not support this provision because we believe it is unnecessary, given that we already use exit surveys that capture almost all of the content this legislation would require.

Section 108 would amend section 2108(1) of Title 5 concerning Veteran preference so that any Veteran who served a total of more than 180 days would qualify, rather than only those who served more than 180 consecutive days.

We note that this provision would amend title 5 and apply to the entire Federal government. As a result, we defer to OPM on this provision.

Section 109 would amend section 705(a) of the Veterans Access, Choice, and Accountability Act of 2014 to clarify that recruitment,

relocation, or retention incentives are not subject to the limitations on awards and bonuses available in the Department.

VA supports this provision. Currently, the limitations on awards and bonuses include recruitment, retention, and relocation incentives, which have severely limited the Department's ability to offer incentives to hire and retain critical positions. Under these limitations, the Department has attempted to reserve the bulk of the funds that are available to provide incentives to positions, particularly medical professionals with specialized skills and expertise that would be difficult or impossible to replace. This has resulted in an inequitable treatment among employees, as there are fewer resources available for those otherwise deserving and equally dedicated employees.

If this authority were enacted, VA would reallocate funds already appropriated for recruitment and retention of highly qualified employees.

Section 110 would amend section 7309 of Title 38 to remove the requirements that the Chief Officer of VA's Readjustment Counseling Service (RCS) must have at least 3 years of experience providing direct counseling services or outreach services through RCS, as well as 3 years of experience administering direct counseling services or outreach services through RCS.

VA supports this provision. This would provide greater flexibility to appoint the Chief Officer of RCS, which oversees VA's Vet Centers, a critical component to providing Veterans and Servicemembers readjustment counseling and other services.

There would be no costs associated with this provision.

Section 111 would require, within 120 days of the date of the enactment of this Act, the Secretary to submit a report to Congress on vacancies within the Veterans Health Administration. This report would have to include vacancies of personnel appointed under section 7401 of title 38, vacancies of human resource specialists in VHA, a description of any impediments to filling certain vacancies, and an update on the implementation of several plans and reports.

We do not believe section 111 is necessary, but we do not oppose this requirement. Until the system enhancement previously mentioned is implemented in FY 2018, collecting this information is a manual and intensive effort. As a result, we are concerned that the 120 day deadline would be difficult to meet. We believe that we would be in a better position to gather this information within the next year.

Section 201 would create a new section 724 providing that for any reduction in force by VA, competing employees would be released with due effect to the following in order of priority: tenure of employment, military preference, efficiency or performance ratings, and length of service.

We do not oppose section 201 because this would only change the order of consideration for how reductions in force would occur. However, we would defer to OPM, to ensure that reduction in force procedures remain consistent across the Government. We note that for hybrid title 38 positions, we think it would be appropriate to also consider the level and type of licensure, as well as the scope of practice, in making such determinations.

Section 202 would create a new section 725 authorizing the Secretary to arrange, with the agreement of a private-sector organization, for the temporary assignment of VA employees to such organization to occupy a position in that organization and for the private sector employee who held that position to temporarily occupy the position of the VA employee. In essence, these employees would be trading positions for a temporary period. The VA employee would return to work for the Department, and if either employee failed to carry out the agreement, the employee would be liable to the United States for payment of all expenses of the assignment, with certain exceptions; such liability would be a debt that could be waived if the Secretary determined collecting it would be against equity and good conscience and not in the best interests of the United States. The VA employee would be prohibited from using pre-decisional, draft deliberative, or other information for the benefit or advantage of the private sector organization. Assignments would be for periods between 3 months and 4 years. VA employees assigned to the private sector organization would be considered, during the period of assignment to be on detail to a regular work assignment in the Department for all purposes. The private sector employee assigned to VA employment would generally not be considered a Federal employee with certain exceptions and would have other constraints imposed upon the scope of that employee's work with the Department. The private sector organization would be prohibited from charging VA, as direct or indirect costs under a Federal contract, for the pay or benefits paid by the organization to the employee assigned to VA. The Secretary would be required to take into account certain considerations in operating this program.

In theory, VA supports the concept of rotational assignments for professional development, and notes that the Administration submitted, in the context of the FY 2018 NDAA, a similar proposal to provide government-wide authority for industry exchange programs. We note, however, that the potential for conflicts of interest in this provision are significant, notwithstanding the language in the bill attempting to limit this. There are several areas where this provision is ambiguous, and we would appreciate the opportunity to discuss this further with the Committee prior to taking a position on this section. We would recommend that the Committee work with the Office of Government Ethics on the appropriate language to address issues related to conflicts of interest.

Section 203 would amend section 7306 to allow for the appointment of VISN Directors in addition to medical center Directors to suit the needs of the Department. It would also remove the requirement for these Directors to be qualified doctors of medicine, or doctors or dental surgery or dental medicine. It would further amend that section to allow the Secretary to establish qualifications for these Directors and appoint them under this authority. The Secretary and the Director would be required to enter into an agreement that permits employees appointed under this authority to transfer to SES positions in other Federal agencies and to be deemed career appointees who are not subject to competition or certification by a qualifications review board.

Section 207 of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 (Public Law 115-41),

signed June 23, 2017, significantly amended VA's authority to hire directly VISN and medical center Directors. In this context, we would like the opportunity to discuss this proposal further with OPM and the Committee to consider the effects of these proposed changes before taking a position on this section.

Section 204 would create a new subchapter VII in chapter 74 concerning pay for medical center Directors and VISN Directors. The new section 7481 would provide that pay for these Directors would consist of basic pay and market pay, which would be determined by the Secretary on a case-by-case basis and consist of pay intended to reflect the needs of the Department with respect to recruitment and retention of such Directors. The bill would impose other requirements in terms of determining market pay under this section. The Secretary would be required, not less frequently than once every 2 years, to set forth within defined parameters Department-wide minimum and maximum amounts for total pay for Directors, and to publish such limits in the Federal Register. Pay under this section would be considered pay for all purposes, including retirement benefits. A decrease in the pay of a Director resulting from an adjustment in market pay could not be considered an adverse action, while a decrease resulting from an involuntary reassignment in connection with a disciplinary action would not be subject to appeal or judicial review. The OPM Director would be required to undertake periodic reviews of the Secretary's determinations and certify to Congress each year whether or not the market pay is in accordance with the requirements of this section. If the Director determined the amounts were not in accordance with the requirements of this section, the Director would report to Congress on such determination as soon as practicable after making such determination.

We appreciate the Committee's interest in this regard. Similar to section 203, we note that given the recent change (Public Law 115-41) in our appointment authority for VISN and medical center Directors, we would like to discuss this proposal further with OPM and the Committee prior to taking a position on the specific provisions in this section. We anticipate there would be additional costs to implement this section.

Section 205 would create a new section 7413 that would require the Secretary to provide to VHA human resources professionals training on how best to recruit and retain VHA employees. The Secretary would provide such training in a manner considered appropriate considering budget, travel, and other constraints. The Secretary would be required to ensure that each VHA human resources professional received such training as soon as practicable after being hired and annually thereafter. The Secretary would be required to ensure that a medical center Director, VISN Director, or senior officer at Central Office certified that the professional completed such training. The Secretary would be required to report annually on the training provided under this authority, including the cost of such training, and the number of professionals who receive such training.

We do not support section 205 because VA already has the authority to conduct such training. VA provides training to human resources professionals currently, and we are concerned that the spe-

cific requirements in this provision could constrain our ability to adapt training to emerging needs. We also have some technical concerns with this provision that we will share with the Committee.

Section 206 would require the Secretary to include education and training of marriage and family therapists and licensed professional mental health counselors in carrying out the education and training programs conducted under section 7302(a)(1). The Secretary would be required, to the degree practicable, to ensure that the licensing and credentialing standards for therapists and counselors participating in this program are the same as the licensing and credentialing standards for eligibility of other participants in the program. Finally, the Secretary would be required to apportion funding for education and training equally among the professions included in the program.

In general, we currently have the authority to carry out this section. VA has already established training programs for licensed professional mental health counselors and marriage and family therapists. We are concerned with the potential effect this could have on the quality of the education and training standards, and we would appreciate the opportunity to discuss this further with the Committee. We are also concerned that the language, particularly in subsection (c) of this provision, is too prescriptive and could limit VA's flexibility to adjust training needs and resources to meet operational needs.

Section 207 would require, within 180 days of the date of enactment of this Act, the Secretary and the Surgeon General to enter into a memorandum of understanding (MOU) for the assignment of not fewer than 500 commissioned officers of the Regular Corps of the Public Health Service to VA. The Secretary would reimburse the Surgeon General for expenses incurred in assigning commissioned officers to VA. Within 1 year of enactment, the Secretary and Surgeon General would each be required to submit to Congress a report on the MOU and the commissioned officers assigned under this authority.

We do not support this provision because it is unnecessary. VA and the Department of Health and Human Services (HHS) signed an MOU earlier this year to allow for commissioned officers of the Public Health Service to serve in VA. We would like the opportunity to discuss this further with the Committee and HHS to determine what, if any, legislative authority we need in this area.

