

practices that have failed these communities, the Protect and Serve Act's aim is to further criminalize. This bill will be received as yet another attack on these communities and threatens to exacerbate what is already a discriminatory system of mass incarceration in this country. Continuing to undermine police-community relations in this manner sows seeds of division, which ultimately threatens public safety and undermines the work of law enforcement.

For the reasons summarized above, we urge you to vote against the Protect and Serve Act as it comes before the U.S. House of Representatives. There is no justification for creating a new crime for offenses committed against law enforcement. At a time when we need to foster healing between law enforcement and our communities, we should not be considering legislation which not only does nothing to advance the goal of officer safety, but will further erode the relationship between police and communities.

Thank you for your consideration of this matter. If you have any questions, please contact Kanya Bennett of the ACLU; Sakira Cook of The Leadership Conference or Sonia Gill Hernandez of the NAACP Legal Defense and Educational Fund, Inc.

Sincerely,

American Civil Liberties Union; Anti-Defamation League; Campaign for Youth Justice; Church of Scientology National Affairs Office; CLASP; The Daniel Initiative; Defending Rights & Dissent; Friends Committee on National Legislation; Human Rights Watch; Government Information Watch; Law Enforcement Action Partnership; The Leadership Conference on Civil and Human Rights; Muslim Advocates; NAACP.

NAACP Legal Defense and Educational Fund, Inc.; National Action Network; National Association of Criminal Defense Lawyers; National Association of Social Workers; National Bar Association; National Center for Transgender Equality; Nation Council of Jewish Women; The National Council for Incarcerated and Formerly Incarcerated Women and Girls; National Council of Churches; People for the American Way; PolicyLink; South Asian Americans Leading Together; Southern Poverty Law Center; StoptheDrugWar.org.

Mr. NADLER. Mr. Speaker, I yield back the balance of my time.

Mr. GOODLATTE. Mr. Speaker, I yield myself the balance of my time.

I just want to make it very clear how important this legislation is for protecting law enforcement officers because it sends a message that we are going to handle these cases in a new way.

Some have criticized this bill, claiming that it is a hate crime. While I share those individuals' concerns about Federal hate crime statutes, I am pleased to tell the Members of this Congress that this bill before us did not create a new Federal hate crime. That is because the legislation does not use the language from the hate crime statute that requires the government prove the defendant acted "because of the actual or perceived" status of the victim.

What this bill does is penalize knowingly attacking a law enforcement officer. Given the increase in ambush-style attacks on law enforcement, which was detailed earlier, this bill represents a solution to a growing problem: the killing of police officers. It is narrowly tailored to accomplish that goal.

Therefore, I want to assure those Members who may be concerned about

its intent that it is definitely not changing our Federal hate crime statutes.

This legislation this week, National Police Week, sends an important signal not just to our Nation's law enforcement officers, 900,000 strong, but far beyond that, to all Americans, that we are placing a very, very high priority on saving the lives of men and women who put their lives on the line to protect us, to protect our freedoms, to protect our opportunities, to protect our families, to protect our communities, and making sure that people who ambush police officers and take police officers' lives are held fully accountable, which is what this bill does. It is a good bill. It is an important bill. I urge my colleagues to support it.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate on the bill has expired.

AMENDMENT NO. 1 PRINTED IN PART A OF HOUSE REPORT 115-677 OFFERED BY MR. GOODLATTE

Mr. GOODLATTE. Mr. Speaker, I have an amendment at the desk.

The SPEAKER pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 3, beginning on line 13, strike "knowingly causes serious bodily injury to a law enforcement officer" and insert "knowingly assaults a law enforcement officer causing serious bodily injury".

Beginning on page 5, strike line 24 and all that follows through page 6, line 8, and insert the following:

"(1) LAW ENFORCEMENT OFFICER.—The term 'law enforcement officer' means an employee of a governmental or public agency who is authorized by law—

"(A) to engage in or supervise the prevention, detection, or the investigation of any criminal violation of law; or

"(B) to engage in or supervise the detention or the incarceration of any person for any criminal violation of law."

The SPEAKER pro tempore. Pursuant to House Resolution 891, the gentleman from Virginia (Mr. GOODLATTE) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Virginia.

Mr. GOODLATTE. Mr. Speaker, I yield myself such time as I may consume.

This amendment makes two small, but important changes to the underlying legislation.

It first clarifies the language of the bill to assure those who are prosecuted are acting with some level of intent in injuring a police officer. It does this by changing the language from "knowingly causing serious bodily injury to a law enforcement officer" to "knowingly assaults a law enforcement officer causing serious bodily harm." This change will avoid covering situations where someone unintentionally harms a police officer.

The amendment also amends the definition of law enforcement officer to ensure it covers all law enforcement officers who are putting themselves in

harm's way each day, including correction officers.

Mr. Speaker, this amendment is important because it ensures that, in practice, this statute can be used more efficiently to protect law enforcement officers. It also ensures that nobody who wears a badge will be unintentionally excluded from the bill's protections.

Mr. Speaker, I urge my colleagues to support this amendment, and I reserve the balance of my time.

Mr. NADLER. Mr. Speaker, I claim the time in opposition to the amendment.

The SPEAKER pro tempore. The gentleman from New York is recognized for 5 minutes.

Mr. NADLER. Mr. Speaker, I support the amendment, and I yield back the balance of my time.

Mr. GOODLATTE. Mr. Speaker, that is good news, and I yield back the balance of my time.

The SPEAKER pro tempore. Pursuant to the rule, the previous question is ordered on the bill and on the amendment offered by the gentleman from Virginia (Mr. GOODLATTE).

The question is on the amendment offered by the gentleman from Virginia (Mr. GOODLATTE).

The amendment was agreed to.

□ 1545

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. GOODLATTE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

#### VETERANS CEMETERY BENEFIT CORRECTION ACT

Mr. ROE of Tennessee. Mr. Speaker, pursuant to House Resolution 891, I call up the bill (S. 2372) to amend title 38, United States Code, to provide outer burial receptacles for remains buried in National Parks, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 891, an amendment in the nature of a substitute consisting of the text of H.R. 5674, as reported by the Committee on Veterans' Affairs, as modified by the amendment printed in part B of House Report 115-677, is adopted, and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

S. 2372

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 “John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018” or the “VA MISSION Act of 2018”.

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

Sec. 1. Short title; table of contents.

**TITLE I—CARING FOR OUR VETERANS**

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

**Subtitle A—Developing an Integrated High-Performing Network**

**CHAPTER 1—ESTABLISHING COMMUNITY CARE PROGRAMS**

Sec. 101. Establishment of Veterans Community Care Program.

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

Sec. 103. Conforming amendments for State veterans homes.

Sec. 104. Access standards and standards for quality.

Sec. 105. Access to walk-in care.

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

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

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

Sec. 109. Remediation of medical service lines.

**CHAPTER 2—PAYING PROVIDERS AND IMPROVING COLLECTIONS**

Sec. 111. Prompt payment to providers.

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

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

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

**CHAPTER 3—EDUCATION AND TRAINING PROGRAMS**

Sec. 121. Education program on health care options.

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

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

**CHAPTER 4—OTHER MATTERS RELATING TO NON-DEPARTMENT OF VETERANS AFFAIRS PROVIDERS**

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

Sec. 132. Improving information sharing with community providers.

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

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

**CHAPTER 5—OTHER NON-DEPARTMENT HEALTH CARE MATTERS**

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

Sec. 142. Veterans Choice Fund flexibility.

Sec. 143. Sunset of Veterans Choice Program.

Sec. 144. Conforming amendments.

**Subtitle B—Improving Department of Veterans Affairs Health Care Delivery**

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

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

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

**Subtitle C—Family Caregivers**

Sec. 161. Expansion of family caregiver program of Department of Veterans Affairs.

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

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

**TITLE II—VA ASSET AND INFRASTRUCTURE REVIEW**

**Subtitle A—Asset and Infrastructure Review**

Sec. 201. Short title.

Sec. 202. The Commission.

Sec. 203. Procedure for making recommendations.

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

Sec. 205. Implementation.

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

Sec. 207. Congressional consideration of Commission report.

Sec. 208. Other matters.

Sec. 209. Definitions.

**Subtitle B—Other Infrastructure Matters**

Sec. 211. Improvement to training of construction personnel.

Sec. 212. Review of enhanced use leases.

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

**TITLE III—IMPROVEMENTS TO RECRUITMENT OF HEALTH CARE PROFESSIONALS**

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

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

Sec. 303. Establishing the Department of Veterans Affairs Specialty Education Loan Repayment Program.

Sec. 304. Veterans healing veterans medical access and scholarship program.

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

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

**TITLE IV—HEALTH CARE IN UNDERSERVED AREAS**

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

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

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

**TITLE V—OTHER MATTERS**

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

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

Sec. 503. Definition of major medical facility project.

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

Sec. 505. Department of Veterans Affairs personnel transparency.

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

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

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

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

Sec. 510. Appropriation of amounts.

Sec. 511. Technical correction.

**TITLE I—CARING FOR OUR VETERANS**

**SEC. 100. SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE.**

(a) **SHORT TITLE.**—This title may be cited as the “Caring for Our Veterans Act of 2018”.

