S. 2413

At the request of Mr. SANDERS, the names of the Senator from Oregon (Mr. MERKLEY), the Senator from Rhode Island (Mr. WHITEHOUSE), the Senator from New Mexico (Mr. UDALL), the Senator from West Virginia (Mr. ROCKEFELLER), the Senator from Pennsylvania (Mr. CASEY) and the Senator from Louisiana (Ms. LANDRIEU) were added as cosponsors of S. 2413, a bill to improve the provision of medical services and benefits to veterans, and for other purposes.

S. RES. 451

At the request of Mr. BARRASSO, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. Res. 451, a resolution recalling the Government of China's forcible dispersion of those peaceably assembled in Tiananmen Square 25 years ago, in light of China's continued abysmal human rights record.

S. RES. 453

At the request of Mr. RUBIO, the names of the Senator from Minnesota (Mr. FRANKEN) and the Senator from Georgia (Mr. CHAMBLISS) were added as cosponsors of S. Res. 453, a resolution condemning the death sentence against Meriam Yahia Ibrahim Ishag, a Sudanese Christian woman accused of apostasy.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. MCCONNELL (for himself, Mr. ENZI, Mr. THUNE, Mr. PAUL, Mr. BLUNT, Mr. VITTER, and Mrs. FISCHER):

S. 2414. A bill to amend the Clean Air Act to prohibit the regulation of emissions of carbon dioxide from new or existing power plants under certain circumstances; to the Committee on Environment and Public Works.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2414

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Coal Country Protection Act'' or the ''Protecting Jobs, Families, and the Economy From EPA Overreach Act''.

SEC. 2. REGULATION OF EMISSIONS OF CARBON DIOXIDE FROM NEW OR EXISTING POWER PLANTS.

(a) LIMITATION ON REGULATION.—The Clean Air Act is amended by inserting after section 312 (42 U.S.C. 7612) the following:

''SEC. 313. LIMITATION ON REGULATION OF EMISSIONS OF CARBON DIOXIDE FROM NEW OR EXISTING POWER PLANTS.

''(a) DEFINITION OF NEW OR EXISTING POWER PLANT.—In this section, the term 'new or existing power plant' means a fossil fuel-fired power plant that commences operation at any time.

''(b) LIMITATION.—Notwithstanding any other provision of law (including regulations), the Administrator may not promulgate any regulation or guidance that limits or prohibits any new carbon dioxide emissions from a new or existing power plant, and no such regulation or guidance shall have any force or effect, until the date on which—

''(1) the Secretary of Labor certifies to the Administrator that the regulation or guidance will not generate any loss of employment;

''(2) the Director of the Congressional Budget Office certifies to the Administrator that the regulation or guidance will not result in any loss in the gross domestic product of the United States;

''(3) the Administrator of the Energy Information Administration certifies to the Administrator that the regulation or guidance will not generate any increase in electricity rates in the United States; and

''(4) the Chairperson of the Federal Energy Regulatory Commission and the President of the North American Electric Reliability Corporation certify to the Administrator the reliability of electricity delivery under the regulation or guidance.''.

(b) TECHNICAL CORRECTION.—The Clean Air Act is amended by redesignating the second section 317 (42 U.S.C. 7617) (relating to economic impact assessment) as section 318.

By Mr. SANDERS (for himself, Mr. ROCKEFELLER, Mr. BEGICH, Mrs. SHAHEEN, Mr. KAINE, Mr. REED, Mr. MERKLEY, Mr. CASEY, Mr. WHITEHOUSE, Mr. BLUMENTHAL, Mr. HEINRICH, Mr. UDALL of New Mexico, Mr. SCHATZ, Ms. BALDWIN, Mr. WYDEN, Mr. LEAHY, Mr. BROWN, Ms. HEITKAMP, Ms. LANDRIEU, Mr. BOOKER, Mr. DURBIN, Mr. SCHUMER, and Ms. HIRONO):

S. 2422. A bill to improve the access of veterans to medical services from the Department of Veterans Affairs, and for other purposes; read the first time.

Mr. SANDERS. Mr. President, as chairman of the Senate Committee on Veterans' Affairs, I rise today to introduce the Ensuring Veterans Access to Care Act of 2014.

I thank the 16 cosponsors of this legislation, and they are Senators ROCKEFELLER, BEGICH, SHAHEEN, KAINE, REED, MERKLEY, CASEY, WHITEHOUSE, BLUMENTHAL, HEINRICH, UDALL of New Mexico, SCHATZ, BALDWIN, WYDEN, HIRONO, and LEAHY.

It is safe to say there is broad bipartisan agreement among all of us that every veteran in this country who enters the VA health care system deserves high-quality care and deserves that care in a timely manner.

Overall, talking to veterans in Vermont and, in fact, throughout this country, talking to the veterans service organizations who represent their interests and reading independent studies, they all confirm that by and large, once veterans get into the VA health care system, the system is, in fact, quite good.

However, it has become clear—and I think all of us are aware of what has happened in the last month—that while quality is generally good, there are too many veterans throughout this country waiting too long to access this care.

In recent years, the VA has seen a huge increase in its patient load.

In fact, in the last 4 years, 2 million new veterans have come into the system, many of them with very complicated health care cases, including TBI, post-traumatic stress disorder, and many of the needs that older veterans and older people generally have.

Despite this fact, it is still absolutely unacceptable that some veterans are forced onto long waiting lists for care, and it is totally intolerable—it is reprehensible—that any VA employee could be manipulating data in Phoenix or anyplace else to hide how long veterans have been on waiting lists to see doctors. This is an issue that must be dealt with and must be dealt with rapidly and strongly.

These problems are real, and they have to be addressed. But they should not be an excuse to walk away from a system that serves 6.5 million veterans every single year and 230,000 veterans every single day. This is a system we must fix, not a system that we should ditch.

We must focus on the underlying problems and work to transform the VA.

In general, what our legislation does is it works in three basic areas. No. 1, we give greater authority to the Secretary to fire incompetent senior officials. No. 2, we take very significant steps to shorten the wait times that many veterans are now experiencing. And No. 3, we address the long-term health care needs of the VA in terms of a shortage of staff, doctors, and nurses that currently exists in various locations around the country.

Let me go through some of those issues right now.

Several weeks ago my Republican colleague from Florida requested a vote on legislation that would allow VA Secretaries to immediately remove senior executives due to poor performance.

So let us be clear. I strongly support the effort to make sure that we get rid of incompetent or worse senior executives at the VA. There is no debate about that. But here is what the debate is about. I do not think it is a good idea to give the Secretary of an institution, of an agency that has some 300,000 employees, the ability to simply fire without any due process.

What I worry about is that you can move toward a situation where the VA health care system is politicized in a way that it should not be.

Let me give an example. A new President comes in with a new Secretary. The new Secretary says—whether it is a Democratic President or a Republican President—I want to get rid of 300 senior-level appointees and bring in 300 new people. Four years later, another President comes in—different party—and says: We are going to get rid of those 300 people and bring in 300 more people.

I do not think that provides the kind of stability that the largest integrated

health care system in America needs or deserves. I worry about the politicization.

Second, I worry about an instance where a whistleblower stands up who is critical of this or that aspect of the VA. That person could be fired without due process.

I worry there may be a situation where somebody is fired—not because of bad performance; maybe they are a woman and somebody doesn't like a woman in that position; maybe they are gay, maybe they are black, maybe they are whatever—and that person does not have any ability to appeal that decision.

I think that is wrong. I think that is bad policy. On the other hand, what I do believe is that person should be taken out of his or her job immediately, but that person must have the right to have an expedited appeal.

What our legislation does is give the person a week to bring forth the appeal and gives the appropriate appeal body 3 weeks to make a decision.

Now, we are dealing with people who are M.D.s, Ph.D.s, high-level people whose professionalism is on the line. I don't think you can fire people willy-nilly without giving them a chance in an expedited manner to express their point of view.

That is one difference I have with my colleague from Florida on his proposal.

Let me talk a little bit about the major concern I have; that is, how do we shorten wait times? How do we make certain in those areas of the country where there are long waiting periods or where veterans may be geographically a long distance away from a facility that they get timely care?

The legislation that I have authored takes immediate action to provide timely access for care for our veterans. First, this legislation would standardize VA's process for providing non-VA care when the Department is unable to provide care to the veterans within its stated goal. As the DVA—Disabled American Veterans—pointed out in a release today, VA must continue to be responsible for coordinating their care amongst various VA and non-VA providers. This legislation accomplishes that goal by providing a framework for consistent decision-making regarding non-VA care. Under this legislation VA would coordinate non-VA care by taking into account wait times for care, the health of the veteran, the distance the veteran would be required to travel, as well as the veteran's choice.

This bill also addresses VA system-wide health care provider shortages. But in terms of the wait lists, what we say in English is: If there is an unacceptable wait time or if a veteran is a long distance away from a provider, we are going to allow—and we must allow—that veteran to get health care through a private provider, through a federally qualified community health center, through a Department of Defense military base, if that is available, through an Indian health service, if that is available—and that exists now in Alaska—and that might be expanded. So the bottom line is if there are waiting lists beyond what is reasonable, the veterans in this country should be able to get into non-VA health care in a timely manner, and this bill does that.

But importantly, this bill also addresses a very significant issue that I think we cannot ignore, and that is it appears to me that in many parts of this country we simply don't have the doctors and nurses we need when an influx of veterans is coming into the system.

I was talking to some very knowledgeable people today who were telling me about burnout. Primary care physicians and psychiatrists are seeing many more patients and turnover rates are much too high. The last thing we want to do is to see rapid turnover because people are burnt out and don't have the time to do the quality work they want to do.

Let me quote an article that appears in the New York Times on May 29 which addresses this issue. This is what it says:

> Dr. Phyllis Hollenbeck, a primary care physician, took a job at the Veterans Affairs medical center in Jackson, Miss., in 2008 expecting fulfilling work and a lighter patient load than she had in private practice. What she found was quite different: 13-hour workdays fueled by large patient loads that kept growing as colleagues quit and were not replaced.
>
> Appalled by what she saw, Dr. Hollenbeck filed a whistle-blower complaint and changed jobs. A subsequent investigation by the Department of Veterans Affairs concluded last fall that indeed the Jackson hospital did not have enough primary care doctors, resulting in nurse practitioners' handling far too many complex cases and in numerous complaints from veterans about the delayed care. ''It was unethical to put us in that position,'' Dr. Hollenbeck said of the overstressed primary care unit in Jackson. ''Your heart gets broken.''

In this case we had a physician who wanted to do the right thing, wanted to spend the appropriate amounts of time that were needed with the patients, and she was unable to do that. What we are hearing is in many parts of this country primary care physicians are saying: We cannot do it; too many people are coming in. This is an issue that has to be addressed, and our legislation does that.