Section 208(a) and (b) would require, within 1 year of the date of enactment of this Act, the Under Secretary for Health to develop a comprehensive competency assessment tool for VHA human resources employees to assess the knowledge of such employees on how employees appointed under section 7401(1) are treated differently than employees appointed under other authorities. Within 2 years of the date of enactment of this Act, and once every 2 years thereafter, the Secretary would have to submit a certification to Congress as to whether an assessment of all VHA human resources employees was conducted and whether such employees used the results of such assessment to identify and address competency gaps. Within 18 months of the date of enactment of this Act, the Under Secretary for Health would be required to evaluate the extent to

which these training strategies are effective at improving the skills and competencies of VHA human resources employees.

Section 208(c) would require, within 1 year of enactment, the Under Secretary for Health to establish clear lines of authority that provide the Assistant Deputy Under Secretary for Health for Workforce Services the ability to oversee and hold the heads of the human resources offices of VA medical centers accountable for implementing initiatives to improve human resources processes and for ensuring employees undertake the assessment required under subsection (a). Within 1 year of enactment of this Act, the Secretary would be required to clarify the lines of authority and processes for the Under Secretary for Health and the Assistant Secretary for Human Resources and Administration with respect to overseeing holding the VISN and VA medical center Directors accountable for the consistent application of Federal classification policies.

Section 208(d) would require the Secretary to ensure the Under Secretary for Health and the Assistant Secretary for Human Resources and Administration are responsible for monitoring the status of corrective actions taken at human resources offices of VA medical centers and that such actions are implemented.

Section 208(e) would require the Secretary to ensure that meaningful distinctions are made in performance ratings for VHA employees.

Section 208(f) would require, within 1 year of enactment of this Act, the Under Secretary for Health and the Assistant Secretary for Human Resources and Administration to develop a plan to implement a modern information technology (IT) system to support employee performance management processes.

Section 208(g) would require, within 1 year of enactment of this Act, the Under Secretary for Health to establish clear lines of authority and accountability for developing, implementing, and monitoring strategies for improving employee engagement across VHA. The Under Secretary for Health would be required to report to Congress on whether VHA should establish an employee engagement office at the headquarters level with appropriate oversight of VISN and VA medical center employee engagement initiatives.

We do not believe this section is necessary. We are currently implementing the requirements of these provisions based on the recommendation of a Government Accountability Office (GAO) report (GAO 17-30). We also have some technical concerns we believe need to be addressed, and we will be glad to provide those to the Committee.

Section 208(h) would require, within 1 year of enactment, the Comptroller General to examine the overlapping functions of human resource structures within VHA and the Office of the Assistant Secretary of Human Resources, whether there are opportunities to centralize offices and tasks that are duplicative, and whether the use of multiple hiring structures has had an effect on the speed with which VA hires new employees. The Comptroller General would report to Congress on the Comptroller General's findings.

VA defers to the Comptroller General on this provision.

Section 209 would require, within 120 days of enactment of this Act, the Secretary to report to Congress on the effect the freeze on the hiring of Federal civilian employees ordered by the President on January 23, 2017, has had on the ability of VA to provide care and services to Veterans.

We do not believe this is necessary, and do not support it, as the hiring freeze was only in effect, at most, for a limited number of positions not related to patient care or access. We also do not believe it would be possible to identify to any meaningful degree any effects that may have occurred as a result of the hiring freeze.

Section 210 would require, within 180 days of enactment of this Act, the Secretary to report to Congress on how the Secretary plans to implement the portions of the plan of the OPM Director to reduce the size of the Federal workforce through attrition as it pertains to VA.

We believe this provision is unnecessary. VA is working to implement an agency reform plan, consistent with the OMB Director's requirements. We are looking at how we will be filling administrative positions that become vacant, along with other potential actions, and will be updating these plans and assessments in the future. We would be happy to share with the Committee the plan the Department submits to OMB when it is available.

Section 211 would require, within 180 days of enactment of this Act, the Secretary to publish online information on staffing levels for nurses at each VA medical facility. The head of each medical facility would be required to update the information as changes to the staffing level of nurses at the facility occur. The Secretary would be required to consult with Centers for Medicare & Medicaid Services in developing the information required by this section. The Secretary would be required to submit a report to Congress discussing and assessing the use by medical center Directors of authorities to provide nurses pay that reflects market conditions, the adequacy of training resources for nurse recruiters, the key recruitment and retention incentives of VHA for nurses, and other factors.

We do not support this provision for two major reasons. First, the staffing levels referenced in the bill are not defined. Second, the actual number of nurses varies on an almost daily basis given the volatility in terms of staffing. It would be incredibly cumbersome to maintain this information and update it in real time. We already report to Congress each year on efforts to provide nurses greater pay, and this report would be duplicative of that effort.

Section 212 would require, within 1 year of enactment of this Act, the Secretary, in consultation with the OPM Director, to ensure that the job description, position classification, and grade for each position as a police officer or firefighter in VA are in accordance with standards for the classification of such positions prepared by OPM. The Secretary would be required to develop a staffing model for the positions of police officers and firefighters within the Department. The VA Inspector General would be required to conduct an audit of VA's efforts to recruit and retain police officers and firefighters and report to the Secretary and Congress on the audit's findings. Finally, the Secretary would be required to report to Congress on the use by medical center Directors of special pay incentives to recruit and retain trained and qualified police officers

and the steps the Secretary plans to take to address the critical shortage of police officers throughout the Department.

We have some concerns with this provision. We believe the reviews required by this section could require a considerable amount of resources. We would like the opportunity to discuss this proposal further with the Committee and OPM to determine what we may be able to do currently to address the Committee's concerns and interests in this matter.

Section 213 would require, within 1 year of enactment of this Act, the VA Inspector General to complete a study on how VHA communicates its directives, policies, and handbooks to the field, including the compliance with such documents, and the effectiveness of each VISN in disseminating information to employees within the Network and Veterans served by the Network.

The Department defers to the Inspector General on this provision.

As noted above, VA will be providing follow-up views for the record on S. 1279, the Veterans Health Administration Reform Act, the draft Department of Veterans Affairs Quality Employment Act of 2017, and section 10 of the Veterans Choice Act of 2017.

S. XXXX—VETERANS CHOICE ACT OF 2017

The draft Veterans Choice Act of 2017 contains a number of provisions intended to improve VA's community care program. Community care has helped significantly expand access to care for Veterans nationally and plays an important role in VA's effort to build a modern, integrated health care network.

Section 3(a) of the bill would amend section 1703 of title 38 to authorize the Veterans Choice Program. Under this Program, all enrolled Veterans would be eligible to elect to receive hospital care, medical services, mental health services, and certain diagnostic services, outpatient dental services, and diagnostic services from specified eligible providers. These services could be provided through telemedicine, at the election of the Veteran. The Secretary would be required to enter into consolidated, competitively bid regional contracts with health care organizations or third party administrators to establish networks of eligible providers for the purpose of providing sufficient access to care and services. The bill would define various responsibilities for these organizations or administrators, including enrolling covered Veterans, conducting referrals and authorizations, customer service, and maintaining an interoperable electronic health record. These parties would be required to leverage advanced technology to allow Veterans to make their own appointments, including online and through smart phone applications. Veterans who need assistance making their appointments could receive assistance from the organization or administrator or the Secretary. The organizations or administrators would be required to meet capability, capacity, and access standards established by the Secretary, including those established pursuant to sections 9 and 10 of this bill. Providers who currently furnish care or services under another authority would be offered the opportunity to furnish care and services through this Program.

Under the Veterans Choice Program, the rates paid for care or services could not exceed the Medicare rate, except in highly rural

areas, in the State of Alaska, in a State with an All-Payer Model Agreement that became effective on January 1, 2014, or at other rates established by the Secretary if no Medicare rate exists. The Secretary would be authorized to recover from a third party for any care furnished for a non-service-connected disability, and the Secretary would be responsible for paying the copayment, deductible, or coinsurance charged to the Veteran for care or services. Veterans could not be required to pay a greater amount for receiving care or services than they would if they had received comparable care or services at a VA medical facility or from a VA medical provider.

The proposed amendments to section 1703 would impose other requirements. For example, VA would have to ensure the Veterans Health Identification Card issued to every enrolled Veteran includes the words “Choice eligible” and additional information needed to serve as an identification card for the Program. Additionally, the Secretary would be required to monitor a number of quality and access standards related to the care furnished under this Program. These changes would become effective upon the termination of the current Veterans Choice Program operated pursuant to section 101 of the Veterans Access, Choice, and Accountability Act of 2014.

We support many of the principles in the proposed section 1703. We appreciate that the section’s eligibility criteria would be simple to administer by making every enrolled Veteran eligible to participate. We also appreciate the flexibility in terms of eligible providers, and the regional network model generally matches our current plans with the Community Care Network solicitation. We also appreciate the section’s recognition of the importance of ensuring quality care is furnished to Veterans through this Program.