(b) **REFERENCES TO TITLE 38, UNITED STATES CODE.**—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

**Subtitle A—Developing an Integrated High-Performing Network**

**CHAPTER 1—ESTABLISHING COMMUNITY CARE PROGRAMS**

**SEC. 101. ESTABLISHMENT OF VETERANS COMMUNITY CARE PROGRAM.**

(a) **ESTABLISHMENT OF PROGRAM.**—

(1) **IN GENERAL.**—Section 1703 is amended to read as follows:

**“§ 1703. Veterans Community Care Program**

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

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

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

“(B) Ensuring continuity of care and services.

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

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

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

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

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

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

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

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

“(2) The Department of Defense.

“(3) The Indian Health Service.

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

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

“(d) CONDITIONS UNDER WHICH CARE IS REQUIRED TO BE FURNISHED THROUGH NON-DEPARTMENT PROVIDERS.—(1) The Secretary shall, subject to the availability of appropriations, furnish hospital care, medical services, and extended care services to a covered veteran through health care providers specified in subsection (c) if—

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

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

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

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

“(iii) either—

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

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

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

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

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

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

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

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

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

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

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

“(E) Whether the covered veteran faces an unusual or excessive burden to access hospital care, medical services, or extended care services

from the Department medical facility where a covered veteran seeks hospital care, medical services, or extended care services, which shall include consideration of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(i) the entity—

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

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

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

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

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

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

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

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

“(4) Whenever the Secretary provides notice to an entity that the entity is failing to meet contractual obligations entered into under paragraph (1), the Secretary shall submit to the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report on such failure. Such report shall include the following:

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

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

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

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

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

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

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

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

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

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

“(i) PAYMENT RATES FOR CARE AND SERVICES.—(1) Except as provided in paragraph (2), and to the extent practicable, the rate paid for hospital care, medical services, or extended care services under any provision in this title may not exceed the rate paid by the United States to a provider of services (as defined in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u))) or a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d))) under the Medicare program under title XI or title XVIII of the Social Security Act (42 U.S.C. 1301 et seq.), including section 1834 of such Act (42 U.S.C. 1395m), for the same care or services.

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

“(B) In this paragraph, the term ‘highly rural area’ means an area located in a county that has fewer than seven individuals residing in that county per square mile.

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

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

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

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

“(j) TREATMENT OF OTHER HEALTH PLAN CONTRACTS.—In any case in which a covered veteran is furnished hospital care, medical services, or extended care services under this section for a non-service-connected disability described in subsection (a)(2) of section 1729 of this title, the Secretary shall recover or collect reasonable charges for such care or services from a health plan contract described in section 1729 in accordance with such section.

“(k) PAYMENT BY VETERAN.—A covered veteran shall not pay a greater amount for receiving care or services under this section than the amount the veteran would pay for receiving the same or comparable care or services at a medical facility of the Department or from a health care provider of the Department.

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

“(2) A covered veteran described in this paragraph—

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

“(B) has, in the opinion of the primary care provider of the veteran, a medically compelling reason to travel outside the region of the Organ Procurement and Transplantation Network, established under section 372 of the National Organ Transplantation Act (Public Law 98-507; 42 U.S.C. 274), in which the veteran resides, to receive such transplant.

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

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

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

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

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

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

“(v) The cost of such care and services.

“(2) In monitoring the hospital care, medical services, and extended care services furnished

under this section, the Secretary shall do the following:

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

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

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

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

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

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

“(vi) assess the timeliness of such networks in—

“(I) accepting referrals; and

“(II) scheduling and completing appointments.

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

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

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

“(3) Not later than 540 days after the date of the enactment of the Caring for Our Veterans Act of 2018 and not less frequently than once each year thereafter, the Secretary shall submit to the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report on the information gathered under paragraph (2).

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

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

“(o) DEFINITIONS.—In this section:

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

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

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

“(2) The term ‘medical service line’ means a clinic within a Department medical center.”.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by striking the item relating to section 1703 and inserting the following new item:

“1703. Veterans Community Care Program.”.

(b) EFFECTIVE DATE.—Section 1703 of title 38, United States Code, as amended by subsection (a), shall take effect on the later of—

(1) the date that is 30 days after the date on which the Secretary of Veterans Affairs submits the report required under section 101(q)(2) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 38 U.S.C. 1701 note); or

(2) the date on which the Secretary promulgates regulations pursuant to subsection (c).

(c) REGULATIONS.—

(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall promulgate regulations to carry out section 1703 of title 38, United States Code, as amended by subsection (a) of this section.

(2) UPDATES.—

(A) PERIODIC.—Before promulgating the regulations required under paragraph (1), the Secretary shall provide to the appropriate committees of Congress periodic updates to confirm the progress of the Secretary toward developing such regulations.

(B) FIRST UPDATE.—The first update under subparagraph (A) shall occur no later than 120 days from the date of the enactment of this Act.

(C) APPROPRIATE COMMITTEES OF CONGRESS DEFINED.—In this paragraph, the term “appropriate committees of Congress” means—

(i) the Committee on Veterans’ Affairs and the Committee on Appropriations of the Senate; and

(ii) the Committee on Veterans’ Affairs and the Committee on Appropriations of the House of Representatives.

(d) CONTINUITY OF EXISTING AGREEMENTS.—

(1) IN GENERAL.—Notwithstanding section 1703 of title 38, United States Code, as amended by subsection (a), the Secretary of Veterans Affairs shall continue all contracts, memorandums of understanding, memorandums of agreements, and other arrangements that were in effect on the day before the date of the enactment of this Act between the Department of Veterans Affairs and the American Indian and Alaska Native health care systems as established under the terms of the Department of Veterans Affairs and Indian Health Service Memorandum of Understanding, signed October 1, 2010, the National Reimbursement Agreement, signed December 5, 2012, arrangements under section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645), and agreements entered into under sections 102 and 103 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146).

(2) MODIFICATIONS.—Paragraph (1) shall not be construed to prohibit the Secretary and the parties to the contracts, memorandums of understanding, memorandums of agreements, and other arrangements described in such paragraph from making such changes to such contracts, memorandums of understanding, memorandums of agreements, and other arrangements as may be otherwise authorized pursuant to other provisions of law or the terms of the contracts, memorandums of understanding, memorandums of agreements, and other arrangements.

**SEC. 102. AUTHORIZATION OF AGREEMENTS BETWEEN DEPARTMENT OF VETERANS AFFAIRS AND NON-DEPARTMENT PROVIDERS.**

(a) IN GENERAL.—Subchapter I of chapter 17 is amended by inserting after section 1703 the following new section:

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

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

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

“(C) For purposes of subparagraph (A), hospital care, a medical service, or an extended care service may be considered not feasibly available to a veteran from a facility of the Department or through a contract or sharing agreement described in such subparagraph when the Secretary determines the veteran’s medical condition, the travel involved, the nature of the care or services required, or a combination of these factors make the use of a facility of the Department or a contract or sharing agreement described in such subparagraph impracticable or inadvisable.

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

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

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

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

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

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

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

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

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

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

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

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

“(c) ELIGIBLE ENTITY OR PROVIDER CERTIFICATION PROCESS.—The Secretary shall establish by regulation a process for the certification of eligible entities or providers or recertification of eligible entities or providers under this section. Such a process shall, at a minimum—

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

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

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

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

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

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

(e) TERMS OF VETERANS CARE AGREEMENTS.—

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

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

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

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

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

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

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

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

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

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

(2) The Secretary may discontinue a Veterans Care Agreement with an eligible entity or

provider at such time and upon such reasonable notice to the eligible entity or provider as may be specified in regulations prescribed under this section, if an official designated by the Secretary—

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

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

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

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

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

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

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

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

“(4) Disputes under this section must pertain to either the scope of authorization under the Veterans Care Agreement or claims for payment subject to the Veterans Care Agreement and are not claims for the purposes of such laws that would otherwise require application of sections 7101 through 7109 of title 41, United States Code.

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

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

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

“(2)(A) Except as provided in the agreement itself, in subparagraph (B), and unless otherwise provided in this section or regulations prescribed pursuant to this section, an eligible entity or provider that enters into an agreement under this section is not subject to, in the carrying out of the agreement, any law to which providers of services and suppliers under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) are not subject.

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

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

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

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

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

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

(b) **CLERICAL AMENDMENT.**—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1703 the following new item:

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

### **SEC. 103. CONFORMING AMENDMENTS FOR STATE VETERANS HOMES.**

(a) **IN GENERAL.**—Section 1745(a) is amended—

(1) in paragraph (1), by striking “(or agreement under section 1720(c)(1) of this title)” and inserting “(or an agreement)”;

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

“(4)(A) An agreement under this section may be authorized by the Secretary or any Department official authorized by the Secretary, and any such action is not an award for purposes of such laws that would otherwise require the use of competitive procedures for the furnishing of hospital care, medical services, and extended care services.

“(B)(i) Except as provided in the agreement itself, in clause (ii), and unless otherwise provided in this section or regulations prescribed pursuant to this section, a State home that enters into an agreement under this section is not subject to, in the carrying out of the agreement, any provision of law to which providers of services and suppliers under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) are not subject.