Our legislation gives the VA the ability to rapidly hire new doctors, nurses, and other health care providers in areas with identified shortages. It also enables VA's ability to recruit qualified health providers by enhancing scholarship and loan repayment opportunities.

As the Presiding Officer well knows as a member of the committee that deals with this issue, we have a crisis in this country in terms of the lack of primary care practitioners. This is a very serious problem. There are experts who tell us, in fact, that we need 50,000 new primary care physicians in the next 10 to 15 years. This is a national problem, it is a problem within the VA, and what this legislation proposes is that the VA work with the National Health Service Corps in order to provide debt forgiveness, scholarships to medical school students, so when they graduate they can get into the VA and practice the quality medicine we need there.

This bill addresses another issue that has been discussed a lot—and there is widespread bipartisan support for this and support in the House as well—and that is the authorization of 27 major medical facility leases. In many instances these leases would improve access to care closer to home and would increase the availability of specialty care services in those locations that would allow the VA to decompress overutilized VA facilities. This is an important issue in this legislation and I believe there is bipartisan support for it.

Furthermore, this bill would require the President to create a commission to look at VA health care access issues and recommend action to bolster capacity. In the last couple of days I have heard a lot of good ideas about how we can deal with the issue, but we need a high-level commission of some of the most knowledgeable people in this country appointed by the President to report within 90 days some ideas of how the VA can proceed.

I want to thank the 16 or so cosponsors we have. I look forward to working with my Republican colleagues. We have got a problem we have to address, and I hope we can do it in a bipartisan way.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2422

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Ensuring Veterans Access to Care Act of 2014''.

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

TITLE I—IMPROVEMENT OF SCHEDULING SYSTEM FOR HEALTH CARE APPOINTMENTS

SEC. 101. IMPLEMENTATION OF UPGRADED DEPARTMENT OF VETERANS AFFAIRS ELECTRONIC SCHEDULING SYSTEM FOR APPOINTMENTS FOR RECEIPT OF HEALTH CARE FROM THE DEPARTMENT.

(a) IMPLEMENTATION.—

(1) IN GENERAL.—Not later than March 31, 2016, the Secretary of Veterans Affairs shall fully implement an upgraded and centralized electronic scheduling system described in subsection (b) for appointments by eligible individuals for health care from the Department of Veterans Affairs.

(2) AGILE SOFTWARE DEVELOPMENT METHODOLOGIES.—In implementing the upgraded electronic scheduling system required by paragraph (1), the Secretary shall use agile software development methodologies to fully implement portions of such system every 180 days beginning on the date on which the Secretary begins the implementation of such system, or enters into a contract for the implementation of such system, and ending on the date on which such system is fully implemented.

(b) ELECTRONIC SCHEDULING SYSTEM.—The upgraded electronic scheduling system described in this subsection shall include mechanisms to achieve the following:

(1) An efficient and effective graphical user interface with a calendar view for use by employees of the Department in scheduling appointments that enables error-free scheduling of the health care resources of the Department.

(2) A capability to assist employees of the Department to easily and consistently implement policies of the Department with respect to scheduling of appointments, including with respect to priority for appointments for certain eligible individuals.

(3) A capability for employees of the Department to sort and view through a unified interface the availability for each health care provider of the Department or other health care resource of the Department.

(4) A capability for employees of the Department to sort and view appointments for and appointment requests made by a particular eligible individual.

(5) A capability for seamless coordination of appointments for primary care, specialty care, consultations, or any other health care matter among facilities of the Department.

(6) A capability for eligible individuals to access the system remotely and schedule appointments directly through the system.

(7) An electronic timestamp of each activity made by an eligible individual or on behalf of such individual with respect to an appointment or the scheduling of an appointment that shall be kept in the medical record of such individual.

(8) A seamless connection to the Computerized Patient Record System of the Department so that employees of the Department, when scheduling an appointment for an eligible individual, have access to recommendations from the health care provider of such individual with respect to when such individual should receive an appointment.

(9) A capability to provide automated reminders to eligible individuals on upcoming appointments through various electronic and voice media.

(10) A capability to provide automated reminders to employees of the Department when an eligible individual who is on the wait-list for an appointment becomes eligible to schedule an appointment.

(11) A dashboard capability to support efforts to track the following metrics in aggregate and by medical facility with respect to health care provided to eligible individuals under the laws administered by the Secretary:

(A) The number of days into the future that the schedules of health care providers are available to schedule an appointment.

(B) The number of providers available to see patients each day.

(C) The number of support personnel working each day.

(D) The types of appointments available.

(E) The rate at which patients fail to appear for appointments.

(F) The number of appointments canceled by a patient on a daily basis.

(G) The number of appointments canceled by a health care provider on a daily basis.

(H) The number of patients on the wait list at any given time.

(I) The number of appointments scheduled on a daily basis;

(J) The number of appointments available to be scheduled on a daily basis.

(K) The number of patients seen on a daily, weekly, and monthly basis.

(L) Wait-times for an appointment with a health care provider of the Department.

(M) Wait-times for an appointment with a non-Department health care provider.

(N) Wait-times for a referral to a specialist or consult.

(12) A capability to provide data on the capacity of medical facilities of the Department for purposes of determining the resources needed by the Department to provide health care to eligible individuals.

(13) Any other capabilities as specified by the Secretary for purposes of this section.

(c) PLAN.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, 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 plan for implementing the upgraded electronic scheduling system required by subsection (a).

(2) ELEMENTS.—The plan required by paragraph (1) shall include the following:

(A) A description of the priorities of the Secretary for implementing the requirements of the system under subsection (b).

(B) A detailed description of the manner in which the Secretary will fully implement such system, including deadlines for completing each such requirement.

(3) UPDATE.—Not later than 90 days after the submittal of the plan required by paragraph (1), and not less frequently than every 90 days thereafter until such system is fully implemented, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives an update on the status of the implementation of such plan.

(d) USE OF AMOUNTS.—The Secretary may use amounts available to the Department of Veterans Affairs for the appropriations account under the heading ''MEDICAL SERVICES'' in implementing and carrying out the upgraded electronic scheduling system required by subsection (a).

(e) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term ''eligible individual'' means an individual eligible for hospital, nursing home, domiciliary, medical care, or other health care under the laws administered by the Secretary of Veterans Affairs.

SEC. 102. INDEPENDENT ASSESSMENT OF THE SCHEDULING PROCESS FOR MEDICAL APPOINTMENTS FOR CARE FROM DEPARTMENT OF VETERANS AFFAIRS.

(a) INDEPENDENT ASSESSMENT.—

(1) CONTRACT.—Not later than 30 days after the date of the enactment of this Act, the Secretary of Veteran Affairs shall enter into a contract with an independent third party to assess the process at each medical facility of the Department of Veterans Affairs for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(2) ELEMENTS.—In carrying out the assessment required by paragraph (1), the independent third party shall do the following:

(A) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(B) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(C) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(D) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(E) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(F) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(G) Recommend any actions to be taken by the Department to improve the process for scheduling such appointments, including the following:

(i) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(ii) Changes in monitoring and assessment conducted by the Department of wait-times of veterans for such appointments.

(iii) Changes in the system used to schedule such appointments, including changes to improve how the Department—

(I) measures wait-times of veterans for such appointments;

(II) monitors the availability of health care providers of the Department; and

(III) provides veterans the ability to schedule such appointments.

(iv) Such other actions as the independent third party considers appropriate.

(3) TIMING.—The independent third party carrying out the assessment required by paragraph (1) shall complete such assessment not later than 180 days after entering into the contract described in such paragraph.

(b) REPORT.—Not later than 90 days after the date on which the independent third party completes the assessment under this section, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the results of such assessment.

TITLE II—TRAINING AND HIRING OF HEALTH CARE STAFF

SEC. 201. MODIFICATION OF LIABILITY FOR BREACH OF PERIOD OF OBLIGATED SERVICE UNDER HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM FOR PRIMARY CARE PHYSICIANS.

Section 7617 of title 38, United States Code, is amended—

(1) In subsection (c)(1), by striking ''If a participant'' and inserting ''Except as provided in subsection (d), if a participant''; and

(2) by adding at the end the following new subsection:

''(d) Liability shall not arise under subsection (c) in the case of a participant otherwise covered by that subsection who has pursued a course of education or training in primary care if—

''(1) the participant—

''(A) does not obtain, or fails to maintain, employment as a Department employee due to staffing changes approved by the Under Secretary for Health; or

''(B) does not obtain, or fails to maintain, employment in a position of primary care physician in the Veterans Health Administration due, as determined by the Secretary, to a number of primary care physicians in the Administration that is excess to the needs of the Administration; and

''(2) the participant agrees to accept and maintain employment as a primary care physician with another department or agency of the Federal Government (with such employment to be under such terms and conditions as are jointly agreed upon by the participant, the Secretary, and the head of such department or agency, including terms and conditions relating to a period of obligated service as a primary care physician with such department or agency) if such employment is offered to the participant by the Secretary and the head of such department or agency.''.

SEC. 202. PROGRAM OF EDUCATION AT UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES WITH SPECIALIZATION IN PRIMARY CARE.

(a) PROGRAM REQUIRED UNDER HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM.—

(1) IN GENERAL.—Chapter 76 of title 38, United States Code, is amended by adding after subchapter VII the following new subchapter:

''SUBCHAPTER VIII—PROGRAM OF EDUCATION AT UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES WITH SPECIALIZATION IN PRIMARY CARE

''§ 7691. Authority for program

''As part of the Educational Assistance Program, the Secretary shall, in collaboration with the Secretary of Defense, carry out a program to permit individuals to enroll in the Uniformed Services University of the Health Sciences under chapter 104 of title 10 to pursue a medical education with a specialization in primary care. The program shall be known as the Department of Veterans Affairs Primary Care Educational Assistance Program (in this chapter referred to as the 'Primary Care Educational Assistance Program').

''§ 7692. Selection; agreement; ineligibility for certain other educational assistance

''(a) SELECTION.—(1) Medical students at the Uniformed Services University of the Health Sciences pursuant to the Primary Care Educational Assistance Program shall be selected by the Secretary, in consultation with the Secretary of Defense, in accordance with procedures established by the Secretaries for purposes of the Program.

''(2) The procedures referred to in paragraph (1) shall emphasize the basic requirement that students demonstrate a motivation and dedication to a medical career in primary care.

''(3) The number of medical students selected each year for first-year enrollment in the University pursuant to this subsection shall be jointly determined by the Secretary and the Secretary of Defense.

''(b) AGREEMENT.—An agreement between the Secretary and a participant in the Primary Care Educational Assistance Program shall (in addition to the requirements set forth in section 7604 of this title) include the following:

''(1) The Secretary's agreement to cover the costs of the participant's education and training at the Uniformed Services University of the Health Sciences under chapter 104 of title 10 as if the participant were a medical student enrolled in the University pursuant to section 2114 of title 10.