However, we have some significant concerns with certain provisions of proposed section 1703. In many areas, there are provisions that are overly prescriptive and that would narrow the Secretary’s authority to adjust to evolving situations. For example, the Secretary would be prohibited from directing Veterans to certain health care providers. While we support Veterans’ choosing their own providers, we understand that many Veterans do not express a specific preference for an individual provider, and this language could restrict our ability to direct Veterans to high-performing providers who are available. Also, the responsibilities of the regional networks are too specific—we would prefer the language be silent on these matters so that we can adjust responsibilities between VA and our regional networks to ensure the best services are available for Veterans. Furthermore, the language concerning payment rates is too limiting. There will be situations where VA will need to pay more than the Medicare rate other than in highly rural areas, the State of Alaska, and States with All-Payer Model Agreements. We have serious concerns with the language in proposed 1703(h), which would require the Secretary to pay the amount of a Veteran’s copayment, deductible, or coinsurance. This would be inconsistent with private sector and VA’s current practice. Section 1729 currently provides that Veterans are not required to pay a copayment, deductible, or coinsurance required under the terms of their health insurance for care and services furnished by the Depart-

ment. Moreover, requiring the Department to pay a Veteran's copayment, deductible, or coinsurance could significantly increase the Department's expenses, including its administrative costs, in ways that we cannot currently project given the variability in insurance plans and payment responsibilities for the millions of Veterans with such insurance. While we support the principle of ensuring quality care, we are concerned that some of the language in proposed 1703(l) would be too prescriptive, and we would prefer more general language.

Requiring that the words "Choice eligible" appear on a Veterans Health Identification Card (VHIC), as provided for in proposed section 1703(k), would create redundancy and be extremely costly. The bill would make any enrolled Veteran eligible for Choice, and all enrolled Veterans are issued VHICs, so any person with a VHIC would already establish his or her eligibility by virtue of having the VHIC. Requiring Veterans to have a VHIC with the words "Choice eligible" would also produce greater demands on Veterans who would have to come to a VA facility to receive an updated version of their VHIC.

Finally, we are concerned that there is no transition period contemplated by section 3(a)(3). The new 1703 would take effect immediately upon the expiration of the current Veterans Choice Program, based on the exhaustion of the Veterans Choice Fund. We believe that either a clear timeline (such as 1 year from enactment) or an event within the Department's control (such as the publication of regulations) would be preferable for the transition between the current Choice Program and the future Choice Program. We also may encounter problems where individual authorizations made under the current 1703 would no longer have any legal authority for payment upon this transition, as this provision would completely rewrite section 1703. While the Department would try to reduce the potential for this issue, we would not be able to eliminate this problem.

Section 3(b) would prohibit VA from entering into or renewing any contract or agreement under a non-Department provider program, which would include the current Veterans Choice Program; the Patient-Centered Community Care (PC3) program; the Project Access Received Closer to Home (ARCH) program; VA's retail pharmacy network; agreements entered into with DOD, IHS, or other Federal agencies; agreements entered into with academic affiliates of VA; agreements to furnish care, including on a fee basis; or agreements with non-governmental entities. If the Secretary continued to administer any of these programs after the date on which the new Veterans Choice Program begins, they could only be administered under that Program. The Secretary would be required to ensure continuity of care by making services available through regional contracts or other agreements entered into under the new Veterans Choice Program.

We are very concerned with this provision and do not support it. It would require VA to renegotiate, reissue, or terminate every agreement and contract, regardless of the terms or conditions of such an agreement permitting extensions or other flexible authorities. We believe this could affect such agreements as those with DOD, IHS, and tribal health programs, as well as with our aca-

demographic affiliates and contractors. This would include thousands of agreements, would be very difficult and costly to do, and would not produce any clear, tangible benefit. If these agreements would also now be subject to the limitations in proposed section 1703, this provision could put conditions on these agreements that would be unacceptable to certain providers or in certain areas. This could also potentially impact our relationships with certain providers, such as IHS and tribal health programs, which require consultation prior to changes. We also note, given the breadth of section 3(b)(4)(E), that extended care services procured from the community would be included, but note that the language for the Veterans Choice Program in section 1703 does not address such services; as a result, it is unclear what terms and conditions would apply to these services.

Section 4 would establish a new section 1703A authorizing VA to enter into Veterans Care Agreements (VCA). VCAs could be entered into when the Secretary is not feasibly able to furnish hospital care, medical services, or extended care services at VA facilities or when such care or services are not available under the Veterans Choice Program. Providers could opt to enter into a VCA, at the discretion of the eligible provider. The eligibility of Veterans for care would be the same as if they received care in a VA facility. The Secretary would be prohibited from directing Veterans seeking care or services to health care providers who have entered into contracts or sharing agreements under different authorities, except for Veterans Choice Agreements authorized under section 101 of the Veterans Access, Choice, and Accountability Act of 2014 or under the regional contracts or other arrangements made under section 1703, as revised by section 3 of this bill.

The Secretary would be required to establish a process for the certification of eligible providers. VCAs would have to include certain terms, including accepting payment at Medicare rates (except in highly rural or underserved areas), accepting payment as payment in full, and other terms and conditions. Each VCA would permit the provider to submit to the Secretary clinical justification for any services furnished without authorization when seeking payment, and the Secretary would review these submissions on a case-by-case basis in determining whether or to pay the provider for such services. The Secretary would be required to review periodically VCAs of a material size to determine whether it is feasible and advisable to furnish the care and services at a VA facility or through contracts or sharing agreements. VCAs would not be subject to laws requiring competitive procedures in selecting the party with which to enter the agreement. Parties entering into a VCA would not be treated as a Federal contractor by the Office of Federal Contract Compliance Programs (OFCCP) of the Department of Labor, and they would not be subject to any laws that such a provider would not be subject to under the original Medicare fee-for-service program under Parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), except for laws applying to integrity, ethics, fraud, or that subject a person to civil or criminal penalties. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000c et seq.) would apply to parties entering into a VCA. The Secretary would be required to establish a system or systems, consistent with

those used by the Centers for Medicare and Medicaid Services, to monitor the quality of care provided and would be required to establish administrative procedures for dispute resolution. The Secretary would be required to prescribe an interim final rule within 1 year of enactment to carry out this section.

We generally support this provision, but have some concerns we would like to address. In particular, proposed section 1703A(a)(2)(A)(ii) would prohibit the Secretary from entering into a VCA if care or services are available under the new Veterans Choice Program. Although we appreciate the intent of this provision, we believe there may be situations where the clinical need of the Veteran will require the use of a VCA notwithstanding the availability of such services under the Choice Program. For example, a Veteran may require a certain type of orthopedic procedure, and while orthopedics in general are “available” under a contract, the specific procedure or a specialist may not be included within the contract, or would only be available at a lesser quality. In other situations, a Veteran may elect to receive care from a certain provider that would be ideally suited to furnishing the care required, but who is not a member of the network. We want to ensure we have flexibility in situations like these to deliver the care the Veteran requires in a timely and appropriate way. We also note these provisions apply for when the Secretary may “enter into” agreements, rather than “use” agreements. We have found, through our experience with the current Veterans Choice Program that it is more efficient to enter into these agreements before they are needed to ensure that there is no delay in the receipt of care by eligible Veterans. We believe the language could be modified slightly to impose restrictions on the utilization of VCAs to ensure the integrity and use of the network of providers under the new Veterans Choice Program.

Proposed section 1703A(e)(2) is unclear, and depending upon what the intent is, we may or may not support it. If the provision is intended to simply allow providers to submit claims for care that was unconnected or unrelated to the services VA originally authorized, we are concerned this could create situations where VA pays for services that were neither authorized nor clinically needed. This would create a significant administrative burden on both the providers and VA. If, on the other hand, this is intended to apply only in limited circumstances for care that VA would have authorized, then we have no objection to it.

Regarding proposed section 1703A(g), VA agrees with the idea of monitoring how VCAs are utilized by VA. However, we are concerned that the threshold for when an agreement for the purchase of extended care services is considered to be of “material size,” i.e., exceeding “\$1,000,000 annually,” is too low. Costs for long term extended care and nursing home care costs can easily exceed this level. The threshold also does not account for providers who may have a national presence.

Section 5(a) would establish a new section 1703B concerning payment of non-Department health care providers. Specifically, VA would be required to comply with the provisions in this section and in chapter 39 of title 31 (the Prompt Payment Act). Non-Department providers would be required to submit a claim for reimburse-

ment within 180 days, and the Secretary would have to pay claims according to specified time standards or else interest would accrue on the amount owed. If a provider submits a clean claim, VA would have to pay the claim within 30 days if it was submitted electronically or 45 days if it was submitted other than electronically. If a claim were not clean, the Secretary would have to inform the provider within 10 days on the steps that would be needed to make it clean. By January 1, 2020, the Secretary would only be authorized to accept claims electronically except in certain circumstances.

We generally support section 5(a), but have some concerns with a few of the provisions. For example, we think there should be more flexibility to accept paper claims from smaller providers, such as Homemaker/Home Health Aides. We are also concerned that, as written, this language could require that late payments of providers who have entered into contracts with the Regional Networks could subject VA to interest payments, even though VA has no privity of contract with these providers and is paying the Network on time. Finally, we do not believe the Committee had transactions between VA and other Federal entities in mind when it included a prompt payment standard in the draft bill. An exception could be added in this section to address this issue.