“(ii) A State home that enters into an agreement under this section is subject to—

“(I) all provisions of law regarding integrity, ethics, or fraud, or that subject a person to civil or criminal penalties;

“(II) all provisions of law that protect against employment discrimination or that otherwise ensure equal employment opportunities; and

“(III) all provisions in subchapter V of chapter 17 of this title.

“(iii) Notwithstanding subparagraph (B)(ii)(I), a State home that enters into an agreement under this section may not be treated as a Federal contractor or subcontractor for purposes of chapter 67 of title 41 (known as the ‘McNamara-O’Hara Service Contract Act of 1965’).”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to care provided on or after the effective date of regulations issued by the Secretary of Veterans Affairs to carry out this section.

### **SEC. 104. ACCESS STANDARDS AND STANDARDS FOR QUALITY.**

(a) **IN GENERAL.**—Subchapter I of chapter 17, as amended by section 102, is further amended by inserting after section 1703A the following new sections:

#### **“§ 1703B. Access standards**

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

“(2) The Secretary shall ensure that the access standards established under paragraph (1) define such categories of care to cover all care

and services within the medical benefits package of the Department of Veterans Affairs.

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

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

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

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

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

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

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

“(1) conduct a review of such standards; and

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

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

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

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

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

“(A) the requested care is clinically necessary; and

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

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

“(i)(1) The term ‘appropriate committees of Congress’ means—

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

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

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

**“§ 1703C. Standards for quality**

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

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

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

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

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

“(i) Timely care.  
“(ii) Effective care.  
“(iii) Safety, including, at a minimum, complications, readmissions, and deaths.  
“(iv) Efficiency.

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

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

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

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

“(b) *PUBLICATION AND CONSIDERATION OF PUBLIC COMMENTS.*—(1) Not later than one year after the date on which the Secretary establishes standards for quality under subsection (a), the Secretary shall publish the quality rating of medical facilities of the Department in the publicly available Hospital Compare website through the Centers for Medicare & Medicaid Services for the purpose of providing veterans with information that allows them to compare performance measure information among Department and non-Department health care providers.

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

“(c)(1) The term ‘appropriate committees of Congress’ means—

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

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

“(2) The term ‘covered veterans’ refers to veterans described in section 1703(b) of this title.”.

(b) *CLERICAL AMENDMENT.*—The table of sections at the beginning of chapter 17, as amended by section 102, is further amended by inserting after the item relating to section 1703A the following new items:

“1703B. Access standards.  
“1703C. Standards for quality.”.

**SEC. 105. ACCESS TO WALK-IN CARE.**

(a) *IN GENERAL.*—Chapter 17 is amended by inserting after section 1725 the following new section:

**“§ 1725A. Access to walk-in care**

“(a) *PROCEDURES TO ENSURE ACCESS TO WALK-IN CARE.*—The Secretary shall develop procedures to ensure that eligible veterans are able to access walk-in care from qualifying non-Department entities or providers.

“(b) *ELIGIBLE VETERANS.*—For purposes of this section, an eligible veteran is any individual who—

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

“(2) has received care under this chapter within the 24-month period preceding the furnishing of walk-in care under this section.

“(c) *QUALIFYING NON-DEPARTMENT ENTITIES OR PROVIDERS.*—For purposes of this section, a qualifying non-Department entity or provider is a non-Department entity or provider that has entered into a contract or other agreement with the Secretary to furnish services under this section.

“(d) *FEDERALLY-QUALIFIED HEALTH CENTERS.*—Whenever practicable, the Secretary may use a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B))) to carry out this section.

“(e) *CONTINUITY OF CARE.*—The Secretary shall ensure continuity of care for those eligible veterans who receive walk-in care services under this section, including through the establishment of a mechanism to receive medical records from walk-in care providers and provide pertinent patient medical records to providers of walk-in care.

“(f) *COPAYMENTS.*—(1)(A) The Secretary may require an eligible veteran to pay the United States a copayment for each episode of hospital care or medical services provided under this section if the eligible veteran would be required to pay a copayment under this title.

“(B) An eligible veteran not required to pay a copayment under this title may access walk-in care without a copayment for the first two visits in a calendar year. For any additional visits, a copayment at an amount determined by the Secretary may be required.

“(C) An eligible veteran required to pay a copayment under this title may be required to pay a regular copayment for the first two walk-in care visits in a calendar year. For any additional visits, a higher copayment at an amount determined by the Secretary may be required.

“(2) After the first two episodes of care furnished to an eligible veteran under this section, the Secretary may adjust the copayment required of the veteran under this subsection based upon the priority group of enrollment of the eligible veteran, the number of episodes of care furnished to the eligible veteran during a year, and other factors the Secretary considers appropriate under this section.

“(3) The amount or amounts of the copayments required under this subsection shall be prescribed by the Secretary by rule.

“(4) Section 8153(c) of this title shall not apply to this subsection.

“(g) *REGULATIONS.*—Not later than one year after the date of the enactment of the Caring for Our Veterans Act of 2018, the Secretary shall promulgate regulations to carry out this section.

“(h) *WALK-IN CARE DEFINED.*—In this section, the term ‘walk-in care’ means non-emergent care provided by a qualifying non-Department entity or provider that furnishes episodic care and not longitudinal management of conditions

and is otherwise defined through regulations the Secretary shall promulgate.”.

(b) *EFFECTIVE DATE.*—Section 1725A of title 38, United States Code, as added by subsection (a) shall take effect on the date upon which final regulations implementing such section take effect.

(c) *CLERICAL AMENDMENT.*—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1725 the following new item:

“§ 1725A. Access to walk-in care.”.

**SEC. 106. STRATEGY REGARDING THE DEPARTMENT OF VETERANS AFFAIRS HIGH-PERFORMING INTEGRATED HEALTH CARE NETWORK.**

(a) *IN GENERAL.*—Subchapter II of chapter 73 is amended by inserting after section 7330B the following new section:

**“§ 7330C. Quadrennial Veterans Health Administration review**

“(a) *MARKET AREA ASSESSMENTS.*—(1) Not less frequently than every four years, the Secretary of Veterans Affairs shall perform market area assessments regarding the health care services furnished under the laws administered by the Secretary.

“(2) Each market area assessment established under paragraph (1) shall include the following:

“(A) An assessment of the demand for health care from the Department, disaggregated by geographic market areas as determined by the Secretary, including the number of requests for health care services under the laws administered by the Secretary.

“(B) An inventory of the health care capacity of the Department of Veterans Affairs across the Department’s system of facilities.

“(C) An assessment of the health care capacity to be provided through contracted community care providers and providers who entered into a provider agreement with the Department under section 1703A of title 38, as added by section 102, including the number of providers, the geographic location of the providers, and categories or types of health care services provided by the providers.

“(D) An assessment obtained from other Federal direct delivery systems of their capacity to provide health care to veterans.

“(E) An assessment of the health care capacity of non-contracted providers where there is insufficient network supply.

“(F) An assessment of the health care capacity of academic affiliates and other collaborations of the Department as it relates to providing health care to veterans.

“(G) An assessment of the effects on health care capacity of the access standards and standards for quality established under sections 1703B and 1703C of this title.

“(H) The number of appointments for health care services under the laws administered by the Secretary, disaggregated by—

“(i) appointments at facilities of the Department of Veterans Affairs; and

“(ii) appointments with non-Department health care providers.

“(3)(A) The Secretary shall submit to the appropriate committees of Congress the market area assessments established in paragraph (1).

“(B) The Secretary also shall submit to the appropriate committees of Congress the market area assessments completed by or being performed on the day before the date of the enactment of the Caring for Our Veterans Act of 2018.

“(4)(A) The Secretary shall use the market area assessments established under paragraph (1) to—

“(i) determine the capacity of the health care provider networks established under section 1703(h) of this title;

“(ii) inform the Department budget, in accordance with subparagraph (B); and

“(iii) inform and assess the appropriateness of the access standards established under section 1703B of this title and standards for quality

under section 1703C and to make recommendations for any changes to such standards.

“(B) The Secretary shall ensure that the Department budget for any fiscal year (as submitted with the budget of the President under section 1105(a) of title 31) reflects the findings of the Secretary with respect to the most recent market area assessments under paragraph (1) and health care utilization data from the Department and non-Department entities or providers furnishing care and services to covered veterans as described in section 1703(b).

“(b) STRATEGIC PLAN TO MEET HEALTH CARE DEMAND.—(1) Not later than one year after the date of the enactment of the Caring for Our Veterans Act of 2018 and not less frequently than once every four years thereafter, the Secretary shall submit to the appropriate committees of Congress a strategic plan that specifies a four-year forecast of—

“(A) the demand for health care from the Department, disaggregated by geographic area as determined by the Secretary;

“(B) the health care capacity to be provided at each medical center of the Department; and

“(C) the health care capacity to be provided through community care providers.