''(2) The participant's agreement to serve as a full-time employee in the Veterans Health Administration in a position as a primary care physician for a period of time (in this subchapter referred to as the 'period of obligated service') of one calendar year for each school year or part thereof for which the participant was a medical student at the Uniformed Services University of the Health Sciences pursuant to the Primary Care Educational Assistance Program, but for not less than one year.

''(c) INELIGIBILITY FOR OTHER EDUCATIONAL ASSISTANCE.—An individual who receives education and training under the Primary Care Educational Assistance Program shall not be eligible for other assistance under this chapter in connection with such education and training.

''§ 7693. Obligated service

''(a) IN GENERAL.—Each participant in the Primary Care Educational Assistance Program shall provide service as a full-time employee of the Department in the Veterans Health Administration in a primary care position for the period of obligated service provided in the agreement of the participant entered into for purposes of this subchapter. Such service shall be provided in a full-time primary care clinical practice in an assignment or location determined by the Secretary.

''(b) SERVICE COMMENCEMENT DATE.—(1) Not later than 60 days before a participant's service commencement date, the Secretary shall notify the participant of that service commencement date. That date is the date for the beginning of the participant's period of obligated service.

''(2) As soon as possible after a participant's service commencement date, the Secretary shall—

''(A) in the case of a participant who is not a full-time employee in the Veterans Health Administration, appoint the participant as such an employee; and

''(B) in the case of a participant who is an employee in the Veterans Health Administration but is not serving in a position for which the participant's course of education or training prepared the participant, assign the participant to such a position.

''(3) A participant's service commencement for purposes of this subsection date is the date upon which the participant becomes licensed to practice medicine in a State.

''(c) COMMENCEMENT OF OBLIGATED SERVICE.—A participant in the Primary Care Educational Assistance Program shall be considered to have begun serving the participant's period of obligated service—

''(1) on the date on which the participant is appointed as a full-time employee in the Veterans Health Administration pursuant to subsection (b)(2)(A); or

''(2) if the participant is a full-time employee in the Veterans Health Administration and assigned to a position pursuant to subsection (b)(2)(B), on the date on which the participant is so assigned to such position.

''§ 7694. Breach of agreement: liability

''(a) LIABILITY DURING COURSE OF EDUCATION OR TRAINING.—(1) A participant in the Primary Care Educational Assistance Program shall be liable to the United States for the amount which has been paid on behalf of the participant under the agreement entered into for purposes of this subchapter if any of the following occurs:

''(A) The participant fails to maintain an acceptable level of academic standing in the Uniformed Services University of the Health Sciences.

''(B) The participant is dismissed from the Uniformed Services University of the Health Sciences for disciplinary reasons.

''(C) The participant voluntarily terminates the course of medical education and training in the Uniformed Services University of the Health Sciences before the completion of such course of education and training.

''(D) The participant fails to become licensed to practice medicine in a State during a period of time determined under regulations prescribed by the Secretary.

''(2) Liability under this subsection is in lieu of any service obligation arising under a participant's agreement for purposes of this subchapter.

''(b) LIABILITY DURING PERIOD OF OBLIGATED SERVICE.—(1) Except as provided in subsection (c) and subject to paragraph (2), if

a participant in the Primary Care Educational Assistance Program breaches the agreement entered into for purposes of this subchapter by failing for any reason to complete the participant's period of obligated service, the United States shall be entitled to recover from the participant an amount equal to—

''(A) the total amount paid under this subchapter on behalf of the participant; multiplied by

''(B) a fraction—

''(i) the numerator of which is—

''(I) the total number of months in the participant's period of obligated service; minus

''(II) the number of months served by the participant pursuant to the agreement; and

''(ii) the denominator of which is the total number of months in the participant's period of obligated service.

''(2) Any period of internship or residency training of a participant shall not be treated as satisfying the participant's period of obligated service for purposes of this subsection.

''(c) EXCEPTIONS.—Liability shall not arise under subsection (b) in the case of a participant otherwise covered by that subsection if—

''(1) the participant—

''(A) does not obtain, or fails to maintain, employment as a Department employee due to staffing changes approved by the Under Secretary for Health; or

''(B) does not obtain, or fails to maintain, employment in a position of primary care physician in the Veterans Health Administration due, as determined by the Secretary, to a number of primary care physicians in the Administration that is excess to the needs of the Administration; and

''(2) the participant agrees to accept and maintain employment as a primary care physician with another department or agency of the Federal Government (with such employment to be under such terms and conditions as are jointly agreed upon by the participant, the Secretary, and the head of such department or agency, including terms and conditions relating to a period of obligated service as a primary care physician with such department or agency) if such employment is offered to the participant by the Secretary and the head of such department or agency.

''§ 7695. Funding

''(a) IN GENERAL.—Amounts for the Primary Care Educational Assistance Program shall be derived from amounts available to the Secretary for the Veterans Health Administration.

''(b) TRANSFER.—(1) The Secretary shall transfer to the Secretary of Defense amounts required by the Secretary of Defense to carry out the Primary Care Educational Assistance Program.

''(2) Amounts transferred to the Secretary of Defense pursuant to paragraph (1) shall be credited to the appropriation or account providing funding for the Uniformed Services University of the Health Sciences. Amounts so credited shall be merged with amounts in the appropriation or account to which credited and shall be available, subject to the terms and conditions applicable to such appropriation or account, for the Uniformed Services University of the Health Sciences.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 76 of such title is amended by adding after the item relating to section 7684 the following:

''SUBCHAPTER VIII—PROGRAM OF EDUCATION AT UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES WITH SPECIALIZATION IN PRIMARY CARE

''7691. Authority for program.

''7692. Selection; agreement; ineligibility for certain other educational assistance.

''7693. Obligated service.

''7694. Breach of agreement: liability.

''7695. Funding.''.

(b) INCLUSION OF PROGRAM IN HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM.—Section 7601(a) of such title is amended—

(1) in paragraph (4), by striking ''; and'' and inserting a semicolon;

(2) in paragraph (5), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(6) the enrollment of individuals in the Uniformed Services University of the Health Sciences for specialization in primary care provided for in subchapter VIII of this chapter.''.

(c) APPLICATION REQUIREMENTS.—

(1) IN GENERAL.—Subsection (a)(1) of section 7603 of such title is amended in the matter preceding subparagraph (A) by striking '', or VI'' and inserting '', VI, or VIII''.

(2) NO PRIORITY FOR APPLICATIONS.—Subsection (d) of such section is amended—

(A) by striking ''In selecting'' and inserting ''(1) Except as provided in paragraph (2), in selecting''; and

(B) by adding at the end the following new paragraph:

''(2) Paragraph (1) shall not apply with respect to applicants for participation in the Program of Education at Uniformed Services University of the Health Sciences With Specialization in Primary Care pursuant to subchapter VIII of this chapter.''.

(d) AGREEMENT REQUIREMENTS.—Section 7604 of such title is amended by striking '', or VI'' each place it appears and inserting '', VI, or VIII''.

SEC. 203. TREATMENT OF STAFFING SHORTAGE AND BIANNUAL REPORT ON STAFFING OF MEDICAL FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) STAFFING SHORTAGE.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, and not later than September 30 each year thereafter, the Secretary of Veterans Affairs shall determine, and publish in the Federal Register, the five occupations of health care providers of the Department of Veterans Affairs for which there is the largest staffing shortage throughout the Department.

(2) RECRUITMENT AND APPOINTMENT.—Notwithstanding sections 3304 and 3309 through 3318 of title 5, United States Code, the Secretary may, upon a determination by the Secretary under paragraph (1) or a modification to such determination under paragraph (2), that there is a staffing shortage throughout the Department with respect to a particular occupation of health care provider, recruit and directly appoint highly qualified health care providers to a position to serve as a health care provider in that particular occupation for the Department.

(3) PRIORITY IN HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM TO CERTAIN PROVIDERS.—Section 7612(b)(5) of title 38, United States Code, is amended—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) by redesignating subparagraph (B) as subparagraph (C); and

(C) by inserting after subparagraph (A) the following new subparagraph (B):

''(B) shall give priority to applicants pursuing a course of education or training towards a career in an occupation for which the Secretary has, in the most current determination published in the Federal Register pursuant to section 203(a)(1) of the Ensuring Veterans Access to Care Act of 2014, determined that there is one of the largest staffing shortage throughout the Department with respect to such occupation; and''.

(b) REPORTS.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, and not later than December 31 of each even numbered year thereafter until 2024, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report assessing the staffing of each medical facility of the Department of Veterans Affairs.

(2) ELEMENTS.—Each report submitted under paragraph (1) shall include the following:

(A) The results of a system-wide assessment of all medical facilities of the Department to ensure the following:

(i) Appropriate staffing levels for health care providers to meet the goals of the Secretary for timely access to care for veterans.

(ii) Appropriate staffing levels for support personnel, including clerks.

(iii) Appropriate sizes for clinical panels.

(iv) Appropriate numbers of full-time staff, or full-time equivalent, dedicated to direct care of patients.

(v) Appropriate physical plant space to meet the capacity needs of the Department in that area.

(vi) Such other factors as the Secretary considers necessary.

(B) A plan for addressing any issues identified in the assessment described in subparagraph (A), including a timeline for addressing such issues.

(C) A list of the current wait times and workload levels for the following clinics in each medical facility:

(i) Mental health.

(ii) Primary care.

(iii) Gastroenterology.

(iv) Women's health.

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

(D) A description of the results of the determination of the Secretary under paragraph (1) of subsection (a) and a plan to use direct appointment authority under paragraph (2) of such subsection to fill staffing shortages, including recommendations for improving the speed at which the credentialing and privileging process can be conducted.

(E) The current staffing models of the Department for the following clinics, including recommendations for changes to such models:

(i) Mental health.

(ii) Primary care.

(iii) Gastroenterology.

(iv) Women's health.

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

(F) A detailed analysis of succession planning at medical facilities of the Department, including the following:

(i) The number of positions in medical facilities throughout the Department that are not filled by a permanent employee.

(ii) The length of time each such position described in clause (i) remained vacant or filled by a temporary or acting employee.

(iii) A description of any barriers to filling the positions described in clause (i).

(iv) A plan for filling any positions that are vacant or filled by a temporary or acting employee for more than 180 days.

(v) A plan for handling emergency circumstances, such administrative leave or sudden medical leave for senior officials.

(G) The number of health care providers who have been removed from their position or have retired, by provider type, during the two-year period preceding the submittal of the report.

(H) Of the health care providers specified in subparagraph (G) that have been removed from their position, the following:

(i) The number of such health care providers who were reassigned to another position in the Department.