Section 5(b) would require the Secretary, not later than 2 years after the date of the enactment of this Act, to enter into an agreement with a third-party entity to process claims for reimbursement through an electronic interface.

We are concerned about the intended scope of this provision. If the electronic interface processing the claims is only preparing them for adjudication and approval by VA, we do not support this provision because VA is currently working on a process internally that would perform this function. If the term “process” is intended to cover adjudication and payment as well, we would like to discuss with the Committee our reservations about such an arrangement and propose potential alternatives instead.

Section 6 would amend section 1745 to authorize the Secretary to enter into agreements with State Veterans Homes that would not be subject to laws requiring competitive procedures in selecting the party with which to enter the agreement. State Homes entering into these agreements would not be subject to any laws that such a provider would not be subject to under the original Medicare fee-for-service program under Parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), except for laws applying to integrity, ethics, fraud, or that subject a person to civil or criminal penalties. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000c et seq.) would apply to State homes entering into these agreements. These changes would become effective upon the Secretary’s publishing regulations to implement these new authorities.

We generally support section 6, although, we have similar concerns to those we expressed regarding section 4 with respect to the applicability of certain laws.

Section 7 would amend section 1705 to require the Secretary, upon the enrollment of a Veteran in the VA health care system, to assign the Veteran to a dedicated primary care provider of the Department, unless the Veteran elects to choose a primary care pro-

vider from among the health care providers furnishing care in the network established under the new Veterans Choice Program.

We do not support section 7 because this would require all enrolled Veterans to be enrolled in provider panels, even if we do not furnish care to those Veterans. We typically only assign Veterans to a panel once they have expressed interest in receiving care from the Department. We are concerned that assigning other Veterans to panels will complicate our projection models for demand and our estimates for resources for our facilities. We are also concerned that the ability of a Veteran to elect to choose a primary care provider from among VA's network of community providers could allow for the control and coordination of care, including the authorization of care (and the obligation of Federal funds), to move to a non-Federal agent, which presents issues concerning the proper use of appropriated funds.

Section 8 would require the Secretary to enter into national contracts with private health care providers to make dialysis treatments available in the community. Veterans would be able to choose the provider from which they would receive dialysis services. Under subsection (c), the Secretary could not pay more than the Medicare rate for the same dialysis services or treatment.

While we support the intent of this proposal, we are concerned that this could potentially limit the Department's ability to furnish dialysis care. This provision would limit VA to paying the Medicare rate; we currently pay more than the Medicare rate in certain circumstances, and it is unclear if we could enter into contracts for the same care at a reduced rate. If we were unable to enter into these contracts, VA would not be able to provide this essential clinical service.

Section 9 would require VA to establish a demand profile with respect to each health service furnished under the laws administered by the Secretary. The demand profile would have to include various factors, such as the number of requests for services, the number of appointments (both in VA and the community), the capacity of the Department to provide such services, and an assessment of the need for community care for the service. The Secretary would use these profiles to inform the capability and capacity of the provider networks established in the new Veterans Choice Program. Within 120 days of the date of enactment of this Act, the Secretary would be required to submit to Congress a strategic plan with a 5 year forecast on the demand for care and the Department's capacity and capability to satisfy that demand within its facilities. The Secretary would have to update the strategic plan annually.

VA agrees in concept with the provisions in section 9; however, we believe this provision is not necessary as VA has currently embarked upon a national market-by-market assessment effort that will produce the same level of information called for in the bill. VA's market-by-market assessment is in response to a requirement in section 240 of Division A of Public Law 114-223, the "Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017." That law requires VA to develop a national realignment strategy. As a result, the assessment of VA's 98 market-places across the United States is currently underway.

Section 10 would require the Secretary to establish uniform access standards for furnishing health care services, including through community providers, for urgent care, routine care, referral or specialty care, and wellness or preventive care. These access standards would have to include the average time a Veteran is expected to wait to receive an appointment, the average time a Veteran is expected to drive to arrive at an appointment, the average time a Veteran is expected to wait at a facility to receive health care services, and such other factors as the Secretary considers appropriate. The Secretary would be required to coordinate with DOD, the Department of Health and Human Services (HHS), private entities, and other non-governmental entities in establishing these standards. The Secretary would be required to submit a report to Congress within 120 days of the date of the enactment of this Act detailing the standards established under this section.

We do not have views on section 10 at this time.

Section 11 would require the Secretary, within 1 year of enactment, to procure a commercial, off-the-shelf electronic health record platform that conforms to the standards of interoperability required under section 713 of the National Defense Authorization Act for Fiscal Year 2014. The bill would define a number of requirements for this system, including its interoperability with DOD's systems and private sector systems and compliance with national standards identified by the VA and the DOD Interagency Program Office in collaboration with HHS' Office of the National Coordinator for Health Information Technology.

VA does not believe section 11 is necessary because the Secretary has already announced his intention to procure a commercial system for VA's Electronic Health Record capability. Similar to our concern with other provisions, we note that the specificity in this provision could limit the Secretary's ability to ensure this new system is responsive to Veterans' needs.

Finally, section 12 would make various conforming amendments to reflect the changes made by section 3 of this bill by updating references in other statutes to VA's community care authorities.

We support section 12 as a measure to consolidate VA's community care programs.

We are unable to provide cost estimates on the bill at this time but will follow up after the hearing with any estimates we can develop and our thoughts on the potential budget implications. We will also provide technical comments for your consideration.

S. XXXX—IMPROVING VETERANS ACCESS TO COMMUNITY CARE ACT OF
2017

The draft Improving Veterans Access to Community Care Act of 2017 also contains a number of provisions intended to improve VA's community care program.

Section 101(a)(1) would create a new section 1703A, establishing the Veterans Community Care Program. Many of the terms and conditions governing this Program would be similar to those applicable to the existing Veterans Choice Program. Under this new Program, hospital care and medical services would be furnished to eligible Veterans at the election of the Veteran through contracts or agreements with eligible providers. The Secretary would be re-

sponsible for coordinating care and services, including ensuring that an eligible Veteran receives an appointment for care and services within the wait-time goals of the Veterans Health Administration (VHA). To be eligible under the Program, Veterans would have to be enrolled in VA health care and meet one of the following criteria: reside in a location, other than Guam, American Samoa, or the Republic of the Philippines that requires the Veteran to travel by air, boat or ferry to reach a VA medical facility; be enrolled in Project ARCH; the Veteran and the Veteran's VA provider determine the Veteran should be eligible based upon the eligibility criteria in the current Veterans Choice Program, namely being unable to schedule an appointment within the clinically indicated timeframe, residing more than 40 miles driving distance from the nearest VA medical facility with a full-time primary care physician, residing within a State without a full-service VA medical center, or facing an unusual or excessive burden in accessing services from a VA medical facility. The Veteran and provider could also determine whether the Veteran should be eligible under the Program based upon a compelling reason that the Veteran needs to receive care and services from a non-Department facility. The Secretary would be required to establish a process to review any disagreement between Veterans and their providers, and the Secretary would make the final determination as to the eligibility of the Veteran.

While we appreciate the intent of the eligibility criteria for Veterans, we are concerned with how this program is structured. We fully agree that the provider-patient relationship should be the basis for eligibility to receive community care. However, the draft bill would combine this approach with the current administrative eligibility criteria in the Choice Program. We believe this would result in an ultimately confusing "hybrid" standard that would be difficult for providers to apply. In addition, we believe continuing to use administrative criteria would be inappropriate, as they are arbitrary in nature and not informed by the patient-provider relationship. The proposed approach would also be unduly limiting in terms of the types of clinical factors that a provider could consider; for example, a Veteran who lived across the street from a full-service VA medical center with no wait times and who was fully ambulatory would not appear to qualify under any of these provisions, and yet the Veteran may require a certain type of service that would be best delivered by a community provider. We would like to work with the Committee to better understand the underlying issue that proposed subsection (b)(2), concerning the review of provider determinations, is intended to address.

Under section 1703A, providers would have to meet the same eligibility criteria in the current Veterans Choice Program to participate in the new Program, including maintaining the same or similar credentials and licenses as VA providers. The Secretary would be authorized to create a tiered provider network, but would not be able to prioritize providers in a tier over providers in any other tier in a manner that limits the choice of an eligible Veteran to select that provider. The Secretary would be required to enter into contracts with eligible providers for furnishing care and services, but before entering into such a contract, the Secretary would be required, to the maximum extent practicable and consistent with the

requirements of this section, to furnish care and services with eligible providers pursuant to sharing agreements, existing contracts, or other processes available for procuring care. In this section, the term “contract” would have the definition given that term in subpart 2.101 of the Federal Acquisition Regulations. Providers would be paid under a negotiated rate that, to the extent practicable, would not exceed the Medicare rate, with limited exceptions for highly rural areas, Alaska, and States with an All-Payer Model Agreement. Eligible providers would be prohibited from collecting any amount greater than the negotiated rate. The Secretary would be authorized in negotiating rates to incorporate the use of value-based reimbursement models to promote the provision of high-quality care. The Secretary would be authorized to collect from third-parties the costs of furnishing care for non-service-connected disabilities under this section, and such collections would be deposited into the Medical Community Care account and remain available until expended.