“(2) In preparing the strategic plan under paragraph (1), the Secretary shall—

“(A) assess the access standards and standards for quality established under sections 1703B and 1703C of this title;

“(B) assess the market area assessments established under subsection (a);

“(C) assess the needs of the Department based on identified services that provide management of conditions or disorders related to military service for which there is limited experience or access in the national market, the overall health of veterans throughout their lifespan, or other services as the Secretary determines appropriate;

“(D) consult with key stakeholders within the Department, the heads of other Federal agencies, and other relevant governmental and non-governmental entities, including State, local, and tribal government officials, members of Congress, veterans service organizations, private sector representatives, academics, and other policy experts;

“(E) identify emerging issues, trends, problems, and opportunities that could affect health care services furnished under the laws administered by the Secretary;

“(F) develop recommendations regarding both short- and long-term priorities for health care services furnished under the laws administered by the Secretary;

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

“(H) conduct a comprehensive examination of programs and policies of the Department regarding the delivery of health care services and the demand of health care services for veterans in future years;

“(I) assess the remediation of medical service lines of the Department as described in section 1706A in conjunction with the utilization of non-Department entities or providers to offset remediation; and

“(J) consider such other matters as the Secretary considers appropriate.

“(c) RESPONSIBILITIES.—The Secretary shall be responsible for—

“(1) overseeing the transformation and organizational change across the Department to achieve such high performing integrated health care network;

“(2) developing the capital infrastructure planning and procurement processes, whether minor or major construction projects or leases; and

“(3) developing a multi-year budget process that is capable of forecasting future year budget requirements and projecting the cost of delivering health care services under a high-performing integrated health care network.

“(d) APPROPRIATE COMMITTEES OF CONGRESS DEFINED.—In this section, the term ‘appropriate committees of Congress’ means—

“(1) the Committee on Veterans’ Affairs and the Committee on Appropriations of the Senate; and

“(2) the Committee on Veterans’ Affairs and the Committee on Appropriations of the House of Representatives.”

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 7330B the following new item:

“7330C. Quadrennial Veterans Health Administration review.”

**SEC. 107. APPLICABILITY OF DIRECTIVE OF OFFICE OF FEDERAL CONTRACT COMPLIANCE PROGRAMS.**

(a) IN GENERAL.—Notwithstanding the treatment of certain laws under subsection (i) of section 1703A of title 38, United States Code, as added by section 102 of this title, Directive 2014–01 of the Office of Federal Contract Compliance Programs of the Department of Labor (effective as of May 7, 2014) shall apply to any entity entering into an agreement under such section 1703A or section 1745 of such title, as amended by section 103, in the same manner as such directive applies to subcontractors under the TRICARE program for the duration of the moratorium provided under such directive.

(b) APPLICABILITY PERIOD.—The directive described in subsection (a), and the moratorium provided under such directive, shall not be altered or rescinded before May 7, 2019.

(c) TRICARE PROGRAM DEFINED.—In this section, the term “TRICARE program” has the meaning given that term in section 1072 of title 10, United States Code.

**SEC. 108. PREVENTION OF CERTAIN HEALTH CARE PROVIDERS FROM PROVIDING NON-DEPARTMENT HEALTH CARE SERVICES TO VETERANS.**

(a) IN GENERAL.—On and after the date that is one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall deny or revoke the eligibility of a health care provider to provide non-Department health care services to veterans if the Secretary determines that the health care provider—

(1) was removed from employment with the Department of Veterans Affairs due to conduct that violated a policy of the Department relating to the delivery of safe and appropriate health care; or

(2) violated the requirements of a medical license of the health care provider that resulted in the loss of such medical license.

(b) PERMISSIVE ACTION.—On and after the date that is one year after the date of the enactment of this Act, the Secretary may deny, revoke, or suspend the eligibility of a health care provider to provide non-Department health care services if the Secretary determines such action is necessary to immediately protect the health, safety, or welfare of veterans and the health care provider is under investigation by the medical licensing board of a State in which the health care provider is licensed or practices.

(c) SUSPENSION.—The Secretary shall suspend the eligibility of a health care provider to provide non-Department health care services to veterans if the health care provider is suspended from serving as a health care provider of the Department.

(d) COMPTROLLER GENERAL REPORT.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the implementation by the Secretary of this section, including the following:

(1) The aggregate number of health care providers denied or suspended under this section

from participation in providing non-Department health care services.

(2) An evaluation of any impact on access to health care for patients or staffing shortages in programs of the Department providing non-Department health care services.

(3) An explanation of the coordination of the Department with the medical licensing boards of States in implementing this section, the amount of involvement of such boards in such implementation, and efforts by the Department to address any concerns raised by such boards with respect to such implementation.

(4) Such recommendations as the Comptroller General considers appropriate regarding harmonizing eligibility criteria between health care providers of the Department and health care providers eligible to provide non-Department health care services.

(e) NON-DEPARTMENT HEALTH CARE SERVICES DEFINED.—In this section, the term “non-Department health care services” means services—

(1) provided under subchapter I of chapter 17 of title 38, United States Code, at non-Department facilities (as defined in section 1701 of such title);

(2) provided under section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note);

(3) purchased through the Medical Community Care account of the Department; or

(4) purchased with amounts deposited in the Veterans Choice Fund under section 802 of the Veterans Access, Choice, and Accountability Act of 2014.

**SEC. 109. REMEDIATION OF MEDICAL SERVICE LINES.**

(a) IN GENERAL.—Subchapter I of chapter 17 is amended by inserting after section 1706 the following new section:

**“§ 1706A. Remediation of medical service lines**

“(a) IN GENERAL.—Not later than 30 days after determining under section 1703(e)(1) that a medical service line of the Department is providing hospital care, medical services, or extended care services that does not comply with the standards for quality established by the Secretary, the Secretary shall submit to Congress an assessment of the factors that led the Secretary to make such determination and a plan with specific actions, and the time to complete them, to be taken to comply with such standards for quality, including the following:

“(1) Increasing personnel or temporary personnel assistance, including mobile deployment teams.

“(2) Special hiring incentives, including the Education Debt Reduction Program under subchapter VII of chapter 76 of this title and recruitment, relocation, and retention incentives.

“(3) Utilizing direct hiring authority.

“(4) Providing improved training opportunities for staff.

“(5) Acquiring improved equipment.

“(6) Making structural modifications to the facility used by the medical service line.

“(7) Such other actions as the Secretary considers appropriate.

“(b) RESPONSIBLE PARTIES.—In each assessment submitted under subsection (a) with respect to a medical service line, the Secretary shall identify the individuals at the Central Office of the Veterans Health Administration, the facility used by the medical service line, and the central office of the relevant Veterans Integrated Service Network who are responsible for overseeing the progress of that medical service line in complying with the standards for quality established by the Secretary.

“(c) INTERIM REPORTS.—Not later than 180 days after submitting an assessment under subsection (a) with respect to a medical service line, the Secretary shall submit to Congress a report on the progress of that medical service line in complying with the standards for quality established by the Secretary and any other measures the Secretary will take to assist the medical

service line in complying with such standards for quality.

“(d) ANNUAL REPORTS.—Not less frequently than once each year, the Secretary shall—

“(1) submit to Congress an analysis of the remediation actions and costs of such actions taken with respect to each medical service line with respect to which the Secretary submitted an assessment and plan under paragraph (1) in the preceding year, including an update on the progress of each such medical service line in complying with the standards for quality and timeliness established by the Secretary and any other actions the Secretary is undertaking to assist the medical service line in complying with standards for quality as established by the Secretary; and

“(2) publish such analysis on the internet website of the Department.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1706 the following new item:

“1706.A. Remediation of medical service lines.”.

## CHAPTER 2—PAYING PROVIDERS AND IMPROVING COLLECTIONS

### SEC. 111. PROMPT PAYMENT TO PROVIDERS.

(a) IN GENERAL.—Subchapter 1 of chapter 17 is amended by inserting after section 1703C, as added by section 104 of this title, the following new section:

#### “§ 1703D. Prompt payment standard

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

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

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

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

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

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

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

“(d) OVERDUE CLAIMS.—(1) Any claim that has not been denied with notice, made pending with notice, or paid to the health care entity or provider by the Secretary shall be overdue if the notice or payment is not received by the entity provider within the time periods specified in subsection (a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(A) a feasibility assessment to determine the capacity of the Department to process such claims in a timely manner; and

“(B) a cost benefit analysis comparing the capacity of the Department to a third party entity capable of processing such claims.

“(3) The review required under paragraph (2) shall apply to claims for hospital care, medical services, or extended care services furnished under section 1703 of this Act, as amended by the Caring for Our Veterans Act of 2018, that are processed by the Department.

“(h) REPORT ON ENCOUNTER DATA SYSTEM.—(1) Not later than 90 days after the date of the enactment of the Caring for Our Veterans Act of 2018, the Secretary shall submit to the appropriate committees of Congress a report on the feasibility and advisability of adopting a funding mechanism similar to what is utilized by other Federal agencies to allow a contracted entity to act as a fiscal intermediary for the Federal Government to distribute, or pass through, Federal Government funds for certain non-underwritten hospital care, medical services, or extended care services.

“(2) The Secretary may coordinate with the Department of Defense, the Department of Health and Human Services, and the Department of the Treasury in developing the report required by paragraph (1).

“(i) DEFINITIONS.—In this section:

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

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

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

“(2) The term ‘clean electronic claim’ means the transmission of data for purposes of payment of covered health care expenses that is submitted to the Secretary which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the entity or provider that furnished the care or service, submitted in such format as prescribed by the Secretary in regulations for the purpose of paying claims for care or services.