(ii) The number of such health care providers who left the Department.

SEC. 204. CLINIC MANAGEMENT TRAINING PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall implement a clinic management training program to provide in-person, standardized education on health care management to all managers of, and health care providers at, medical facilities of the Department of Veterans Affairs.

(b) ELEMENTS.—The clinic management training program required by subsection (a) shall include the following:

(1) Training on how to manage the schedules of health care providers of the Department, including the following:

(A) Maintaining such schedules in a manner that allows appointments to be booked at least eight weeks in advance.

(B) Proper planning procedures for vacation, leave, and graduate medical education training schedules.

(2) Training on the appropriate number of appointments that a health care provider should conduct on a daily basis, based on specialty.

(3) Training on how to determine whether there are enough available appointment slots to manage demand for different appointment types and mechanisms for alerting management of insufficient slots.

(4) Training on how to properly use the data produced by the scheduling dashboard required by section 101(b)(11) of this Act to meet demand for health care, including the following:

(A) Training on determining the next available appointment for each health care provider at the medical facility.

(B) Training on determining the number of health care providers needed to meet demand for health care at the medical facility.

(C) Training on determining the number of exam rooms needed to meet demand for such health care in an efficient manner.

(5) Training on how to properly use the appointment scheduling system of the Department, including any new scheduling system implemented by the Department.

(6) Training on how to optimize the use of technology, including the following:

(A) Telemedicine.

(B) Electronic mail.

(C) Text messaging.

(D) Such other technologies as specified by the Secretary.

(7) Training on how to properly use physical plant space at medical facilities of the Department to ensure efficient flow and privacy for patients and staff.

SEC. 205. INCLUSION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES IN NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall use the funds transferred under subsection (e) to award scholarship and loan repayment contracts under sections 338A and 338B of the Public Health Service Act (42 U.S.C. 2541, 2541–1) to eligible individuals who agree to a period of obligated service under section 338A(f)(1) or 338B(f)(1) of such Act, as applicable, at a health facility of the Department of Veterans Affairs.

(b) HEALTH PROFESSIONAL SHORTAGE AREAS.—For purposes of selecting individuals eligible for the scholarships and loan repayment contracts under subsection (a), all health facilities of the Department of Veterans Affairs shall be deemed health professional shortage areas, as defined in section 332 of the Public Health Service Act (42 U.S.C. 254e).

(c) REQUIREMENT.—The Secretary of Health and Human Services shall ensure that a minimum of 5 scholarships or loan repayment contracts are awarded to individuals who agree to a period of obligated service at Veterans Affairs facilities in each State.

(d) APPLICABILITY OF NHSC PROGRAM REQUIREMENTS.—Except as otherwise provided in this section, the terms of the National Health Service Corps Scholarship Program and the National Health Service Corps Loan Repayment Program shall apply to participants awarded a grant or loan repayment contract under subsection (a) in the same manner that such terms apply to participants awarded a grant or loan repayment contract under section 338A or 338B of the Public Health Service Act.

(e) INCLUSION OF GERIATRICIANS.—For purposes of awarding scholarships and loan repayments contracts to eligible individuals who agree to a period of obligated service at a health facility of the Department of Veterans Affairs pursuant to this section, in sections 338A and 338B of the Public Health Service Act (42 U.S.C. 2541, 2541–1), the term ''primary health services'' shall include geriatrics.

(f) FUNDING.—The Secretary of Veterans Affairs shall transfer $20,000,000 for fiscal year 2014, and such sums as may be necessary for each fiscal year thereafter, from accounts of the Veterans Health Administration to the Secretary of Health and Human Services to award scholarships and loan repayment contracts, as described in subsection (a). All funds so transferred shall be used exclusively for the purposes described in such subsection.

SEC. 206. AUTHORIZATION OF EMERGENCY APPROPRIATIONS.

There is authorized to be appropriated for the Department of Veterans Affairs such sums as may be necessary to carry out this title.

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

SEC. 301. IMPROVEMENT OF ACCESS BY VETERANS TO HEALTH CARE FROM NON-DEPARTMENT OF VETERANS AFFAIRS PROVIDERS.

(a) IMPROVEMENT OF ACCESS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall ensure timely access of all veterans to the hospital care, medical services, and other health care for which such veterans are eligible under the laws administered by the Secretary through the enhanced use of authorities specified in paragraph (2) on the provision of such care and services through non-Department of Veterans Affairs providers (commonly referred to as ''non-Department of Veterans Affairs medical care'').

(2) AUTHORITIES ON PROVISION OF CARE THROUGH NON-DEPARTMENT PROVIDERS.—The authorities specified in this paragraph are the following:

(A) Section 1703 of title 38, United States Code, relating to contracts for the provision of hospital care and medical services through non-Department facilities.

(B) Section 1725 of such title, relating to reimbursement of certain veterans for the reasonable value of emergency treatment at non-Department facilities.

(C) Section 1728 of such title, relating to reimbursement of certain veterans for customary and usual charges of emergency treatment from sources other than the Department.

(D) Section 1786 of such title, relating to health care services furnished to newborn children of women veterans who are receiving maternity care furnished by the Department at a non-Department facility.

(E) Any other authority under the laws administered by the Secretary to provide hospital care, medical services, or other health care from a non-Department provider, including the following:

(i) 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))).

(ii) The Department of Defense.

(iii) The Indian Health Service.

(3) REQUIREMENTS.—In ensuring timely access of all veterans to the care and services described in paragraph (1) through the enhanced use of authorities specified in paragraph (2), the Secretary shall require the following:

(A) That each veteran who has not received hospital care, medical services, or other health care from the Department and is seeking an appointment for primary care under the laws administered by the Secretary receive an appointment for primary care at a time consistent with timeliness measures established by the Secretary for purposes of providing primary care to all veterans.

(B) That the determination whether to refer a veteran for specialty care through a non-Department provider shall take into account the urgency and acuity of such veteran's need for such care, including—

(i) the severity of the condition of such veteran requiring specialty care; and

(ii) the wait-time for an appointment with a specialist with respect to such condition at the nearest medical facility of the Department with the capacity to provide such care.

(C) That the determination whether a veteran shall receive hospital care, medical services, or other health care from the Department through facilities of the Department or through non-Department providers pursuant to the authorities specified in paragraph (2) shall take into account, in the manner specified by the Secretary, the following:

(i) The distance the veteran would be required to travel to receive care or services through a non-Department provider compared to the distance the veteran would be required to travel to receive care or services from a medical facility of the Department.

(ii) Any factors that might limit the ability of the veteran to travel, including age, access to transportation, and infirmity.

(iii) The wait-time for the provision of care or services through a non-Department provider compared to the wait-time for the provision of care or services from a medical facility of the Department.

(iv) Where the veteran would prefer to receive the care and services described in paragraph (1), unless the preference of the veteran conflicts with any of the other requirements of this paragraph.

(D) That the Department maximize the use of hospital care, medical services, and other health care available to the Department through non-Department providers, including providers available to provide such care and services as follows:

(i) Pursuant to contracts under the Patient-Centered Community Care Program of the Department.

(ii) Pursuant to contracts between a facility or facilities of the Department and a local facility or provider.

(iii) Pursuant to contracts with Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B))), the Department of Defense, or the Indian Health Service.

(iv) On a fee-for-service basis.

(b) MEDICAL RECORDS.—In providing hospital care, medical services, and other health care to veterans through non-Department providers pursuant to the authorities specified in paragraph (2), the Secretary shall ensure that any such provider submits to the Department any medical record related to the care and services provided to a veteran by that provider for inclusion in the electronic medical record of such veteran maintained by the Department upon the completion of the provision of such care and services to such veteran.

(c) REPORTS.—

(1) INITIAL REPORT.—Not later than 45 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the implementation of the requirements under subsection (a) and (b), including a plan to enforce the proper implementation of such requirements systematically throughout the Department.

(2) PERIODIC REPORTS.—Not later than 90 days after the submittal of the report required by paragraph (1), and every 90 days thereafter for one year, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report that includes the following:

(A) The progress of the Secretary in carrying out the plan under paragraph (1) to enforce the proper implementation of the requirements under subsection (a) and (b) systematically throughout the Department.

(B) The impact of the implementation of such requirements on wait-times for veterans to receive hospital care, medical services, and other health care, disaggregated by—

(i) new patients;

(ii) existing patients;

(iii) primary care; and

(iv) specialty care.

(C) Any recommendations for changes or improvements to such requirements.

(D) Any requests for additional funding necessary to carry out such requirements.

SEC. 302. EXTENSION OF AND REPORT ON JOINT INCENTIVES PROGRAM OF DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE.

(a) EXTENSION.—Section 8111(d)(3) of title 38, United States Code, is amended by striking ''September 30, 2015'' and inserting ''September 30, 2020''.

(b) REPORTS.—

(1) REPORT ON IMPLEMENTATION OF RECOMMENDATIONS.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall jointly submit to Congress a report on the implementation by the Department of Veterans Affairs and the Department of Defense of the findings and recommendations of the Comptroller General of the United States in the September 2012 report entitled ''VA and DoD Health Care: Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities'' (GAO–12–992).

(2) COMPTROLLER GENERAL REPORT.—

(A) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report assessing and providing recommendations for improvement to the program to identify, provide incentives to, implement, fund, and evaluate creative coordination and sharing initiatives between the Department of Veterans Affairs and the Department of Defense required under section 8111(d) of such title.

(B) ELEMENTS.—The report required by subparagraph (A) shall include the following:

(i) An assessment of the extent to which the program described in subparagraph (A) has accomplished the goal of such program to improve the access to, and quality and cost effectiveness of, the health care provided by the Veterans Health Administration and the Military Health System to the beneficiaries of both the Department of Veterans Affairs and the Department of Defense.

(ii) An assessment of whether administration of such program through the Health Executive Committee of the Department of Veterans Affairs-Department of Defense Joint Executive Committee established under section 320 of such title provides sufficient leadership attention and oversight to ensure maximum benefits to the Department of Veterans Affairs and the Department of Defense through collaborative efforts.

(iii) An assessment of whether additional authorities to jointly construct, lease, or acquire facilities would facilitate additional collaborative efforts under such program.

(iv) An assessment of whether the funding for such program is sufficient to ensure consistent identification of potential opportunities for collaboration and oversight of existing collaborations to ensure a meaningful partnership between the Department of Veterans Affairs and the Department of Defense and remove any barriers to integration or collaboration.

(v) An assessment of whether existing processes for identifying opportunities for collaboration are sufficient to ensure maximum collaboration between the Veterans Health Administration and the Military Health System.

(vi) Such legislative or administrative recommendations for improvement to such program as the Comptroller General considers appropriate to enhance the use of such program to increase access to health care.