We do not support the provision requiring providers to maintain the same or similar credentials and licenses as VA providers; while this is a requirement in the current Veterans Choice Program, we have found it to be administratively difficult (and at times impossible) to implement in certain situations. We believe strongly in the importance of ensuring our providers furnish quality care, but recommend a different approach than this obligation. We are also concerned that some of the language regarding the terms of the agreements with providers contemplates a direct relationship between VA and the providers, rather than a relationship between VA and a network administrator, and a separate relationship between the administrator and the provider. Similarly, we do not support the provision that would require the deposit of collected funds into the Medical Community Care account. Funds collected by VA under sections 1725 and 1729 of title 38, and section 2651 of title 42 are currently deposited in the Medical Care Collections Fund, where they may be used to support both VA and community care. We believe creating a separate collection account would be duplicative and would limit our funding flexibility. Finally, we note that referencing the definition of “third party” in section 1729 produces a narrower effect than if the definition in section 1725 were referenced.

The Secretary would be required to provide Veterans information about this Program upon their enrollment and when they become eligible based on a determination between the Veteran and his or her provider. The Secretary would be required to ensure that follow up care, including specialty and ancillary services deemed necessary, are furnished through the Program at the election of the Veteran. Veterans would be required to pay a copayment for care under this Program, but the copayment could be no more than what the Veteran would owe if such care or services were furnished directly by the Department. The Secretary would also be required to establish a claims processing system to ensure prompt and accurate payment of bills and claims for authorized care. Under subsection (j), a Veteran’s election to receive care under this Program would serve as written consent for purposes of section 7332(b)(1), which governs the disclosure of certain protected health informa-

tion. Providers would be required under subsection (k)(1) to submit copies of the Veteran's medical records upon the completion of the provision of such care and services, but these records could not be required prior to reimbursement. Under subsection (m), the Secretary would be required to track missed appointments to ensure the Department does not pay for care or services that were not rendered.

We note that subsection (j) is no longer needed given the amendments to section 7332 made by Public Law 115–26. In terms of subsection (k)(1), we believe it would be better for the records to be required as determined by the Secretary to ensure that the records are provided in a timely fashion and that care provided by VA and others is informed. We also recommend against including subsection (m), regarding the tracking of missed appointments, as our experience with the current Veterans Choice Program has proven this difficult to implement. We have taken other precautions to ensure the Department is not paying for care and services that were not provided, and we believe this approach is more suitable for the legislation's intent.

Section 101(a)(3) would terminate the current Veterans Choice Program authority and make other conforming amendments.

We do not support this provision, as the Department will need a transition period during which it can prepare for the future of community care while still ensuring Veterans receive care through the current Choice Program.

Section 101(a)(4) would require a report within 1 year of the date of enactment of this Act providing information about services rendered under the new Program.

We note that subparagraph (D) of this provision would require a report on the results of a survey of Veterans who have received care or services under this program. Given the time it may take us to develop a survey, VA may not be able to gather meaningful information in the time between OMB approval of the information collection and the reporting deadline. Regarding subparagraph (E), which would require an assessment of the effect of furnishing care and services under new section 1703A on wait times, we have not found reliable data that would support a firm assessment through the current Choice Program, and we believe we would encounter the same issues under this proposal.

Section 101(b) would provide that services under various programs and authorities be considered services under the Veterans Community Care Program established under the new section 1703A, including PC3, contracts through VA's retail pharmacy network, VCAs, and health care agreements with other Federal and non-Federal agencies.

We are not sure exactly what it means for services under another program to be "considered" services under the Veterans Community Care Program. If this would require that all of the agreements and programs identified in this subsection meet the terms and conditions of the Veterans Community Care Program, we would not support that requirement.

Section 101(c) would state that all amounts required to carry out the new Program would be derived from the Medical Community Care account, and that all amounts in the Veterans Choice Fund

would be transferred to the Medical Community Care account. Section 802 of the Veterans Access, Choice, and Accountability Act of 2014 would be repealed, and conforming amendments would be made to section 4003 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015.

We agree with the importance of consolidating funding for community care, but we recommend that the transfer of funds from and the repeal of the Veterans Choice Fund only apply to unobligated funds and provide a delayed effective date to support the transition from the current program to the future program.

Section 101(d) would require, within 90 days of the enactment of this Act, the Secretary to establish consistent criteria and standards for furnishing non-Department care, including the eligibility requirements of providers and reimbursement rates (which, to the extent practicable, would be the Medicare rate). These standards would not apply to the Veterans Community Care Program established under section 101(a)(1).

We support the intent of subsection (d). We have minor technical recommendations that we would be pleased to discuss with the Committee.

Section 101(e) would require the Secretary to establish a working group to assess the feasibility and advisability of considering under subsection (b) services under health care agreements with health care providers of the Indian Health Service (IHS) and tribal health programs to be provided under the Veterans Community Care Program. The working group would include representatives of IHS, tribal health programs, and Veterans who receive services from either IHS or tribal health programs. Within 180 days of enactment of this Act, the working group would be required to submit a report to the Secretary on the feasibility and advisability of considering such services to be services under the Veterans Community Care Program, and within 90 days of receiving this report, the Secretary would be required to submit a report to Congress on the feasibility and advisability of implementing the working group's recommendations.

We do not oppose greater coordination and discussion with IHS or tribal health programs, but we do not believe the timelines in the legislation are realistic. We also do not believe it is necessary to require this coordination in law, as we are already working with these groups to improve cultural understanding and resource sharing. We also note that the Federal Advisory Committee Act (FACA) would likely apply to the working group, given the inclusion of non-government personnel.

Section 102(a) would create a new section 1703B regarding prompt payment of providers. It would require substantially the same things required by section 5(a) of the draft Veterans Choice Act of 2017, with a few exceptions. For example, this bill would authorize the Secretary to accept claims and medical records submitted other than electronically if the Secretary determines the provider is unable to submit claims or medical records electronically. It would also authorize the Secretary to accept non-electronic claims if the Secretary determines doing so is necessary for the timely processing of claims due to a failure or serious malfunction

of the electronic interface of the Department (required in section 102(b)) for submitting claims.

As discussed with respect to section 5(a) of the draft Veterans Choice Act of 2017, we generally support these provisions and appreciate the flexibility contained in this version.

Section 102(b) would require, not later than January 1, 2019, the Chief Information Officer of the Department to establish an electronic interface for health care providers to submit claims for reimbursement under section 1703B. The bill would define various requirements in terms of functions of the interface and protection of information. By January 1, 2018, or before entering into a contract to procure or design and build such an interface, the Secretary would be required to conduct an analysis to determine whether it would be better to build or buy such an interface and submit a report on such analysis to Congress. The bill would define various requirements of this analysis and report, and the Secretary would not be authorized to spend any amounts to procure or design and build the electronic interface until 60 days after the required report is submitted to Congress.

We are concerned about the intended scope of this provision. If the electronic interface processing the claims is only preparing them for adjudication and approval by VA, we do not support this provision because VA is currently working on a process internally that would perform this function. If the provision is intended to cover adjudication and payment as well, we would like to discuss with the Committee our reservations about such an arrangement and propose potential alternatives instead. We also caution that the deadline in subsection (b)(2) of January 1, 2018, for making a decision to internally design and build or enter into a contract to procure an electronic interface is likely too soon, given the uncertainty regarding community care funding, continuing developments of the design of the new EHR, and the potential implications to other information technology projects.

Section 103 would amend 38 U.S.C. § 1151(a) by adding a paragraph that would require VA to pay compensation if a Veteran's disability or death was caused by hospital care or medical services furnished under proposed section 1703A of title 38, United States Code, and the proximate cause of the disability or death was carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault by the provider or an event not reasonably foreseeable.

VA fully supports ensuring that Veterans have access to high quality care, and that they are made whole in the event of a medical error. However, VA does not support this provision as written based on several concerns. First, section 103 would expand section 1151(a) to require VA benefit payments where the "proximate cause" of a Veteran's disability or death was the negligence of a non-Department health care provider or an unforeseeable event occurring during treatment by such a provider. The "term 'proximate cause' is used to label generically the judicial tools used to limit a person's responsibility for the consequences of that person's own acts. At bottom, the notion of proximate cause reflects 'ideas of what justice demands, or of what is administratively possible and convenient.'" *Holmes v. Sec. Investor Prot. Corp.*, 503 U.S. 258, 268

(1992) (quoting W. Keeton, D. Dobbs, R. Keeton, & D. Owen, *Prosser and Keeton on Law of Torts* §41, p. 264 (5th ed. 1984)). Section 103 would make the Federal government liable for disability or death that is the proximate result of a non-Department medical provider's negligence or an unforeseeable event. This is contrary to the basic principle of American law, which holds an individual legally responsible for injuries caused by his or her negligent conduct.

Second, VA adjudicators would be required to develop evidence regarding care that is not provided by VA employees or in VA facilities, including DOD and other Federal health care providers and academic affiliates, and to determine whether a Veteran's disability was proximately caused by negligence on the part of the community provider or an unforeseeable event occurring during non-Department medical care. See 38 U.S.C. §5103A. This would entail gathering medical and other records from community providers as well as expert medical opinions about whether the event that occurred during the non-Department treatment was not foreseeable. This development burden of obtaining and evaluating evidence from non-Department providers and facilities can be expected to slow the adjudication of other Veterans' claims for benefits and potentially add to the disability compensation backlog.