“(3) The term ‘clean paper claim’ means a paper claim for payment of covered health care expenses that is submitted to the Secretary which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the entity or provider that furnished the care or service, submitted in such format as prescribed by the Secretary in regulations for the purpose of paying claims for care or services.

“(4) The term ‘fraudulent claims’ means the knowing misrepresentation of a material fact or facts by a health care entity or provider made to induce the Secretary to pay a claim that was not legally payable to that provider.

“(5) The term ‘health care entity or provider’ includes any non-Department health care entity or provider, but does not include any Federal health care entity or provider.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1703C, as added by section 104 of this title, the following new item:

“1703D. Prompt payment standard.”.

### SEC. 112. AUTHORITY TO PAY FOR AUTHORIZED CARE NOT SUBJECT TO AN AGREEMENT.

(a) IN GENERAL.—Subchapter IV of chapter 81 is amended by adding at the end the following new section:

#### “§ 8159. Authority to pay for services authorized but not subject to an agreement

“(a) IN GENERAL.—If, in the course of furnishing hospital care, a medical service, or an extended care service authorized by the Secretary and pursuant to a contract, agreement, or other arrangement with the Secretary, a provider who is not a party to the contract, agreement, or other arrangement furnishes hospital care, a medical service, or an extended care service that the Secretary considers necessary, the Secretary may compensate the provider for the cost of such care or service.

“(b) NEW CONTRACTS AND AGREEMENTS.—The Secretary shall take reasonable efforts to enter into a contract, agreement, or other arrangement with a provider described in subsection (a)

to ensure that future care and services authorized by the Secretary and furnished by the provider are subject to such a contract, agreement, or other arrangement.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 8158 the following new item:

“8159. Authority to pay for services authorized but not subject to an agreement.”.

**SEC. 113. IMPROVEMENT OF AUTHORITY TO RECOVER THE COST OF SERVICES FURNISHED FOR NON-SERVICE-CONNECTED DISABILITIES.**

(a) BROADENING SCOPE OF APPLICABILITY.—Section 1729 is amended—

(1) in subsection (a)—

(A) in paragraph (2)(A)—

(i) by striking “the veteran’s” and inserting “the individual’s”; and

(ii) by striking “the veteran” and inserting “the individual”; and

(B) in paragraph (3)—

(i) in the matter preceding subparagraph (A), by striking “the veteran” and inserting “the individual”; and

(ii) in subparagraph (A), by striking “the veteran’s” and inserting “the individual’s”;

(2) in subsection (b)—

(A) in paragraph (1)—

(i) by striking “the veteran” and inserting “the individual”; and

(ii) by striking “the veteran’s” and inserting “the individual’s”; and

(B) in paragraph (2)—

(i) in subparagraph (A)—

(I) by striking “the veteran” and inserting “the individual”; and

(II) by striking “the veteran’s” and inserting “the individual’s”; and

(ii) in subparagraph (B)—

(I) in clause (i), by striking “the veteran” and inserting “the individual”; and

(II) in clause (ii)—

(aa) by striking “the veteran” and inserting “the individual”; and

(bb) by striking “the veteran’s” each place it appears and inserting “the individual’s”;

(3) in subsection (e), by striking “A veteran” and inserting “An individual”; and

(4) in subsection (h)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A), by striking “a veteran” and inserting “an individual”;

(ii) in subparagraph (A), by striking “the veteran” and inserting “the individual”; and

(iii) in subparagraph (B), by striking “the veteran” and inserting “the individual”; and

(B) in paragraph (2)—

(i) by striking “A veteran” and inserting “An individual”;

(ii) by striking “a veteran” and inserting “an individual”; and

(iii) by striking “the veteran” and inserting “the individual”.

(b) MODIFICATION OF AUTHORITY.—Subsection (a)(1) of such section is amended by striking “(1) Subject” and all that follows through the period and inserting the following: “(1) Subject to the provisions of this section, in any case in which the United States is required by law to furnish or pay for care or services under this chapter for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect from a third party the reasonable charges of care or services so furnished or paid for to the extent that the recipient or provider of the care or services would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished or paid for by a department or agency of the United States.”.

(c) MODIFICATION OF ELIGIBLE INDIVIDUALS.—Subparagraph (D) of subsection (a)(2) of such section is amended to read as follows:

“(D) that is incurred by an individual who is entitled to care (or payment of the expenses of care) under a health-plan contract.”.

**SEC. 114. PROCESSING OF CLAIMS FOR REIMBURSEMENT THROUGH ELECTRONIC INTERFACE.**

The Secretary of Veterans Affairs may enter into an agreement with a third-party entity to process, through the use of an electronic interface, claims for reimbursement for health care provided under the laws administered by the Secretary.

**CHAPTER 3—EDUCATION AND TRAINING PROGRAMS**

**SEC. 121. EDUCATION PROGRAM ON HEALTH CARE OPTIONS.**

(a) IN GENERAL.—The Secretary of Veterans Affairs shall develop and administer an education program that teaches veterans about their health care options through the Department of Veterans Affairs.

(b) ELEMENTS.—The program under subsection (a) shall—

(1) teach veterans about—

(A) eligibility criteria for care from the Department set forth under sections 1703, as amended by section 101 of this title, and 1710 of title 38, United States Code;

(B) priority groups for enrollment in the system of annual patient enrollment under section 1705(a) of such title;

(C) the copayments and other financial obligations, if any, required of certain individuals for certain services; and

(D) how to utilize the access standards and standards for quality established under sections 1703B and 1703C of such title;

(2) teach veterans about the interaction between health insurance (including private insurance, Medicare, Medicaid, the TRICARE program, the Indian Health Service, tribal health programs, and other forms of insurance) and health care from the Department; and

(3) provide veterans with information on what to do when they have a complaint about health care received from the Department (whether about the provider, the Department, or any other type of complaint).

(c) ACCESSIBILITY.—In developing the education program under this section, the Secretary shall ensure that materials under such program are accessible—

(1) to veterans who may not have access to the internet; and

(2) to veterans in a manner that complies with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

(d) ANNUAL EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall develop a method to evaluate the effectiveness of the education program under this section and evaluate the program using the method not less frequently than once each year.

(2) REPORT.—Not less frequently than once each year, the Secretary shall submit to Congress a report on the findings of the Secretary with respect to the most recent evaluation conducted by the Secretary under paragraph (1).

(e) DEFINITIONS.—In this section:

(1) MEDICAID.—The term “Medicaid” means the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) MEDICARE.—The term “Medicare” means the Medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.).

(3) TRICARE PROGRAM.—The term “TRICARE program” has the meaning given that term in section 1072 of title 10, United States Code.

**SEC. 122. TRAINING PROGRAM FOR ADMINISTRATION OF NON-DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE.**

(a) ESTABLISHMENT OF PROGRAM.—The Secretary of Veterans Affairs shall develop and implement a training program to train employees and contractors of the Department of Veterans Affairs on how to administer non-Department health care programs, including the following:

(1) Reimbursement for non-Department emergency room care.

(2) The Veterans Community Care Program under section 1703 of such title, as amended by section 101.

(3) Management of prescriptions pursuant to improvements under section 131.

(b) ANNUAL EVALUATION AND REPORT.—The Secretary shall—

(1) develop a method to evaluate the effectiveness of the training program developed and implemented under subsection (a);

(2) evaluate such program not less frequently than once each year; and

(3) not less frequently than once each year, submit to Congress the findings of the Secretary with respect to the most recent evaluation carried out under paragraph (2).

**SEC. 123. CONTINUING MEDICAL EDUCATION FOR NON-DEPARTMENT MEDICAL PROFESSIONALS.**

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall establish a program to provide continuing medical education material to non-Department medical professionals.

(2) EDUCATION PROVIDED.—The program established under paragraph (1) shall include education on the following:

(A) Identifying and treating common mental and physical conditions of veterans and family members of veterans.

(B) The health care system of the Department of Veterans Affairs.

(C) Such other matters as the Secretary considers appropriate.

(b) MATERIAL PROVIDED.—The continuing medical education material provided to non-Department medical professionals under the program established under subsection (a) shall be the same material provided to medical professionals of the Department to ensure that all medical professionals treating veterans have access to the same materials, which supports core competencies throughout the community.

(c) ADMINISTRATION OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall administer the program established under subsection (a) to participating non-Department medical professionals through an internet website of the Department of Veterans Affairs.

(2) CURRICULUM AND CREDIT PROVIDED.—The Secretary shall determine the curriculum of the program and the number of hours of credit to provide to participating non-Department medical professionals for continuing medical education.

(3) ACCREDITATION.—The Secretary shall ensure that the program is accredited in as many States as practicable.

(4) CONSISTENCY WITH EXISTING RULES.—The Secretary shall ensure that the program is consistent with the rules and regulations of the following:

(A) The medical licensing agency of each State in which the program is accredited.

(B) Such medical credentialing organizations as the Secretary considers appropriate.

(5) USER COST.—The Secretary shall carry out the program at no cost to participating non-Department medical professionals.