SEC. 303. TRANSFER OF AUTHORITY FOR PAYMENTS FOR HOSPITAL CARE, MEDICAL SERVICES, AND OTHER HEALTH CARE FROM NON-DEPARTMENT PROVIDERS TO THE CHIEF BUSINESS OFFICE OF THE VETERANS HEALTH ADMINISTRATION OF THE DEPARTMENT.

(a) TRANSFER OF AUTHORITY.—

(1) IN GENERAL.—Effective on October 1, 2014, the Secretary of Veterans Affairs shall transfer the authority to pay for hospital care, medical services, and other health care through non-Department providers to the Chief Business Office of the Veterans Health Administration of the Department of Veterans Affairs from the Veterans Integrated Service Networks and medical centers of the Department of Veterans Affairs.

(2) MANNER OF CARE.—The Chief Business Office shall work in consultation with the Office of Clinical Operations and Management of the Department of Veterans Affairs to ensure that care and services described in paragraph (1) is provided in a manner that is clinically appropriate and effective.

(3) NO DELAY IN PAYMENT.—The transfer of authority under paragraph (1) shall be carried out in a manner that does not delay or impede any payment by the Department for hospital care, medical services, or other health care provided through a non-Department provider under the laws administered by the Secretary.

(b) BUDGETARY EFFECT.—The Secretary shall, for each fiscal year that begins after the date of the enactment of this Act—

(1) include in the budget for the Chief Business Office of the Veterans Health Administration amounts to pay for hospital care, medical services, and other health care provided through non-Department providers, including any amounts necessary to carry out the transfer of authority to pay for such care and services under subsection (a), including any increase in staff; and

(2) not include in the budget of each Veterans Integrated Service Network and medical center of the Department amounts to pay for such care and services.

(c) REMOVAL FROM PERFORMANCE GOALS.—For each fiscal year that begins after the date of the enactment of this Act, the Secretary shall not include in the performance goals of any employee of a Veterans Integrated Service Network or medical center of the Department any performance goal that might disincentivize the payment of Department amounts to provide hospital care, medical services, or other health care through a non-Department provider.

SEC. 304. ENHANCEMENT OF COLLABORATION BETWEEN DEPARTMENT OF VETERANS AFFAIRS AND INDIAN HEALTH SERVICE.

(a) OUTREACH TO TRIBAL-RUN MEDICAL FACILITIES.—The Secretary of Veterans Affairs shall, in consultation with the Director of the Indian Health Service, conduct outreach to each medical facility operated by an Indian tribe or tribal organization through a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to raise awareness of the ability of such facilities, Indian tribes, and tribal organizations to enter into agreements with the Department of Veterans Affairs under which the Secretary reimburses such facilities, Indian tribes, or tribal organizations, as the case may be, for health care provided to veterans eligible for health care at such facilities.

(b) METRICS FOR MEMORANDUM OF UNDERSTANDING PERFORMANCE.—The Secretary of Veterans Affairs shall implement performance metrics for assessing the performance by the Department of Veterans Affairs and the Indian Health Service under the memorandum of understanding entitled ''Memorandum of Understanding between the Department of Veterans Affairs (VA) and the Indian Health Service (IHS)'' in increasing access to health care, improving quality and coordination of health care, promoting effective patient-centered collaboration and partnerships between the Department and the Service, and ensuring health-promotion and disease-prevention services are appropriately funded and available for beneficiaries under both health care systems.

(c) REPORT.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Director of the Indian Health Service shall jointly submit to Congress a report on the feasibility and advisability of the following:

(1) Entering into agreements for the reimbursement by the Secretary of the costs of direct care services provided through organizations receiving amounts pursuant to grants made or contracts entered into under section 503 of the Indian Health Care Improvement Act (25 U.S.C. 1653) to veterans who are otherwise eligible to receive health care from such organizations.

(2) Including the reimbursement of the costs of direct care services provided to veterans who are not Indians in agreements between the Department and the following:

(A) The Indian Health Service.

(B) An Indian tribe or tribal organization operating a medical facility through a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(C) A medical facility of the Indian Health Service.

(d) DEFINITIONS.—In this section:

(1) INDIAN.—The terms ''Indian'' and ''Indian tribe'' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(2) MEDICAL FACILITY OF THE INDIAN HEALTH SERVICE.—The term ''medical facility of the Indian Health Service'' includes a facility operated by an Indian tribe or tribal organization through a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(3) TRIBAL ORGANIZATION.—The term ''tribal organization'' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

SEC. 305. ENHANCEMENT OF COLLABORATION BETWEEN DEPARTMENT OF VETERANS AFFAIRS AND NATIVE HAWAIIAN HEALTH CARE SYSTEMS.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall, in consultation with Papa Ola Lokahi and such other organizations involved in the delivery of health care to Native Hawaiians as the Secretary considers appropriate, enter into contracts or agreements with Native Hawaiian health care systems that are in receipt of funds from the Secretary of Health and Human Services pursuant to grants awarded or contracts entered into under section 6(a) of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11705(a)) for the reimbursement of direct care services provided to eligible veterans as specified in such contracts or agreements.

(b) DEFINITIONS.—In this section, the terms ''Native Hawaiian'', ''Native Hawaiian health care system'', and ''Papa Ola Lokahi'' have the meanings given those terms in section 12 of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11711).

SEC. 306. AUTHORIZATION OF EMERGENCY APPROPRIATIONS.

There is authorized to be appropriated for the Department of Veterans Affairs such sums as may be necessary to carry out this title.

TITLE IV—HEALTH CARE ADMINISTRATIVE MATTERS

SEC. 401. IMPROVEMENT OF ACCESS OF VETERANS TO MOBILE VET CENTERS OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) IMPROVEMENT OF ACCESS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall improve the access of veterans to telemedicine and other health care through the use of mobile vet centers of the Department of Veterans Affairs by providing standardized requirements for the operation of such centers.

(2) REQUIREMENTS.—The standardized requirements required by paragraph (1) shall include the following:

(A) The number of days each mobile vet center of the Department is expected to travel per year.

(B) The number of locations each center is expected to visit per year.

(C) The number of appointments each center is expected to conduct per year.

(D) The method and timing of notifications given by each center to individuals in the area to which such center is traveling, including notifications informing veterans of the availability to schedule appointments at the center.

(3) USE OF TELEMEDICINE.—The Secretary shall ensure that each mobile vet center of the Department has the capability to provide telemedicine services.

(b) REPORTS.—Not later than one year after the date of the enactment of this Act, and not later than September 30 each year thereafter, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the following:

(1) The use of mobile vet centers to provide telemedicine services to veterans during the year preceding the submittal of the report, including the following:

(A) The number of days each mobile vet center was open to provide such services.

(B) The number of days each mobile vet center traveled to a location other than the headquarters of the mobile vet center to provide such services.

(C) The number of appointments each center conducted to provide such services on average per month and in total during such year.

(2) An analysis of the effectiveness of using mobile vet centers to provide health care services to veterans through the use of telemedicine.

(3) Any recommendations for an increase in the number of mobile vet centers of the Department.

(4) Any recommendations for an increase in the telemedicine capabilities of each mobile vet center.

(5) The feasibility and advisability of using temporary health care providers, including locum tenens, to provide direct health care services to veterans at mobile vet centers.

(6) Such other recommendations on improvement of the use of mobile vet centers by the Department as the Secretary considers appropriate.

SEC. 402. COMMISSION ON ACCESS TO CARE.

(a) ESTABLISHMENT OF COMMISSION.—

(1) IN GENERAL.—There is established the Commission on Access to Care (in this section referred to as the ''Commission'') to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the next 10 to 20 years.

(2) MEMBERSHIP.—

(A) VOTING MEMBERS.—The Commission shall be composed of 10 voting members who are appointed by the President as follows:

(i) At least two members who represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code.

(ii) At least one member from among persons who are experts concerning a public or private hospital system.

(iii) At least one member from among persons who are familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B))).

(iv) At least two members from among persons who are familiar with the Veterans Health Administration.

(B) NONVOTING MEMBERS.—In addition to members appointed under subparagraph (A), the Commission shall be composed of 10 nonvoting members who are appointed by the President as follows:

(i) At least two members who represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code.

(ii) At least one member from among persons who are experts in a public or private hospital system.

(iii) At least one member from among persons who are familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B))).

(iv) At least two members from among persons who are familiar with the Veterans Health Administration.

(C) DATE.—The appointments of members of the Commission shall be made not later than 60 days after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Commission. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING.—Not later than 15 days after the date on which seven voting members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS.—The Commission shall meet at the call of the Chairperson.

(6) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON.—The Commission shall select a Chairperson and Vice Chairperson from among its members.

(b) DUTIES OF COMMISSION.—

(1) EVALUATION AND ASSESSMENT.—The Commission shall undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.

(2) MATTERS EVALUATED AND ASSESSED.—The matters evaluated and assessed by the Commission shall include the following:

(A) The appropriateness of current standards of the Department of Veterans Affairs concerning access to health care.

(B) The measurement of such standards.

(C) The appropriateness of performance standards and incentives in relation to standards described in subparagraph (A).

(D) Staffing levels throughout the Veterans Health Administration and whether they are sufficient to meet current demand for health care from the Administration.

(3) REPORTS.—The Commission shall submit to the President, through the Secretary of Veterans Affairs, reports as follows:

(A) Not later than 90 days after the date of the initial meeting of the Commission, an interim report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(B) Not later than 180 days after the date of the initial meeting of the Commission, a final report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(c) POWERS OF THE COMMISSION.—

(1) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS.—

(1) COMPENSATION OF MEMBERS.—Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF.—

(A) IN GENERAL.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION.—The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF THE COMMISSION.—The Commission shall terminate 30 days after the date on which the Commission submits its report under subsection (b)(3)(B).

(f) FUNDING.—The Secretary of Veterans Affairs shall make available to the Commission from amounts appropriated or otherwise made available to the Secretary such amounts as the Secretary and the Chairperson of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) EXECUTIVE ACTION.—

(1) ACTION ON RECOMMENDATIONS.—The President shall require the Secretary of Veterans Affairs and such other heads of relevant Federal departments and agencies to implement each recommendation set forth in a report submitted under subsection (b)(3) that the President—

(A) considers feasible and advisable; and

(B) determines can be implemented without further legislative action.

(2) REPORTS.—Not later than 60 days after the date on which the President receives a report under subsection (b)(3), the President shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives and such other committees of Congress as the President considers appropriate a report setting forth the following:

(A) An assessment of the feasibility and advisability of each recommendation contained in the report received by the President.

(B) For each recommendation assessed as feasible and advisable under subparagraph (A) the following:

(i) Whether such recommendation requires legislative action.

(ii) If such recommendation requires legislative action, a recommendation concerning such legislative action.

(iii) A description of any administrative action already taken to carry out such recommendation.