Third, under 38 U.S.C. §1151(b), a recovery under the Federal Tort Claims Act as a result of a judgment or settlement for a disability or death for which compensation is awarded under 38 U.S.C. §1151(a) results in a suspension of the section 1151 benefits until the amount of the judgment or settlement is recouped. In contrast, section 103 does not provide for a suspension of compensation for any recovery by a Veteran or Veteran's survivors from the non-Department provider as a result of a private lawsuit based upon the same disability or death. As a result, a Veteran or a Veteran's survivor could receive a recovery of both section 1151 benefits and tort damages based upon a judgment or settlement. This would create an inequity by allowing duplicative recovery for the same disability or death for persons whose entitlement is based on care furnished by community providers.

We have not yet had time to estimate the costs for section 103. However, we do know that, in FY 2016, 2.2 million Veterans received care from community providers under existing VA statutory authorities. During the first three quarters of FY 2017, 1.2 million Veterans have received such care. VA purchases care from more than 500,000 community providers, and the number continues to grow. VA's FY 2018 budget requests a 13 percent increase in funding for community care. As a result, VA could potentially be liable for section 1151 benefits for any of these 2 million Veterans who suffer additional disability or death due to negligence or an unforeseeable event caused by community care provided by community providers despite the absence of a causal connection between the additional disability or death and VA medical treatment.

Section 104 would add a sunset provision to section 1703 of title 38 terminating that program on December 31, 2018. It would make other conforming amendments similar to those proposed in section 12 of the draft Veterans Choice Act of 2017.

We support section 104.

Section 201 would add a new section 1703C to authorize the Secretary to enter into VCAs, similar to the authority that would be provided under section 4 of the draft Veterans Choice Act of 2017. However, there are a few differences in the proposed section 1703C that section 201 would create. First, the draft Veterans Choice Act of 2017 would require that care be unavailable under the Veterans Choice Program established in that draft bill prior to entering into a VCA, while the Improving Veterans Access to Community Care Act of 2017 has no such limitation. The draft Veterans Choice Act of 2017 would authorize providers to opt out of a VCA, but the Improving Veterans Access to Community Care Act of 2017 does not include this provision. The draft Veterans Choice Act of 2017 would limit the ability of the Secretary to direct patients to providers that have entered into contracts or agreements under other authorities, while the Improving Veterans Access to Community Care Act of 2017 does not include such a restriction. The draft Improving Veterans Access to Community Care Act of 2017 would include greater flexibility in terms of the Medicare rate through inclusion of the phrase “to the extent practicable” in prescribing the rates the Secretary would pay under VCAs. While we believe the draft Veterans Choice Act of 2017 would allow the Secretary, on a case-by-case basis, to determine whether or not to pay for care not authorized, the Improving Veterans Access to Community Care Act of 2017 would allow the Secretary to pay a provider who provides services in the course of treatment pursuant to an agreement with the Secretary but is not a party to the agreement. Finally, the draft Veterans Choice Act of 2017 would state uniformly that the OFCCP would not have authority over parties to a VCA, while, through section 205, the Improving Veterans Access to Community Care Act of 2017 would apply the limits established for the TRICARE Program in Directive 2014–01 of OFCCP to any health care provider entering into an agreement or contract with VA under section 1703A, 1703C, or 1745.

We support section 201 and prefer those provisions that differ from the draft Veterans Choice Act of 2017.

Section 205 would apply the OFCCP moratorium to VA, and VA supports that provision. We recommend against including a specific deadline, as that would allow flexibility in the event that the OFCCP Directive is further revised. Many of the technical concerns we identified with the draft Veterans Choice Act of 2017 regarding VCAs apply here as well, and we look forward to working with the Committee and the Department of Labor to address concerns.

Section 202 would modify VA’s authority under section 1745 and is identical to section 6 of the draft Veterans Choice Act of 2017.

VA’s views on that provision apply here as well.

Section 203 would amend section 106 of the Veterans Access, Choice, and Accountability Act of 2014 to require that, at the beginning of each fiscal year, the Secretary to transfer to VHA an amount equal to the estimated amount required to furnish hospital care, medical services, and other health care through non-Department providers during the fiscal year. The Secretary would be authorized to make adjustments to the amount transferred to accommodate variances in demand for such care and services from non-Department providers.

We support section 203 because this would provide greater flexibility to adjust resource allocations based upon actual demand.

Section 204 would create a new section 1730B, which would allow the Secretary, notwithstanding sections 1341(a)(1) and 1501 of title 31, to record an obligation of the United States for non-Department care on the date on which a claim for payment is approved, rather than the date on which the care or services are authorized.

VA understands this provision is intended to bring the Department closer to industry practices in terms of allocating resources for care and developing better estimates concerning our community care liabilities. VA appreciates the Committee's willingness to engage on this issue given our prior discussions on this, and we look forward to working with you further on this proposal.

Section 205 of the bill is discussed above in the analysis of section 201, and the Department's views on this provision are provided in that discussion.

We are unable to provide cost estimates on the bill at this time, but will follow up after the hearing with any estimates we can develop and our thoughts on the potential budget implications. We will also provide technical comments for your consideration.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or Members of the Committee may have.

Title 38. Veterans' Benefits

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Part I. General Provisions

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Chapter 7. Employees

SUBCHAPTER I. GENERAL EMPLOYEE MATTERS

Sec.

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725. Annual performance plan for political appointees.

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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SEC. 726. ANNUAL REPORT ON PERFORMANCE AWARDS AND BONUSES AWARDED TO CERTAIN HIGH-LEVEL EMPLOYEES

(a) *IN GENERAL.*—Not later than 30 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 the performance awards and bonuses awarded to Regional Office Directors of the Department, Directors of Medical Centers of the Department, and Directors of Veterans Integrated Service Networks.

(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) *APPROPRIATE COMMITTEES OF CONGRESS.*—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.*

Part II. General Benefits

Chapter 17. Hospital, Nursing Home, Domiciliary, and Medical Care

SUBCHAPTER I. GENERAL

Sec.

1701. Definitions.

1702. Presumptions: psychosis after service in World War II and following periods of war; mental illness following service in the Persian Gulf War.

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

1703. *Veterans Community Care Program.*

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

1703B. *Access guidelines.*

1703C. *Standards for quality.*

1703D. *Prompt payment standard.*

1704. Preventive health services: annual report.

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

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1725. Reimbursement for emergency treatment.

1725A. *Access to walk-in care.*

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1730B. *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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[SEC. 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.]

SEC. 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 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.*

(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) 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 2017; or

(D) the covered veteran and the covered veteran’s primary care provider 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)(D) 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) Whether an appointment for the hospital care, medical services, or extended care services the covered veteran requires is available from a health care provider of the Department within the lesser of—

(i) the access guidelines for such hospital care, medical services, or extended care services as established by the Secretary; and

(ii) a period determined by a health care provider of the Department to be clinically necessary for the receipt of such hospital care, medical services, or extended care services.

(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, or that the covered veteran is described under subparagraph (C) 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 meets such quality and access standards as the Secretary shall develop.

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

(i) measure access 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) because of an access and quality deficiency of a medical service line 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.*

(3) *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 subsection (g) with respect to such medical service line is complete.*

(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 local clinical appeals process, and such decisions may not be appealed to the Board of Veterans' Appeals.*

(g) *REMEDICATION OF MEDICAL SERVICE LINES.—(1) Not later than 30 days after determining under subsection (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 access guidelines and meet the standards of 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 access guidelines and meet such standards of quality, including the following:*

(A) *Increasing personnel or temporary personnel assistance, including mobile deployment teams.*

(B) *Special hiring incentives, including the Education Debt Reduction Program under subchapter VII of chapter 76 of this title and recruitment, relocation, and retention incentives.*

(C) *Utilizing direct hiring authority.*

(D) *Providing improved training opportunities for staff.*

(E) *Acquiring improved equipment.*

(F) *Making structural modifications to the facility used by the medical service line.*

(G) *Such other actions as the Secretary considers appropriate.*

(2) *In each assessment submitted under paragraph (1) 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 com-*

plying with the access guidelines and meeting the standards of quality established by the Secretary.

(3) Not later than 180 days after submitting an assessment under paragraph (1) 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 access guidelines and meeting the standards of quality established by the Secretary and any other measures the Secretary will take to assist the medical service line in complying with such access guidelines and meeting such standards of quality.

(4) Not less frequently than once each year, the Secretary shall—

(A) 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 meeting the quality and access standards established by the Secretary and any other actions the Secretary is undertaking to assist the medical service line in complying with access guidelines and meeting standards of quality as established by the Secretary; and

(B) publish such analysis on the Internet website of the Department.

(h) ACCESS GUIDELINES AND STANDARDS FOR QUALITY.—(1) The Secretary shall establish access guidelines under section 1703B of this title and standards for quality under section 1703C of this title for furnishing hospital care, medical services, or extended care services to a covered veteran for the purposes of subsections (d) and (e).