(6) MONITORING, EVALUATION, AND REPORT.—The Secretary shall monitor the utilization of the program established under subsection (a), evaluate its effectiveness, and report to Congress on utilization and effectiveness not less frequently than once each year.

(d) NON-DEPARTMENT MEDICAL PROFESSIONAL DEFINED.—In this section, the term “non-Department medical professional” means any individual who is licensed by an appropriate medical authority in the United States and is in good standing, is not an employee of the Department of Veterans Affairs, and provides care to veterans or family members of veterans under the laws administered by the Secretary of Veterans Affairs.

**CHAPTER 4—OTHER MATTERS RELATING TO NON-DEPARTMENT OF VETERANS AFFAIRS PROVIDERS**

**SEC. 131. ESTABLISHMENT OF PROCESSES TO ENSURE SAFE OPIOID PRESCRIBING PRACTICES BY NON-DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE PROVIDERS.**

(a) **RECEIPT AND REVIEW OF GUIDELINES.**—The Secretary of Veterans Affairs shall ensure that all covered health care providers are provided a copy of and certify that they have reviewed the evidence-based guidelines for prescribing opioids set forth by the Opioid Safety Initiative of the Department of Veterans Affairs.

(b) **INCLUSION OF MEDICAL HISTORY AND CURRENT MEDICATIONS.**—The Secretary shall implement a process to ensure that, if care of a veteran by a covered health care provider is authorized under the laws administered by the Secretary, the document authorizing such care includes the available and relevant medical history of the veteran and a list of all medications prescribed to the veteran as known by the Department.

(c) **SUBMITTAL OF MEDICAL RECORDS AND PRESCRIPTIONS.**—

(1) **IN GENERAL.**—The Secretary shall, consistent with section 1703(a)(2)(A), as amended by section 101 of this title, and section 1703A(e)(2)(F), as added by section 102 of this title, require each covered health care provider to submit medical records of any care or services furnished, including records of any prescriptions for opioids, to the Department in the timeframe and format specified by the Secretary.

(2) **RESPONSIBILITY OF DEPARTMENT FOR RECORDING AND MONITORING.**—In carrying out paragraph (1) and upon the receipt by the Department of the medical records described in paragraph (1), the Secretary shall—

(A) ensure the Department is responsible for the recording of the prescription in the electronic health record of the veteran; and

(B) enable other monitoring of the prescription as outlined in the Opioid Safety Initiative of the Department.

(3) **REPORT.**—Not less frequently than annually, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report evaluating the compliance of covered health care providers with the requirements under this section.

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

(1) **IN GENERAL.**—If the Secretary determines that the opioid prescribing practices of a covered health care provider, when treating covered veterans, satisfy a condition described in paragraph (3), the Secretary shall take such action as the Secretary considers appropriate to ensure the safety of all veterans receiving care from that health care provider, including removing or directing the removal of any such health care provider from provider networks or otherwise refusing to authorize care of veterans by such health care provider in any program authorized under the laws administered by the Secretary.

(2) **INCLUSION IN CONTRACTS.**—The Secretary shall ensure that any contracts, agreements, or other arrangements entered into by the Secretary with third parties involved in administering programs that provide care in the community to veterans under the laws administered by the Secretary specifically grant the authority set forth in paragraph (1) to such third parties and to the Secretary, as the case may be.

(3) **CONDITIONS FOR EXCLUSION OR LIMITATION.**—The Secretary shall take such action as is considered appropriate under paragraph (1) when the opioid prescribing practices of a covered health care provider when treating covered veterans—

(A) conflict with or are otherwise inconsistent with the standards of appropriate and safe care;

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

(C) may place at risk the veterans receiving health care from the provider.

(e) **COVERED HEALTH CARE PROVIDER DEFINED.**—In this section, the term “covered health care provider” means a non-Department of Veterans Affairs health care provider who provides health care to veterans under the laws administered by the Secretary of Veterans Affairs, but does not include a health care provider employed by another agency of the Federal Government.

**SEC. 132. IMPROVING INFORMATION SHARING WITH COMMUNITY PROVIDERS.**

Section 7332(b)(2) is amended by striking subparagraph (H) and inserting the following new subparagraphs:

“(H)(i) To a non-Department entity (including private entities and other Federal agencies) for purposes of providing health care, including hospital care, medical services, and extended care services, to patients or performing other health care-related activities or functions.

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

“(I) To a third party in order to recover or collect reasonable charges for care furnished to, or paid on behalf of, a patient in connection with a non-service connected disability as permitted by section 1729 of this title or for a condition for which recovery is authorized or with respect to which the United States is deemed to be a third party beneficiary under the Act entitled ‘An Act to provide for the recovery from tortiously liable third persons of the cost of hospital and medical care and treatment furnished by the United States’ (Public Law 87–693; 42 U.S.C. 2651 et seq.; commonly known as the ‘Federal Medical Care Recovery Act’).”.

**SEC. 133. COMPETENCY STANDARDS FOR NON-DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE PROVIDERS.**

(a) **ESTABLISHMENT OF STANDARDS AND REQUIREMENTS.**—The Secretary of Veterans Affairs shall establish standards and requirements for the provision of care by non-Department of Veterans Affairs health care providers in clinical areas for which the Department of Veterans Affairs has special expertise, including post-traumatic stress disorder, military sexual trauma-related conditions, and traumatic brain injuries.

(b) **CONDITION FOR ELIGIBILITY TO FURNISH CARE.**—(1) Each non-Department of Veterans Affairs health care provider shall, to the extent practicable as determined by the Secretary or otherwise provided for in paragraph (2), meet the standards and requirements established pursuant to subsection (a) before furnishing care pursuant to a contract, agreement, or other arrangement with the Department of Veterans Affairs. Non-Department of Veterans Affairs health care providers furnishing care pursuant to a contract, agreement, or other arrangement shall, to the extent practicable as determined by the Secretary, fulfill training requirements established by the Secretary on how to deliver evidence-based treatments in the clinical areas for which the Department of Veterans Affairs has special expertise.

(2) Each non-Department of Veterans Affairs health care provider who enters into a contract, agreement, or other arrangement after the effective date identified in subsection (c) shall, to the extent practicable, meet the standards and requirements established pursuant to subsection (a) within 6 months of the contract, agreement, or other arrangement taking effect.

(c) **EFFECTIVE DATE.**—This section shall take effect on the day that is one year after the date of the enactment of this Act.

**SEC. 134. DEPARTMENT OF VETERANS AFFAIRS PARTICIPATION IN NATIONAL NETWORK OF STATE-BASED PRESCRIPTION DRUG MONITORING PROGRAMS.**

(a) **IN GENERAL.**—Chapter 17 is amended by inserting after section 1730A the following new section:

**“§1730B. Access to State prescription drug monitoring programs**

“(a) **ACCESS TO PROGRAMS.**—(1) Any licensed health care provider or delegate of such a provider shall be considered an authorized recipient or user for the purpose of querying and receiving data from the national network of State-based prescription drug monitoring programs to support the safe and effective prescribing of controlled substances to covered patients.

“(2) Under the authority granted by paragraph (1)—

“(A) licensed health care providers or delegates of such providers shall query such network in accordance with applicable regulations and policies of the Veterans Health Administration; and

“(B) notwithstanding any general or specific provision of law, rule, or regulation of a State, no State may restrict the access of licensed health care providers or delegates of such providers from accessing that State’s prescription drug monitoring programs.

“(3) No State shall deny or revoke the license, registration, or certification of a licensed health care provider or delegate who otherwise meets that State’s qualifications for holding the license, registration, or certification on the basis that the licensed health care provider or delegate queried or received data, or attempted to query or receive data, from the national network of State-based prescription drug monitoring programs under this section.

“(b) **COVERED PATIENTS.**—For purposes of this section, a covered patient is a patient who—

“(1) receives a prescription for a controlled substance; and

“(2) is not receiving palliative care or enrolled in hospice care.

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

“(1) The term ‘controlled substance’ has the meaning given such term in section 102(6) of the Controlled Substances Act (21 U.S.C. 802(6)).

“(2) The term ‘delegate’ means a person or automated system accessing the national network of State-based prescription monitoring programs at the direction or under the supervision of a licensed health care provider.

“(3) The term ‘licensed health care provider’ means a health care provider employed by the Department who is licensed, certified, or registered within any State to fill or prescribe medications within the scope of his or her practice as a Department employee.

“(4) The term ‘national network of State-based prescription monitoring programs’ means an interconnected nation-wide system that facilitates the transfer to State prescription drug monitoring program data across State lines.

“(5) The term ‘State’ means a State, as defined in section 101(20) of this title, or a political subdivision of a State.”.

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

“1730B. Access to State prescription drug monitoring programs.”.

**CHAPTER 5—OTHER NON-DEPARTMENT HEALTH CARE MATTERS**

**SEC. 141. PLANS FOR USE OF SUPPLEMENTAL APPROPRIATIONS REQUIRED.**

Whenever the Secretary submits to Congress a request for supplemental appropriations or any other appropriation outside the standard budget process to address a budgetary issue affecting the Department of Veterans Affairs, the Secretary shall, not later than 45 days before the date on which such budgetary issue would start

affecting a program or service, submit to Congress a justification for the request, including a plan that details how the Secretary intends to use the requested appropriation and how long the requested appropriation is expected to meet the needs of the Department and certification that the request was made using an updated and sound actuarial analysis.