(iv) A description of any administrative action the President intends to be taken to carry out such recommendation and by whom.

SEC. 403. COMMISSION ON CAPITAL PLANNING FOR DEPARTMENT OF VETERANS AFFAIRS MEDICAL FACILITIES.

(a) ESTABLISHMENT OF COMMISSION.—

(1) ESTABLISHMENT.—There is established the Commission on Capital Planning for Department of Veterans Affairs Medical Facilities (in this section referred to as the ''Commission'').

(2) MEMBERSHIP.—

(A) VOTING MEMBERS.—The Commission shall, subject to subparagraph (B), be composed of 10 voting members as follows:

(i) 1 shall be appointed by the President.

(ii) 1 shall be appointed by the Administrator of General Services.

(iii) 3 shall be appointed by the Secretary of Veterans Affairs, of whom—

(I) 1 shall be an employee of the Veterans Health Administration;

(II) 1 shall be an employee of the Office of Asset Enterprise Management of the Department of Veterans Affairs; and

(III) 1 shall be an employee of the Office of Construction and Facilities Management of the Department of Veterans Affairs.

(iv) 1 shall be appointed by the Secretary of Defense from among employees of the Army Corps of Engineers.

(v) 1 shall be appointed by the majority leader of the Senate.

(vi) 1 shall be appointed by the minority leader of the Senate.

(vii) 1 shall be appointed by the Speaker of the House of Representatives.

(viii) 1 shall be appointed by the minority leader of the House of Representatives.

(B) REQUIREMENT RELATING TO CERTAIN APPOINTMENTS OF VOTING MEMBERS.—Of the members appointed pursuant to clause (i), (ii), and (iv) through (viii) of subparagraph (A), all shall have expertise in capital leasing, construction, or health facility management planning.

(C) NON-VOTING MEMBERS.—The Commission shall be assisted by 10 non-voting members, appointed by the vote of a majority of members of the Commission under subparagraph (A), of whom—

(i) 6 shall be representatives of veterans service organizations recognized by the Secretary of Veterans Affairs; and

(ii) 4 shall be individuals from outside the Department of Veterans Affairs with experience and expertise in matters relating to management, construction, and leasing of capital assets.

(D) DATE OF APPOINTMENT OF VOTING MEMBERS.—The appointments of the members of the Commission under subparagraph (A) shall be made not later than 60 days after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Commission. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING.—Not later than 15 days after the date on which 7 members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS.—The Commission shall meet at the call of the Chair.

(6) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIR AND VICE CHAIR.—The Commission shall select a Chair and Vice Chair from among its members.

(b) DUTIES OF COMMISSION.—

(1) IN GENERAL.—The Commission shall undertake a comprehensive evaluation and assessment of various options for capital planning for Department of Veterans Affairs medical facilities, including an evaluation and assessment of the mechanisms by which the Department currently selects means for the delivery of health care, whether by major construction, major medical facility leases, sharing agreements with the Department of Defense, the Indian Health Service, and Federally Qualified Health Clinics under section 330 of the Public Health Service Act (42 U.S.C. 254b), contract care, multisite care, telemedicine, extended hours for care, or other means.

(2) CONTEXT OF EVALUATION AND ASSESSMENT.—In undertaking the evaluation and assessment, the Commission shall consider—

(A) the importance of access to health care through the Department, including associated guidelines of the Department on access to, and drive time for, health care;

(B) limitations and requirements applicable to the construction and leasing of medical facilities for the Department, including applicable laws, regulations, and costs as determined by both the Congressional Budget Office and the Office of Management and Budget;

(C) the nature of capital planning for Department medical facilities in an era of fiscal uncertainty;

(D) projected future fluctuations in the population of veterans; and

(E) the extent to which the Department was able to meet the mandates of the Capital Asset Realignment for Enhanced Services Commission.

(3) PARTICULAR CONSIDERATIONS.—In undertaking the evaluation and assessment, the Commission shall address, in particular, the following:

(A) The Major Medical Facility Lease Program of the Department, including an identification of potential improvements to the lease authorization processes under that Program.

(B) The management processes of the Department for its Major Medical Facility Construction Program, including processes relating to contract award and management, project management, and processing of change orders.

(C) The overall capital planning program of the Department for medical facilities, including an evaluation and assessment of—

(i) the manner in which the Department determines whether to use capital or non-capital means to expand access to health care;

(ii) the manner in which the Department determines the disposition of under-utilized and un-utilized buildings on campuses of Department medical centers, and any barriers to disposition;

(iii) the effectiveness of the facility master planning initiative of the Department; and

(iv) the extent to which sustainable attributes are planned for to decrease operating costs for Department medical facilities.

(D) The current backlog of construction projects for Department medical facilities, including an identification of the most effective means to quickly secure the most critical repairs required, including repairs relating to facility condition deficiencies, structural safety, and compliance with the Americans With Disabilities Act of 1990.

(4) REPORTS.—Subject to paragraph (5), the Commission shall submit to the Secretary of Veterans Affairs, and to the Committee Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives, reports as follows:

(A) Not later than six months after its initial meeting under subsection (a)(4), a report on the Major Medical Facility Lease Program and the Congressional lease authorization process.

(B) Not later than one year after its initial meeting, a report—

(i) on the management processes of the Department for the construction of Department medical facilities; and

(ii) setting forth an update of any matters covered in the report under subparagraph (A).

(C) Not later than 18 months after its initial meeting, a report—

(i) on the overall capital planning program of the Department for medical facilities; and

(ii) setting forth an update of any matters covered in earlier reports under this paragraph.

(D) Not later than two years after its initial meeting, a report—

(i) on the current backlog of construction projects for Department medical facilities;

(ii) setting forth an update of any matters covered in earlier reports under this paragraph; and

(iii) including such other matters relating to the duties of the Commission that the Commission considers appropriate.

(E) Not later than 27 months after its initial meeting, a report on the implementation by the Secretary of Veterans Affairs pursuant to subsection (g) of the recommendations included pursuant to paragraph (5) in the reports under this paragraph.

(5) RECOMMENDATIONS.—Each report under paragraph (4) shall include, for the aspect of the capital asset planning process of the Department covered by such report, such recommendations as the Commission considers appropriate for the improvement and enhancement of such aspect of the capital asset planning process.

(c) POWERS OF COMMISSION.—

(1) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out this section. Upon request of the Chair of the Commission, the head of such department or agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS.—

(1) COMPENSATION OF MEMBERS.—Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF.—

(A) IN GENERAL.—The Chair of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION.—The Chair of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chair of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF COMMISSION.—The Commission shall terminate 60 days after the date on which the Commission submits its report under subsection (b)(4)(E).

(f) FUNDING.—The Secretary of Veterans Affairs shall make available to the Commission such amounts as the Secretary and the Chair of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) ACTION ON RECOMMENDATIONS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall implement each recommendation included in a report under subsection (b)(4) that the Secretary considers feasible and advisable and can be implemented without further legislative action.

(2) REPORTS.—Not later than 120 days after receipt of a report under subparagraphs (A) through (D) of subsection (b)(4), the Secretary shall submit to the Committee Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report setting forth the following:

(A) An assessment of the feasibility and advisability of each recommendation contained in such report.

(B) For each recommendation assessed as feasible and advisable—

(i) if such recommendation does not require further legislative action for implementation, a description of the actions taken, and to be taken, by the Secretary to implement such recommendation; and

(ii) if such recommendation requires further legislative action for implementation, recommendations for such legislative action.

SEC. 404. REMOVAL OF SENIOR EXECUTIVE SERVICE EMPLOYEES OF THE DEPARTMENT OF VETERANS AFFAIRS FOR PERFORMANCE.

(a) REMOVAL OR TRANSFER.—

(1) IN GENERAL.—Chapter 7 of title 38, United States Code, is amended by adding at the end the following new section:

"§ 713. Senior Executive Service: removal based on performance

''(a) IN GENERAL.—The Secretary may remove any individual from the Senior Executive Service if the Secretary determines the performance of the individual warrants such removal. If the Secretary so removes such an individual, the Secretary may—

''(1) remove the individual from the civil service (as defined in section 2101 of title 5); or

''(2) transfer the individual to a General Schedule position at any grade of the General Schedule for which the individual is qualified and that the Secretary determines is appropriate.

''(b) NOTICE TO CONGRESS.—Not later than 30 days after removing or transferring an individual from the Senior Executive Service under paragraph (1), the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives notice in writing of such removal or transfer and the reason for such removal or transfer.

''(c) APPEAL OF REMOVAL OR TRANSFER.—Any removal or transfer under subsection (a) may be appealed to the Merit Systems Protection Board under section 7701 of title 5 not later than 7 days after such removal or transfer.

''(d) EXPEDITED REVIEW BY MERIT SYSTEMS PROTECTION BOARD.—(1) The Merit Systems Protection Board shall expedite any appeal under section 7701 of title 5 of a removal or transfer under subsection (a) and, in any such case, shall issue a decision not later than 21 days after the date of the appeal.

''(2) In any case in which the Merit Systems Protection Board determines that it cannot issue a decision in accordance with the 21-day requirement under paragraph (1), the Merit Systems Protection Board shall submit to Congress a report that explains the reason why the Merit Systems Protection Board is unable to issue a decision in accordance with such requirement in such case.

''(3) There is authorized to be appropriated such sums as may be necessary for the Merit Systems Protection Board to expedite appeals under paragraph (1).

''(4) The Merit Systems Protection Board may not stay any personnel action taken under this section.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

''713. Senior Executive Service: removal based on performance.''.

(b) ESTABLISHMENT OF EXPEDITED REVIEW PROCESS.—

(1) IN GENERAL.—Not later than 30 days after the date of the enactment of this Act, the Merit Systems Protection Board shall establish and put into effect a process to conduct expedited reviews in accordance with section 713(d) of title 38, United States Code.

(2) INAPPLICABILITY OF CERTAIN REGULATIONS.—Section 1201.22 of title 5, Code of Federal Regulations, as in effect on the day before the date of the enactment of this Act, shall not apply to expedited reviews carried out under section 713(d) of title 38, United States Code.

(3) REPORT BY MERIT SYSTEMS PROTECTION BOARD.—Not later than 30 days after the date of the enactment of this Act, the Merit Systems Protection Board shall submit to Congress a report on the actions the Board plans to take to conduct expedited reviews under section 713(d) of title 38, United States Code, as added by subsection (a). Such report shall include a description of the resources the

Board determines will be necessary to conduct such reviews and a description of whether any resources will be necessary to conduct such reviews that were not available to the Board on the day before the date of the enactment of this Act.