(2) The Secretary shall ensure that the access guidelines and standards for quality required by sections 1703B and 1703C of this title provide covered veterans, employees of the Department, and health care providers in the network established under subsection (j) with relevant comparative information that is clear, useful, and timely, so that covered veterans can make informed decisions regarding their health care.

(3) 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 guidelines and standards for quality as required by sections 1703B and 1703C of this title.

(4) Not later than 270 days after the date of the enactment of the Caring for our Veterans Act of 2017, the Secretary shall submit to the appropriate committees of Congress a report detailing the access guidelines and standards for quality established under sections 1703B and 1703C of this title.

(5) Not later than three years after the date on which the Secretary establishes access guidelines and standards for quality under paragraph (1) and not less frequently than once every three years thereafter, the Secretary shall—

(A) conduct a review of such guidelines and standards; and

(B) submit to the appropriate committees of Congress a report on the findings and any modification to the access guidelines

and standards for quality with respect to the review conducted under subparagraph (A).

(6) The Secretary shall ensure health care providers specified under subsection (c) are able to meet the applicable access guidelines and standards of quality established by the Secretary.

(i) 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.

(j) 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 guidelines or meet the standards of 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 2017, 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 through regulation 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.

(k) 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.) 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 greatest 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.

(1) TREATMENT OF OTHER HEALTH CARE PLANS.—(1) 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 care plan described in paragraph (2) in accordance with such section.

(2) 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, under which hospital care, medical services, or extended care services for individuals are provided or the expenses of such care or 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.

(m) 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.

(n) 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 2017, 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 (j)—*

(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 access guidelines or meet the standards of 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 2017 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 Vet-*

erans' Affairs of the House of Representatives a report on the information gathered under paragraph (2).

(o) **PROHIBITION ON CERTAIN LIMITATIONS.**—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 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.

(p) **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.

SEC. 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 by entering into 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 2018 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.); or*

(3) *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 pro-*

curement 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 the Medicare program.

(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 through regulation 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 payment 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.

(2)(A) Except as provided 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.

SEC. 1703B. ACCESS GUIDELINES

The Secretary shall consult with all pertinent Federal entities to examine health care access measurements and establish localized benchmarking guidelines that can inform provider and veteran clinical decisionmaking. The Secretary shall establish such guidelines for all hospital care, medical services, and extended care services furnished or otherwise made available under laws administered by the Secretary, including through non-Department health care providers.

SEC. 1703C. STANDARDS FOR QUALITY

(a) **IN GENERAL.**—(1) The Secretary shall establish standards for quality, in coordination or consultation with entities pursuant to section 1703(h)(3) of this title, 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, re-admissions, and deaths.*

(iv) *Efficiency.*

(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.*

SEC. 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.—In processing a claim for compensation for hospital care, medical services, or extended care services furnished by a health care entity or provider under this chapter, the Secretary shall act through—

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

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

(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 2017, 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 intentional and deliberate 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. This term, as used in this section, shall not include a good faith interpretation by a health care entity or provider of utilization, medical necessity, coding, and billing requirements of the Secretary.

(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.

Subchapter II. Hospital, Nursing Home, or Domiciliary Care and Medical Treatment

SEC. 1712. DENTAL CARE; DRUGS AND MEDICINES FOR CERTAIN DISABLED VETERANS; VACCINES

(a)(1) * * *

* * * * *

(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 * * *

* * * * *

SEC. 1712A. ELIGIBILITY FOR READJUSTMENT COUNSELING AND RELATED MENTAL HEALTH SERVICES

(a)(1)(A) * * *

(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.

* * * * *

SEC. 1720G. ASSISTANCE AND SUPPORT SERVICES FOR CAREGIVERS

(a) PROGRAM OF COMPREHENSIVE ASSISTANCE FOR FAMILY CAREGIVERS.—(1)(A) * * *

(2) * * *

* * * * *

[(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 302(a) of the Caring for our Veterans Act of 2017, has a serious injury (including traumatic brain injury, psycho-

logical 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) * * *
- (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
- (iv) 【(iii)】 such other matters as the Secretary considers appropriate.

(3)(A) * * *

* * * * *

(ii) * * *

* * * * *

(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.

* * * * *

(C)(i) * * *

* * * * *

(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.*

(iv) [(iii)] 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) * * *

(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)*—

* * * * *

(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.*

* * * * *

(d) DEFINITIONS.—In this section:

* * * * *

(4) * * *

(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.*

(D) [(B)] Any other non-institutional extended care (as such term is used in section 1701(6)(E) of this title).

* * * * *

Subchapter III. Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

* * * * *

SEC. 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 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 shall require all eligible veterans to pay the United States a copayment for each episode of hospital care and medical service provided under this section if otherwise required to pay a copayment under this title.

(B) Those 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 shall be paid.

(C) For those veterans required to pay a copayment under title 38, they are required to pay their regular copayment for their first two walk-in care visits in a calendar year. For any additional visits, a higher copayment at an amount determined by the Secretary shall be paid.

(2) After the first two episodes of care furnished to a 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 veteran, the number of episodes of care furnished to the 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 2017, 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.*

SEC. 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;

* * * * *

(D) [that is incurred by a veteran-] *that is incurred by an individual who 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)(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

* * * * *

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

* * * * *

(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*.

* * * * *

SEC. 1730B. LICENSURE OF HEALTH CARE PROFESSIONALS PROVIDING TREATMENT VIA TELEMEDICINE

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

(b) 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 of 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.).

* * * * *

Subchapter V. Payments to State Homes

* * * * *

SEC. 1745. NURSING HOME CARE AND MEDICATIONS FOR VETERANS WITH SERVICE-CONNECTED DISABILITIES

(a)(1) The Secretary shall enter into a contract [(or agreement under section 1720(c)(1) of this title)] (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:

* * * * *

(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 clause (ii), and unless otherwise provided in this section or regulations prescribed pursuant to this sec-

tion, 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; and

(II) all provisions of law that protect against employment discrimination or that otherwise ensure equal employment opportunities.

(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”).

* * * * *

Subchapter VIII. Health Care of Persons Other Than Veterans

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SEC. 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.

* * * * *

Chapter 23. Burial Benefits

* * * * *

SEC. 2303. DEATH IN DEPARTMENT FACILITY; PLOT ALLOWANCE

(a)(1) * * *

* * * * *

- (2) * * *
- (A) * * *
- (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;

* * * * *

Part V. Boards, Administrations, and Services

* * * * *

Chapter 73. Veterans Health Administration-Organization and Functions

* * * * *

Subchapter I. Organization

* * * * *

SEC. 7309. READJUSTMENT COUNSELING SERVICE

- (a) * * *
- (b) * * *
- (2) * * *
- * * * * *
- (B) have at least three years of experience providing direct counseling services or outreach services [in the Readjustment Counseling Service];
- (C) have at least three years of experience administering direct counseling services or outreach services [in the Readjustment Counseling Service];

* * * * *

Subchapter III. Protection of Patient Rights

* * * * *

SEC. 7332. CONFIDENTIALITY OF CERTAIN MEDICAL RECORDS

* * * * *

- (b)(1) * * *
- (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:

* * * * *

[(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.

(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.

(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").

* * * * *

Chapter 74. Veterans Health Administration-Personnel

SUBCHAPTER I. APPOINTMENTS

Sec.

* * * * *

[7411. Full-time board-certified physicians and dentists: reimbursement of continuing professional education expenses.]

7411. *Reimbursement of continuing professional education expenses.*

7412. Annual determination of staffing shortages; recruitment and appointment for needed occupations.

7413. *Treatment of podiatrists; clinical oversight standards.*

* * * * *

Subchapter I. Appointments

SEC. 7401. APPOINTMENTS IN VETERANS HEALTH ADMINISTRATION

* * * * *

(1) Physicians, dentists, podiatrists, chiropractors, optometrists, registered nurses, physician assistants, *certified clinical perfusionists*, and expanded-function dental auxiliaries.

* * * * *

SEC. 7404. GRADES AND PAY SCALES

(a)(1)(A) * * *

* * * * *

(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.

* * * * *

CLINICAL **[PODIATRIST, CHIROPRACTOR, AND]** *CHIROPRACTOR AND OPTOMETRIST SCHEDULE*

Chief grade.

* * * * *

(c) * * *

(d) **[Except]** *Except for positions described in section 7401(4) of this title and 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.*

* * * * *

[SEC. 7411. FULL-TIME BOARD-CERTIFIED PHYSICIANS AND DENTISTS: REIMBURSEMENT OF CONTINUING PROFESSIONAL EDUCATION EXPENSES

[The Secretary shall reimburse any full-time board-certified physician or dentist appointed under section 7401(1) of this title for expenses incurred, up to \$1,000 per year, for continuing professional education.]

SEC. 7411. REIMBURSEMENT OF CONTINUING PROFESSIONAL EDUCATION EXPENSES

The Secretary shall reimburse any full-time board-certified advanced practice registered nurse, physician, or dentist appointed under section 7401(1) of this title for expenses incurred, up to \$1,000 per year, for continuing professional education.