**SEC. 142. VETERANS CHOICE FUND FLEXIBILITY.**

Section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 38 U.S.C. 1701 note) is amended—

(1) in subsection (c)—

(A) in paragraph (1), by striking “by paragraph (3)” and inserting “in paragraphs (3) and (4)”;

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

“(4) PERMANENT AUTHORITY FOR OTHER USES.—Beginning on March 1, 2019, amounts remaining in the Veterans Choice Fund may be used to furnish hospital care, medical services, and extended care services to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities, including pursuant to non-Department provider programs other than the program established by section 101. Such amounts shall be available in addition to amounts available in other appropriations accounts for such purposes.”; and

(2) in subsection (d)(1), by striking “to subsection (c)(3)” and inserting “to paragraphs (3) and (4) of subsection (c)”.

**SEC. 143. SUNSET OF VETERANS CHOICE PROGRAM.**

Subsection (p) of section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 38 U.S.C. 1701 note) is amended to read as follows:

“(p) AUTHORITY TO FURNISH CARE AND SERVICES.—The Secretary may not use the authority under this section to furnish care and services after the date that is one year after the date of the enactment of the Caring for Our Veterans Act of 2018.”.

**SEC. 144. CONFORMING AMENDMENTS.**

(a) IN GENERAL.—

(1) TITLE 38.—Title 38, United States Code, is amended—

(A) in section 1712(a)—

(i) in paragraph (3), by striking “under clause (1), (2), or (5) of section 1703(a) of this title” and inserting “or entered an agreement”;

(ii) in paragraph (4)(A), by striking “under the provisions of this subsection and section 1703 of this title”;

(B) in section 1712A(e)(1)—

(i) by inserting “or agreements” after “contracts”;

(ii) by striking “(under sections 1703(a)(2) and 1710(a)(1)(B) of this title)”;

(C) in section 2303(a)(2)(B)(i), by striking “with section 1703” and inserting “with sections 1703A, 8111, and 8153”.

(2) SOCIAL SECURITY ACT.—Section 1866(a)(1)(L) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(L)) is amended by striking “under section 603” and inserting “under chapter 17”.

(3) VETERANS’ BENEFITS IMPROVEMENTS ACT OF 1994.—Section 104(a)(4)(A) of the Veterans’ Benefits Improvements Act of 1994 (Public Law 103-446; 38 U.S.C. 1117 note) is amended by striking “in section 1703” and inserting “in sections 1703A, 8111, and 8153”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date described in section 101(b).

**Subtitle B—Improving Department of Veterans Affairs Health Care Delivery**

**SEC. 151. LICENSURE OF HEALTH CARE PROFESSIONALS OF THE DEPARTMENT OF VETERANS AFFAIRS PROVIDING TREATMENT VIA TELEMEDICINE.**

(a) IN GENERAL.—Chapter 17 is amended by inserting after section 1730B, as added by section 134, the following new section:

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

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

“(b) COVERED HEALTH CARE PROFESSIONALS.—For purposes of this section, a covered health care professional is any health care professional who—

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

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

“(3) is required to adhere to all standards for quality relating to the provision of medicine in accordance with applicable policies of the Department; and

“(4) has an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional.

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

“(d) RELATION TO STATE LAW.—(1) The provisions of this section shall supersede any provisions of the law of any State to the extent that such provision of State law are inconsistent with this section.

“(2) No State shall deny or revoke the license, registration, or certification of a covered health care professional who otherwise meets the qualifications of the State for holding the license, registration, or certification on the basis that the covered health care professional has engaged or intends to engage in activity covered by subsection (a).

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

“(f) STATE DEFINED.—In this section, the term ‘State’ means a State, as defined in section 101(20) of this title, or a political subdivision of a State.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 of such title is amended by inserting after the item relating to section 1730B, as added by section 134, the following new item:

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

(c) REPORT ON TELEMEDICINE.—

(1) IN GENERAL.—Not later than one year after the earlier of the date on which services provided under section 1730B of title 38, United States Code, as added by subsection (a), first occur or regulations are promulgated to carry out such section, the Secretary of Veterans Affairs shall submit to the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report on the effectiveness of the use of telemedicine by the Department of Veterans Affairs.

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

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

(B) The satisfaction of health care providers in providing telemedicine furnished by the Department.

(C) The effect of telemedicine furnished by the Department on the following:

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

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

(iii) The productivity of health care providers.

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

(v) The use by veterans of in-person services at Department facilities and non-Department facilities.

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

(E) The number of appointments for the receipt of telemedicine furnished by the Department that were requested during such period, disaggregated by medical facility.

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

**SEC. 152. AUTHORITY FOR DEPARTMENT OF VETERANS AFFAIRS CENTER FOR INNOVATION FOR CARE AND PAYMENT.**

(a) IN GENERAL.—Subchapter I of chapter 17, as amended by this title, is further amended by inserting after section 1703D, as added by section 111, the following new section:

**“§1703E. Center for Innovation for Care and Payment**

“(a) IN GENERAL.—(1) There is established within the Department a Center for Innovation for Care and Payment (in this section referred to as the ‘Center’).

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

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

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

“(B) create cost savings for the Department.

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

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

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

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

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

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

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

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

“(6)(A) Models tested under this section may not be designed in such a way that would allow

the United States to recover or collect reasonable charges from a Federal health care program for care or services furnished by the Secretary to a veteran under pilot programs carried out under this section.

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

“(i) an insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of such Act (42 U.S.C. 1395j);

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

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

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

“(c) LOCATION.—The Secretary shall ensure that each pilot program carried out under this section occurs in an area or areas appropriate for the intended purposes of the pilot program. To the extent practicable, the Secretary shall ensure that the pilot programs are located in geographically diverse areas of the United States.

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

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

“(2) provided for information technology systems.

“(e) NOTICE.—The Secretary shall—

“(1) publish information about each pilot program under this section in the Federal Register; and

“(2) take reasonable actions to provide direct notice to veterans eligible to participate in such pilot programs.

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

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

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

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

“(C) The reasons for such waiver or waivers.

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

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

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

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

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

“(3)(A) Upon receipt of a report submitted under paragraph (2), each House of Congress shall provide copies of the report to the chairman and ranking member of each standing committee with jurisdiction under the rules of the House of Representatives or the Senate to report a bill to amend the provision or provisions of law that would be waived by the Department under this subsection.

“(B) The waiver requested by the Secretary under paragraph (2) shall be considered approved under this paragraph if there is enacted into law a joint resolution approving such request in its entirety.

“(C) For purposes of this paragraph, the term ‘joint resolution’ means only a joint resolution which is introduced within the period of five legislative days beginning on the date on which the Secretary transmits the report to the Congress under such paragraph (2), and—

“(i) which does not have a preamble; and

“(ii) the matter after the resolving clause of which is as follows: ‘that Congress approve the request for a waiver under section 1703E(f) of title 38, United States Code, as submitted by the Secretary on \_\_\_\_\_’, the blank space being filled with the appropriate date.

“(D)(i) Any committee of the House of Representatives to which a joint resolution is referred shall report it to the House without amendment not later than 15 legislative days after the date of introduction thereof. If a committee fails to report the joint resolution within that period, the committee shall be discharged from further consideration of the joint resolution.

“(ii) It shall be in order at any time after the third legislative day after each committee authorized to consider a joint resolution has reported or has been discharged from consideration of a joint resolution, to move to proceed to consider the joint resolution in the House. All points of order against the motion are waived. Such a motion shall not be in order after the House has disposed of a motion to proceed on a joint resolution addressing a particular submission. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. The motion shall not be debatable. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

“(iii) The joint resolution shall be considered as read. All points of order against the joint resolution and against its consideration are waived. The previous question shall be considered as ordered on the joint resolution to its passage without intervening motion except two hours of debate equally divided and controlled by the proponent and an opponent. A motion to reconsider the vote on passage of the joint resolution shall not be in order.

“(E)(i) A joint resolution introduced in the Senate shall be referred to the Committee on Veterans’ Affairs.

“(ii) Any committee of the Senate to which a joint resolution is referred shall report it to the Senate without amendment not later than 15 session days after the date of introduction of a joint resolution described in paragraph (C). If a committee fails to report the joint resolution within that period, the committee shall be discharged from further consideration of the joint resolution and the joint resolution shall be placed on the calendar.

“(iii)(I) Notwithstanding Rule XXII of the Standing Rules of the Senate, it is in order at any time after the third session day on which the Committee on Veterans’ Affairs has reported or has been discharged from consideration of a joint resolution described in paragraph (C) (even though a previous motion to the same effect has been disagreed to) to move to proceed to the consideration of the joint resolution, and all points of order against the joint resolution (and against consideration of the joint resolution) are

waived. The motion to proceed is not debatable. The motion is not subject to a motion to postpone. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the resolution is agreed to, the joint resolution shall remain the unfinished business until disposed of.

“(II) Consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than two hours, which shall be divided equally between the majority and minority leaders or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

“(III) If the Senate has voted to proceed to a joint resolution, the vote on passage of the joint resolution shall occur immediately following the conclusion of consideration of the joint resolution, and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate.