(c) TEMPORARY EXEMPTION FROM CERTAIN LIMITATION ON INITIATION OF REMOVAL FROM SENIOR EXECUTIVE SERVICE.—During the 120-day period beginning on the date of the enactment of this Act, an action to remove an individual from the Senior Executive Service at the Department of Veterans Affairs pursuant to section 713 of title 38, United States Code, as added by subsection (a), or section 7543 of title 5, United States Code, may be initiated, notwithstanding section 3592(b) of title 5, United States Code, or any other provision of law.

(d) CONSTRUCTION.—Nothing in this section or section 713 of title 38, United States Code, as added by subsection (a), shall be construed to apply to an appeal of a removal, transfer, or other personnel action that was pending before the date of the enactment of this Act.

TITLE V—MAJOR MEDICAL FACILITY LEASES

SEC. 501. AUTHORIZATION OF MAJOR MEDICAL FACILITY LEASES.

The Secretary of Veterans Affairs may carry out the following major medical facility leases at the locations specified, and in an amount for each lease not to exceed the amount shown for such location (not including any estimated cancellation costs):

(1) For a clinical research and pharmacy coordinating center, Albuquerque, New Mexico, an amount not to exceed $9,560,000.

(2) For a community-based outpatient clinic, Brick, New Jersey, an amount not to exceed $7,280,000.

(3) For a new primary care and dental clinic annex, Charleston, South Carolina, an amount not to exceed $7,070,250.

(4) For the Cobb County community-based Outpatient Clinic, Cobb County, Georgia, an amount not to exceed $6,409,000.

(5) For the Leeward Outpatient Healthcare Access Center, Honolulu, Hawaii, including a co-located clinic with the Department of Defense and the co-location of the Honolulu Regional Office of the Veterans Benefits Administration and the Kapolei Vet Center of the Department of Veterans Affairs, an amount not to exceed $15,887,370.

(6) For a community-based outpatient clinic, Johnson County, Kansas, an amount not to exceed $2,263,000.

(7) For a replacement community-based outpatient clinic, Lafayette, Louisiana, an amount not to exceed $2,996,000.

(8) For a community-based outpatient clinic, Lake Charles, Louisiana, an amount not to exceed $2,626,000.

(9) For outpatient clinic consolidation, New Port Richey, Florida, an amount not to exceed $11,927,000.

(10) For an outpatient clinic, Ponce, Puerto Rico, an amount not to exceed $11,535,000.

(11) For lease consolidation, San Antonio, Texas, an amount not to exceed $19,426,000.

(12) For a community-based outpatient clinic, San Diego, California, an amount not to exceed $11,946,100.

(13) For an outpatient clinic, Tyler, Texas, an amount not to exceed $4,327,000.

(14) For the Errera Community Care Center, West Haven, Connecticut, an amount not to exceed $4,883,000.

(15) For the Worcester community-based Outpatient Clinic, Worcester, Massachusetts, an amount not to exceed $4,855,000.

(16) For the expansion of a community-based outpatient clinic, Cape Girardeau, Missouri, an amount not to exceed $4,232,060.

(17) For a multispecialty clinic, Chattanooga, Tennessee, an amount not to exceed $7,069,000.

(18) For the expansion of a community-based outpatient clinic, Chico, California, an amount not to exceed $4,534,000.

(19) For a community-based outpatient clinic, Chula Vista, California, an amount not to exceed $3,714,000.

(20) For a new research lease, Hines, Illinois, an amount not to exceed $22,032,000.

(21) For a replacement research lease, Houston, Texas, an amount not to exceed $6,142,000.

(22) For a community-based outpatient clinic, Lincoln, Nebraska, an amount not to exceed $7,178,400.

(23) For a community-based outpatient clinic, Lubbock, Texas, an amount not to exceed $8,554,000.

(24) For a community-based outpatient clinic consolidation, Myrtle Beach, South Carolina, an amount not to exceed $8,022,000.

(25) For a community-based outpatient clinic, Phoenix, Arizona, an amount not to exceed $20,757,000.

(26) For the expansion of a community-based outpatient clinic, Redding, California, an amount not to exceed $8,154,000.

(27) For the expansion of a community-based outpatient clinic, Tulsa, Oklahoma, an amount not to exceed $13,269,200.

SEC. 502. BUDGETARY TREATMENT OF DEPARTMENT OF VETERANS AFFAIRS MAJOR MEDICAL FACILITIES LEASES.

(a) FINDINGS.—Congress finds the following:

(1) Title 31, United States Code, requires the Department of Veterans Affairs to record the full cost of its contractual obligation against funds available at the time a contract is executed.

(2) Office of Management and Budget Circular A–11 provides guidance to agencies in meeting the statutory requirements under title 31, United States Code, with respect to leases.

(3) For operating leases, Office of Management and Budget Circular A–11 requires the Department of Veterans Affairs to record upfront budget authority in an ''amount equal to total payments under the full term of the lease or [an] amount sufficient to cover first year lease payments plus cancellation costs''.

(b) REQUIREMENT FOR OBLIGATION OF FULL COST.—

(1) IN GENERAL.—Subject to the availability of appropriations provided in advance, in exercising the authority of the Secretary of Veterans Affairs to enter into leases provided in this Act, the Secretary shall record, pursuant to section 1501 of title 31, United States Code, as the full cost of the contractual obligation at the time a contract is executed either—

(A) an amount equal to total payments under the full term of the lease; or

(B) if the lease specifies payments to be made in the event the lease is terminated before its full term, an amount sufficient to cover the first year lease payments plus the specified cancellation costs.

(2) SELF-INSURING AUTHORITY.—The requirements of paragraph (1) may be satisfied through the use of a self-insuring authority consistent with Office of Management and Budget Circular A–11.

(c) TRANSPARENCY.—

(1) COMPLIANCE.—Subsection (b) of section 8104 of title 38, United States Code, is amended by adding at the end the following new paragraph:

''(7) In the case of a prospectus proposing funding for a major medical facility lease, a detailed analysis of how the lease is expected to comply with Office of Management and Budget Circular A–11 and section 1341 of title 31 (commonly referred to as the 'Anti-Deficiency Act'). Any such analysis shall include—

''(A) an analysis of the classification of the lease as a 'lease-purchase', 'capital lease', or 'operating lease' as those terms are defined in Office of Management and Budget Circular A–11;

''(B) an analysis of the obligation of budgetary resources associated with the lease; and

''(C) an analysis of the methodology used in determining the asset cost, fair market value, and cancellation costs of the lease.''.

(2) SUBMITTAL TO CONGRESS.—Such section 8104 is further amended by adding at the end the following new subsection:

''(h)(1) Not less than 30 days before entering into a major medical facility lease, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives—

''(A) notice of the Secretary's intention to enter into the lease;

''(B) a detailed summary of the proposed lease;

''(C) a description and analysis of any differences between the prospectus submitted pursuant to subsection (b) and the proposed lease; and

''(D) a scoring analysis demonstrating that the proposed lease fully complies with Office of Management and Budget Circular A–11.

''(2) Each committee described in paragraph (1) shall ensure that any information submitted to the committee under such paragraph is treated by the committee with the same level of confidentiality as is required by law of the Secretary and subject to the same statutory penalties for unauthorized disclosure or use as the Secretary.

''(3) Not more than 30 days after entering into a major medical facility lease, the Secretary shall submit to each committee described in paragraph (1) a report on any material differences between the lease that was entered into and the proposed lease described under such paragraph, including how the lease that was entered into changes the previously submitted scoring analysis described in subparagraph (D) of such paragraph.''.

(d) RULE OF CONSTRUCTION.—Nothing in this section, or the amendments made by this section, shall be construed to in any way relieve the Department of Veterans Affairs from any statutory or regulatory obligations or requirements existing prior to the enactment of this section and such amendments.

Mr. BLUMENTHAL. Mr. President, I am pleased to follow my friend and colleague from Vermont, Senator SANDERS, and I want to begin by thanking him for his leadership, his persistence, and his perseverance in the face of resistance that should not exist. This cause ought to be one that galvanizes the Nation, and perhaps it will, since the Nation has been appalled and astonished by reports of not only cooking the books but covering up that potential criminality—destruction of documents, falsification of records, secret waiting lists, delays that are unacceptable and intolerable for basic, necessary health care our veterans need.

But these issues are longstanding, decades old in this system, and they need to be addressed with system-wide reform.

I am strongly in support, and proudly so, in advocating the Ensuring Veterans Access to Health Care Act that Senator SANDERS has just introduced. It is a version of the omnibus bill and

other measures that have been introduced. It has essential features that will provide better health care sooner and more accessibly to our veterans. It is necessary to pass, but these provisions should have passed literally years ago. In fact, the very first piece of legislation I introduced in the Senate, S. 1060, called the Honoring All Veterans Act, included a provision to deal with this shortage of doctors in this system. It included other health care-related measures to expand the availability and accessibility of health care. These problems, far from new, have been existent for some time. And the coverup, the lying, and falsification of records is potentially now criminal and beyond a failure of public policy; it is a failure in integrity.

I am pleased to join Senator SANDERS to make sure the 9.3 million of the Nation's 22 million who are enrolled in the VA health care system—which is up from about 2.5 million at the end of the first gulf war—have the kind of service they need. This bill will address some basic needs. It provides authority to remove senior executives based on poor job performance and preventing wholesale political firings. The legislation would provide veterans who cannot get timely appointments access to private clinics and the option of going to community health care centers, military hospitals, or private doctors. It would authorize the Veterans' Administration to lease 27 new health facilities in 18 States, including funds for the enhanced lease of the Errera Community Care Center in West Haven, CT, which does profoundly important and excellent work.

The legislation authorizes emergency funding to hire new doctors and nurses and other providers in order to address systemwide health care provider shortages and to take other necessary steps to ensure timely access to care. It addresses the health care primary care shortage for the long term as well by authorizing the National Health Service Corps to award scholarships to medical school students and to forgive college loans for doctors and nurses who work at the VA. These kinds of measures and others in the bill will act to fulfill our basic obligation to our veterans, just as I attempted to do in the Honoring All Veterans Act some years ago, and others have joined since in seeking to do.

My hope is we can reach across the aisle. In fact, I am working with Senator MCCAIN on a bipartisan letter to the Attorney General urging all possible involvement and leadership in a criminal investigation. I hope a similar spirit of bipartisanship will enable us to work with Senators MCCAIN, BURR, and COBURN on their Veterans Choice Act and combine these measures, enlist them in supporting a bipartisan solution and join Senator SANDERS in hoping for that bipartisan effort in this measure because there is no question that the VA budget has grown, but simply has failed to keep pace with surging demand, especially in mental health services and primary care. Too many of our veterans are coming home with serious mental health issues, including post-traumatic stress, traumatic brain injury, and need the care we owe them. We need accountability. Part of it will be firing the officials who should be held responsible, but part of it may also be prosecuting them, and that is the reason I have asked the Attorney General to take the lead to assume much more immediate, significant involvement in any criminal investigation that may be necessary.