* * * * *

SEC. 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.*

* * * * *

Subchapter IV. Pay for Nurses and Other Health-Care Personnel

* * * * *

SEC. 7451. NURSES AND OTHER HEALTH-CARE PERSONNEL: COMPETITIVE PAY

(c)(1) * * *

[(2) The maximum rate of basic pay for any grade for a covered position may not exceed the maximum rate of basic pay established for positions in level IV of the Executive Schedule under section 5316 1 of title 5. The maximum rate of basic pay for a grade for the position of certified registered nurse anesthetist pursuant to an adjustment under subsection (d) may exceed the maximum rate otherwise provided in the preceding sentence.]

(2)(A) The maximum rate of basic pay for any grade for health-care personnel positions referred to in paragraphs (1) and (3) of section 7401 of this title (other than the positions of physician, dentist, and registered nurse) may not exceed the rate of basic pay established for positions in level IV of the Executive Schedule under section 5315 of title 5.

(B) Pursuant to an adjustment under subsection (d), the maximum rate of basic pay for a registered nurse serving as a nurse executive or a grade for the position of certified registered nurse anesthetist may exceed the rate of basic pay established for positions in level IV of the Executive Schedule under section 5315 of title 5 but may not exceed the rate of basic pay established for positions in level I of the Executive Schedule under section 5312 of title 5.

(C) Pursuant to an adjustment under subsection (d), the maximum rate of basic pay for all registered nurses not described in subparagraph (B) may exceed the rate of basic pay established for positions in level IV of the Executive Schedule under section 5315 of title 5 but may not exceed the rate of basic pay established for positions in level III of the Executive Schedule under section 5314 of title 5.

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SEC. 7454. PHYSICIAN ASSISTANTS AND OTHER HEALTH CARE PROFESSIONALS: ADDITIONAL PAY

* * * * *

(d) In this section, the term "compensation" includes all compensation earned by employees when performing duties authorized by the Secretary or when the employee is approved to use annual, sick, family medical, military, or court leave or during any other paid absence for which pay is not already regulated.

SEC. 7455. INCREASES IN RATES OF BASIC PAY

* * * * *

(c)(1) Subject to paragraph (2), the amount of any increase under subsection (a) in the minimum rate for any grade may not (except in the case of nurse anesthetists, licensed practical nurses, licensed vocational nurses, nursing positions otherwise covered by title 5, pharmacists, *certified clinical perfusionists*, and licensed physical therapists) exceed the maximum rate of basic pay (excluding any locality-based comparability payment under section 5304 of title 5

or similar provision of law) for the grade or level by more than 30 percent.

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Chapter 76. Health Professionals Educational Assistance Program

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Subchapter VII. Education Debt Reduction Program

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SEC. 7683. EDUCATION DEBT REDUCTION

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(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]** *”\$240,000* over a total of five years of participation in the Program, of which not more than **[\$24,000]** *\$48,000* of such payments may be made in each year of participation in the Program.

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Part VI. Acquisition and Disposition of Property

* * * * *

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.

* * * * *

8111A. Furnishing of health-care services to members of the Armed Forces during a war or national emergency.

8111B. *Authority to plan, design, construct, or lease a shared medical facility.*

* * * * *

SUBCHAPTER IV. SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

* * * * *

8159. *Authority to pay for services authorized but not subject to an agreement.*

* * * * *

Subchapter I. Acquisition and Operation of Medical Facilities

SEC. 8101. DEFINITIONS

For the purposes of this subchapter:

* * * * *

(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 facility, mechanical equipment, trackage facilities leading thereto, abutting sidewalks, accommodations for attending personnel, and recreation facilities associated therewith.*

* * * * *

SEC. 8104. Congressional Approval of Certain Medical Facility Acquisitions

(a)(1) * * *

* * * * *

【(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:*

(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 \$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) The term “major medical facility lease” means a lease for space for use as a new medical facility at an average annual rental equal to or greater than the dollar threshold for leases procured through the General Services Administration under section 3307(a)(2) of title 40, which shall be subject to annual adjustment in accordance with section 3307(h) of such title.

* * * * *

SEC. 8111B. AUTHORITY TO PLAN, DESIGN, CONSTRUCT, OR LEASE A SHARED MEDICAL FACILITY

(a) IN GENERAL.—(1) The Secretary may enter into agreements with other Federal agencies for the planning, designing, constructing, or leasing of shared medical facilities with the goal of improving access to, and quality and cost effectiveness of, health care provided by the Department and other Federal agencies.

(2) Facilities planned, designed, constructed, or leased under paragraph (1) shall be managed by the Under Secretary for Health.

(b) TRANSFER OF AMOUNTS TO OTHER FEDERAL AGENCIES.—(1) The Secretary may transfer to another Federal agency amounts appropriated to the Department for “Construction, Minor Projects” for use for the planning, design, or construction of a shared medical facility if the estimated share of the project costs to be borne by the

Department does not exceed the threshold for a major medical facility project under section 8104(a)(3)(A) of this title.

(2) The Secretary may transfer to another Federal agency amounts appropriated to the Department for "Construction, Major Projects" for use for the planning, design, or construction of a shared medical facility if—

(A) the estimated share of the project costs to be borne by the Department is more than the threshold for a major medical facility project under subsection (a)(3)(A) of section 8104 of this title; and

(B) the requirements for such a project under such section have been met.

(3) The Secretary may transfer to another Federal agency amounts appropriated to the applicable appropriations account of the Department for the purpose of leasing space for a shared medical facility if the estimated share of the lease costs to be borne by the Department does not exceed the threshold for a major medical facility lease under section 8104(a)(3)(B) of this title.

(c) TRANSFER OF AMOUNTS TO DEPARTMENT.—(1) Amounts transferred to the Department by another Federal agency for the necessary expenses of planning, designing, or constructing a shared medical facility for which the estimated share of the project costs to be borne by the Department does not exceed the threshold for a major medical facility project under section 8104(a)(3)(A) of this title may be deposited in the "Construction, Minor Projects" account of the Department and used for such necessary expenses.

(2) Amounts transferred to the Department by another Federal agency for the necessary expenses of planning, designing, or constructing a shared medical facility for which the estimated share of the project costs to be borne by the Department is more than the threshold for a major medical facility project under section 8104(a)(3)(A) of this title may be deposited in the "Construction, Major Projects" account of the Department and used for such necessary expenses if the requirements for such project under section 8104 of this title have been met.

(3) Amounts transferred to the Department by another Federal agency for the purpose of leasing space for a shared medical facility may be credited to the applicable appropriations account of the Department and shall be available without fiscal year limitation.

(4) Amounts transferred under paragraphs (1) and (2) shall be available for the same time period as amounts in the account to which those amounts are transferred.

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Subchapter IV. Sharing of Medical Facilities, Equipment, and Information

* * * * *

SEC. 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.

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Subchapter V. Enhanced-Use Leases of Real Property

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SEC. 8162. ENHANCED-USE LEASES

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(b)(1) * * *

[(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).

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SOCIAL SECURITY ACT

(42 U.S.C. 1395cc(a)(1)(L))

Title 42. The Public Health and Welfare

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Chapter 7. Social Security

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Subchapter XVIII. Health Insurance for Aged and Disabled

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Part E. Miscellaneous Provisions

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SEC. 1866. AGREEMENTS WITH PROVIDERS OF SERVICES; ENROLLMENT PROCESSES

(a) * * *

(1) * * *

* * * * *

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this

subchapter, to be a participating provider of medical care [under section 1703] *under chapter 17* of title 38, 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,

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VETERANS' BENEFITS IMPROVEMENTS ACT OF 1994

(Public Law 103-446; 38 U.S.C. 1117 note)

* * * * *

Title I. Persian Gulf War Veterans

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SEC. 104. DEVELOPMENT OF MEDICAL EVALUATION PROTOCOL.

(a) UNIFORM MEDICAL EVALUATION PROTOCOL.—(1) * * *

* * * * *

(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.

* * * * *

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2010

(Public Law 111-163; 38 U.S.C. 1720G note)

Title I. Caregiver Support

* * * * *

SEC. 101. ASSISTANCE AND SUPPORT SERVICES FOR CAREGIVERS.

* * * * *

(c) ANNUAL EVALUATION REPORT.—

(1) * * *

(2) CONTENTS.—The report required by paragraph (1) shall include the following:

(A) * * *

* * * * *

(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

* * * * *

(B) * * *

(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.

* * * * *

VETERANS ACCESS, CHOICE, AND ACCOUNTABILITY ACT OF 2014

(Public Law 113-146; 38 U.S.C. 703 note)

* * * * *

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, *other than recruitment, relocation, or retention incentives*, does not exceed the following amounts:

* * * * *

(Public Law 113-146; 38 U.S.C. 1701 note)

* * * * *

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.

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(p) AUTHORITY TO FURNISH CARE AND SERVICES.—*The Secretary may not use the authority under this section to furnish care and services after December 31, 2018.*

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Title VIII. Other Matters

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SEC. 802. VETERANS CHOICE FUND.

* * * * *

(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.

* * * * *

(4) *PERMANENT AUTHORITY FOR OTHER USES.—Beginning in fiscal year 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).

* * * * *