In fact, there is credible and significant evidence of criminal wrongdoing here. The Department of Justice must be involved and in my view must take a leadership role, and that is the reason Senator MCCAIN and I have joined in a letter that we are seeking support for our colleagues to send that would request the Attorney General to take such steps. Only the Attorney General has the resources, expertise, and authority, along with the FBI, to do a prompt and effective criminal investigation. Only the Department of Justice can convene a grand jury and take other necessary steps. Only the FBI can bring to bear the expertise as well as the resources.

The inspector general of the Veterans' Administration has only 165 investigators for the entire Nation. This investigation now spans more than 40 centers where criminality has been alleged. Of the 216 sites visited by the auditors recently, many were found to have issues of scheduling practice defects and potential integrity problems. So there is a reason for the VA inspector general to not only consult with the Department of Justice but also involve the Department of Justice in an active leadership role here, and for the Acting Secretary of the VA to request that involvement, which I hope he will do. I commend what he has done so far, but now is the time for the Department of Justice to be involved in leading.

The audit of the facilities around the country is to be made public—not just the overall results which have been delivered to the President in a report last Friday, but all of the results—site-specific results for locations, for example, the two hospitals in Connecticut in West Haven and in Newington as well as the six medical centers in Connecticut. All of those site-specific audits should be made public.

I have written to the Acting Secretary Sloan Gibson, urging that he make those face-to-face audits of the VA medical facilities public, not only for Connecticut but for the whole country. Restoring trust and credibility will be achieved only if there is more transparency. Nondisclosure would be a bad way to begin a new era of leadership at the VA. Full transparency is absolutely vital to help restore trust and confidence, which has been so gravely threatened and, indeed, undermined.

Finally, I have a few words to say about Secretary Shinseki. The immediate challenge is not about replacing one person, it is about fixing a system that is desperately wrong. I deeply respect Secretary Shinseki's decision to resign last week after concluding that his continued service would be a distraction from the urgent and necessary overhaul of the Veterans' Administration. I respect even more his dedicated service to our Nation. He is a decorated combat veteran who led into battle many of the men and women who now use the Veterans' Administration. His mentors and models, as he so eloquently told our committee, now use the Veterans' Administration. In his heart, I believe he is passionately committed to the cause of serving our veterans, and he deserves gratitude and respect from the American people for his service in the U.S. military and his telling truth to power as the President so powerfully observed.

The Nation must recognize it owes our veterans world-class, first-class medical care that is second to none. Putting them at risk in medical facilities after they have put their lives on the line on the battlefield is a disservice to them and our Nation.

It is abhorrent and atrocious that there have been these potentially criminal acts—destruction of documents and falsification of records—at many of the VA facilities around the country. There is no excuse for it. Whether it is arbitrary deadlines or timelines, there is simply no excuse for that kind of lying. The lying that happened within the VA was not only to General Shinseki, but to the American people. The ones who committed that kind of wrongdoing should be held accountable administratively and criminally.

The wars in Iraq and Afghanistan, and the ongoing global military operations since 9/11, have cast a long shadow on this Nation's history. It involved less than 1 percent of the population, including the families of the brave warriors who have been sent to battle. All of us will live with the consequences, and all of us have an obligation to keep faith with them, leave no veteran behind, and give them prompt and world-class, first-class medical care when they need it right away.

The ''greatest generation'' set a model for them, and they are, indeed, the next greatest generation. We have to do right by them as they have done right by us. No matter what the era, conflict, or war, let us keep faith with all of the veterans and leave no veteran behind.

By Mr. MCCAIN (for himself, Mr. COBURN, Mr. BURR, Mr. FLAKE, Mr. ISAKSON, Mr. INHOFE, Mr. GRASSLEY, Mr. ROBERTS, Mr. HOEVEN, Mr. COATS, Mr. BARRASSO, Mr. JOHANNS, Mr. RUBIO, Mr. CORNYN, Mr. ALEXANDER, Mr. KIRK, Mr. WICKER, Mrs. FISCHER, Mr. PORTMAN, Mr.

TOOMEY, Mr. BOOZMAN, Mr. MORAN, Mr. THUNE, Mr. SCOTT, Mr. ENZI, and Mr. GRAHAM):

S. 2424. A bill to provide veterans with the choice of medical providers and to increase transparency and accountability of operations of the Veterans Health Administration of the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

Mr. MCCAIN. Mr. President, it has been almost 2 months since allegations that some 40 veterans died while waiting for care at the Phoenix VA were first made public. Since that report, we have learned of similar allegations of gross mismanagement and data manipulation at 42 VA medical facilities across the U.S. More troubling, according to the Office of the Inspector General's preliminary report, 1,700 veterans in the Phoenix VA Health Care System who thought they were about to receive care were never even placed on the VA's Electronic Waiting List and are ''at risk of being forgotten or lost in Phoenix HCS's convoluted scheduling process''. Today, it is clear that delaying medical care and manipulating records to hide those delays in care is systemic through the Department of Veterans' Affairs health system. This has created in our veterans' community a crisis of confidence toward the VA—the very agency that was established to care for them.

Today, I joined Senators COBURN, BURR, and FLAKE to introduce the Veterans Choice Act of 2014. This bill would, principally, empower veterans with greater flexibility when choosing their medical care and increase transparency and accountability within the VA to ensure that it delivers quality care to our veterans in a timely manner. Specifically, it would give veterans the option to go to a different doctor if the VA can't schedule an appointment within a reasonable time or if the veteran lives too far away from a VA medical facility. Additionally, this bill would prohibit scheduling or waittime metrics/goals from being used as factors to determining performance awards or bonuses. It would also require the Secretary of the VA to punish employees who falsify data, including civil penalties, suspension or termination. And, empower the Secretary of the VA to remove any top executive at the VA if the Secretary determines that his performance warrants removal.

Put simply, unlike some other proposals that have been made to reform how the VA delivers care, this bill would squarely address the root causes of the tragic circumstances that have brought us to this point.

For almost all this century, Americans have been fighting in faraway places to make this dangerous world safer for the rest of us. They have been brave. They have sacrificed and suffered. They bear wounds and mourn losses they will never completely recover from—and we can never fully compensate them for. But, we can care for the injuries they incurred on our behalf and provide for their physical and emotional recovery from the battles they fought to protect us. Quality care for our veterans is among the most solemn obligations a nation must pay, and we will be judged by God and history by how well we discharge ours.

Indeed, we must be worthy of the sacrifices made on our behalf How we care for those who risked everything for us is the most important test of a Nation's character. Today, we are failing that test. We must do better tomorrow. Much better.

For the 9 million American veterans who depend on the VA for their health care, and for the families whose tragic stories we have heard over the last two months, who I know are still grieving their losses, it is time to provide our veterans with the care, choice, and accountability that they so rightly deserve. I am pleased to be associated with the bill Senator BURR, Senator COBURN and Senator FLAKE introduced today, which would help the nation achieve those laudable, necessary goals. I urge my colleagues—on both sides of the aisle—to support it.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 464—DESIGNATING JUNE 2014 AS ''NATIONAL APHASIA AWARENESS MONTH'' AND SUPPORTING EFFORTS TO INCREASE AWARENESS OF APHASIA

Mr. JOHNSON of South Dakota (for himself and Mr. KIRK) submitted the following resolution; which was considered and agreed to:

S. RES. 464

Whereas aphasia is a communication impairment caused by brain damage that typically results from a stroke;

Whereas aphasia can also occur with other neurological disorders, such as a brain tumor;

Whereas many people with aphasia also have weakness or paralysis in the right leg and right arm, usually due to damage to the left hemisphere of the brain, which controls language and movement on the right side of the body;

Whereas the effects of aphasia may include a loss of, or reduction in, the ability to speak, comprehend, read, and write, but the intelligence of a person with aphasia remains intact;

Whereas, according to the National Institute of Neurological Disorders and Stroke (referred to in this preamble as the ''NINDS''), strokes are the fourth-leading cause of death in the United States;

Whereas strokes are a leading cause of serious, long-term disability in the United States;

Whereas the NINDS estimates that there are approximately 5,000,000 stroke survivors in the United States;

Whereas the NINDS estimates that people in the United States suffer approximately 795,000 strokes per year, with about ⅓ of the strokes resulting in aphasia;

Whereas, according to the NINDS, aphasia affects at least 1,000,000 people in the United States;

Whereas the NINDS estimates that more than 200,000 people in the United States are afflicted with aphasia each year;

Whereas the people of the United States should strive to learn more about aphasia and to promote research, rehabilitation, and support services for people with aphasia and aphasia caregivers throughout the United States; and

Whereas people with aphasia and their caregivers envision a world that recognizes the ''silent'' disability of aphasia and provides opportunity and fulfillment for people affected by aphasia: Now, therefore, be it

Resolved, That the Senate—

(1) designates June 2014 as ''National Aphasia Awareness Month'';

(2) supports efforts to increase awareness of aphasia;

(3) recognizes that strokes, a primary cause of aphasia, are the fourth-largest cause of death and disability in the United States;

(4) acknowledges that aphasia deserves more attention and study to find new solutions for people experiencing aphasia and their caregivers;

(5) supports efforts to make the voices of people with aphasia heard, because people with aphasia are often unable to communicate with others; and

(6) encourages all people in the United States to observe National Aphasia Awareness Month with appropriate events and activities.

SENATE RESOLUTION 465—COMMEMORATING THE CENTENNIAL OF WEBSTER UNIVERSITY

Mr. BLUNT (for himself and Mrs. MCCASKILL) submitted the following resolution; which was considered and agreed to:

S. RES. 465

Whereas in 1915, the Sisters of Loretto established Webster University in Saint Louis, Missouri, as one of the first Catholic colleges for women that is located west of the Mississippi River;

Whereas Webster University has campuses in 8 different countries, introducing people in Europe, Asia, and Africa to United States educational programs, helping to spread United States culture and ideas around the globe, and serving the educational needs of people abroad;

Whereas in 1974, Webster University became one of the first universities in the United States to operate on a military base;

Whereas in 2014, Webster University is located on military bases across the country, serving all branches of the military and directly helping more than 7,700 students who are active members of the Armed Forces, veterans, or direct relatives of individuals with military connections;

Whereas Webster University has been a leader in online education since 1999, and more than 9,000 students are taking courses in the Webster University Online Learning Center, a program that provides quality higher education to students who have access to the Internet and are residing anywhere in the world;

Whereas since 1915, Webster University has conferred more than 184,000 degrees at campuses around the world, including nearly 80,000 degrees in the greater Saint Louis area, demonstrating a local commitment and offering a global education;

Whereas Webster University has a diverse student body and is routinely lauded by organizations working on diversity issues;

Whereas Webster University is the alma mater of more than 160,000 proud alumni; and