“(IV) Appeals from the decisions of the Chair relating to the application of the rules of the Senate, as the case may be, to the procedure relating to a joint resolution shall be decided without debate.

“(F) A joint resolution considered pursuant to this paragraph shall not be subject to amendment in either the House of Representatives or the Senate.

“(G)(i) If, before the passage by one House of the joint resolution of that House, that House receives the joint resolution from the other House, then the following procedures shall apply:

“(I) The joint resolution of the other House shall not be referred to a committee.

“(II) With respect to the joint resolution of the House receiving the joint resolution—

“(aa) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

“(bb) the vote on passage shall be on the joint resolution of the other House.

“(ii) If the Senate fails to introduce or consider a joint resolution under this paragraph, the joint resolution of the House shall be entitled to expedited floor procedures under this subparagraph.

“(iii) If, following passage of the joint resolution in the Senate, the Senate then receives the companion measure from the House of Representatives, the companion measure shall not be debatable.

“(H) This subparagraph is enacted by Congress—

“(i) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a joint resolution, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

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

“(g) LIMITATIONS.—(1) The Secretary may not carry out more than 10 pilot programs concurrently.

“(2)(A) Subject to subparagraph (B), the Secretary may not expend more than \$50,000,000 in any fiscal year from amounts under subsection (d).

“(B) The Secretary may expend more than the amount in subparagraph (A) if—

“(i) the Secretary determines that the additional expenditure is necessary to carry out pilot programs under this section;

“(ii) the Secretary submits to the Committees on Veterans’ Affairs of the Senate and the

House of Representatives a report setting forth the amount of the additional expenditure and a justification for the additional expenditure; and

“(iii) the Chairmen of the Committees on Veterans’ Affairs of the Senate and the House of Representatives transmit to the Secretary a letter approving of the additional expenditure.

“(3) The waiver provisions in subsection (f) shall not apply unless the Secretary, in accordance with the requirements in subsection (f), submits the first proposal for a pilot program not later than 18 months after the date of the enactment of the Caring for Our Veterans Act of 2018.

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

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

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

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

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

“(h) EVALUATION AND REPORTING REQUIREMENTS.—(1) The Secretary shall conduct an evaluation of each model tested, which shall include, at a minimum, an analysis of—

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

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

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

“(i) COORDINATION AND ADVICE.—(1) The Secretary shall obtain advice from the Under Secretary for Health and the Special Medical Advisory Group established pursuant to section 7312 of this title in the development and implementation of any pilot program operated under this section.

“(2) In carrying out the duties under this section, the Secretary shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The Secretary shall use appropriate mechanisms to seek input from interested parties.

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

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

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

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

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

(b) CONFORMING AMENDMENT.—The table of sections at the beginning of such chapter, as amended by this title, is further amended by inserting after the item relating to section 1703D the following new item:

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

**SEC. 153. AUTHORIZATION TO PROVIDE FOR OPERATIONS ON LIVE DONORS FOR PURPOSES OF CONDUCTING TRANSPLANT PROCEDURES FOR VETERANS.**

(a) IN GENERAL.—Subchapter VIII of chapter 17 is amended by adding at the end the following new section:

**“§ 1788. Transplant procedures with live donors and related services**

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

“(b) OTHER SERVICES.—Subject to the availability of appropriations for such purpose, the Secretary shall furnish to a live donor any care or services before and after conducting the transplant procedure under subsection (a) that may be required in connection with such procedure.

“(c) USE OF NON-DEPARTMENT FACILITIES.—In carrying out this section, the Secretary may provide for the operation described in subsection (a) on a live donor and furnish to the live donor the care and services described in subsection (b) at a non-Department facility pursuant to an agreement entered into by the Secretary under this chapter. The live donor shall be deemed to be an individual eligible for hospital care and medical services at a non-Department facility pursuant to such an agreement solely for the purposes of receiving such operation, care, and services at the non-Department facility.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1787 the following new item:

“1788. Transplant procedures with live donors and related services.”.

**Subtitle C—Family Caregivers**

**SEC. 161. EXPANSION OF FAMILY CAREGIVER PROGRAM OF DEPARTMENT OF VETERANS AFFAIRS.**

(a) FAMILY CAREGIVER PROGRAM.—

(1) EXPANSION OF ELIGIBILITY.—

(A) IN GENERAL.—Subparagraph (B) of subsection (a)(2) of section 1720G is amended to read as follows:

“(B) for assistance provided under this subsection—

“(i) before the date on which the Secretary submits to Congress a certification that the Department has fully implemented the information technology system required by section 162(a) of the Caring for Our Veterans Act of 2018, has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001;

“(ii) during the two-year period beginning on the date on which the Secretary submitted to Congress the certification described in clause (i), has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service—

“(I) on or before May 7, 1975; or

“(II) on or after September 11, 2001; or

“(iii) after the date that is two years after the date on which the Secretary submits to Congress the certification described in clause (i), has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder)

incurred or aggravated in the line of duty in the active military, naval, or air service; and”.

(B) PUBLICATION IN FEDERAL REGISTER.—Not later than 30 days after the date on which the Secretary of Veterans Affairs submits to Congress the certification described in subsection (a)(2)(B)(i) of section 1720G of such title, as amended by subparagraph (A) of this paragraph, the Secretary shall publish the date specified in such subsection in the Federal Register.

(2) EXPANSION OF NEEDED SERVICES IN ELIGIBILITY CRITERIA.—Subsection (a)(2)(C) of such section is amended—

(A) in clause (ii), by striking “; or” and inserting a semicolon;

(B) by redesignating clause (iii) as clause (iv); and

(C) by inserting after clause (ii) the following new clause (iii):

“(iii) a need for regular or extensive instruction or supervision without which the ability of the veteran to function in daily life would be seriously impaired; or”.

(3) EXPANSION OF SERVICES PROVIDED.—Subsection (a)(3)(A)(ii) of such section is amended—

(A) in subclause (IV), by striking “; and” and inserting a semicolon;

(B) in subclause (V), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following new subclause:

“(VI) through the use of contracts with, or the provision of grants to, public or private entities—

“(aa) financial planning services relating to the needs of injured veterans and their caregivers; and

“(bb) legal services, including legal advice and consultation, relating to the needs of injured veterans and their caregivers.”.

(4) MODIFICATION OF STIPEND CALCULATION.—Subsection (a)(3)(C) of such section is amended—

(A) by redesignating clause (iii) as clause (iv); and

(B) by inserting after clause (ii) the following new clause (iii):

“(iii) In determining the amount and degree of personal care services provided under clause (i) with respect to an eligible veteran whose need for personal care services is based in whole or in part on a need for supervision or protection under paragraph (2)(C)(ii) or regular instruction or supervision under paragraph (2)(C)(iii), the Secretary shall take into account the following:

“(I) The assessment by the family caregiver of the needs and limitations of the veteran.

“(II) The extent to which the veteran can function safely and independently in the absence of such supervision, protection, or instruction.

“(III) The amount of time required for the family caregiver to provide such supervision, protection, or instruction to the veteran.”.

(5) PERIODIC EVALUATION OF NEED FOR CERTAIN SERVICES.—Subsection (a)(3) of such section is amended by adding at the end the following new subparagraph:

“(D) In providing instruction, preparation, and training under subparagraph (A)(i)(I) and technical support under subparagraph (A)(i)(II) to each family caregiver who is approved as a provider of personal care services for an eligible veteran under paragraph (6), the Secretary shall periodically evaluate the needs of the eligible veteran and the skills of the family caregiver of such veteran to determine if additional instruction, preparation, training, or technical support under those subparagraphs is necessary.”.

(6) USE OF PRIMARY CARE TEAMS.—Subsection (a)(5) of such section is amended, in the matter preceding subparagraph (A), by inserting “(in collaboration with the primary care team for the eligible veteran to the maximum extent practicable)” after “evaluate”.

(7) ASSISTANCE FOR FAMILY CAREGIVERS.—Subsection (a) of such section is amended by adding at the end the following new paragraph:

“(11)(A) In providing assistance under this subsection to family caregivers of eligible veterans, the Secretary may enter into contracts, provider agreements, and memoranda of understanding with Federal agencies, States, and private, nonprofit, and other entities to provide such assistance to such family caregivers.

“(B) The Secretary may provide assistance under this paragraph only if such assistance is reasonably accessible to the family caregiver and is substantially equivalent or better in quality to similar services provided by the Department.

“(C) The Secretary may provide fair compensation to Federal agencies, States, and other entities that provide assistance under this paragraph.”.

(b) MODIFICATION OF DEFINITION OF PERSONAL CARE SERVICES.—Subsection (d)(4) of such section is amended—

(1) in subparagraph (A), by striking “independent”;

(2) by redesignating subparagraph (B) as subparagraph (D); and

(3) by inserting after subparagraph (A) the following new subparagraphs:

“(B) Supervision or protection based on symptoms or residuals of neurological or other impairment or injury.

“(C) Regular or extensive instruction or supervision without which the ability of the veteran to function in daily life would be seriously impaired.”.

**SEC. 162. IMPLEMENTATION OF INFORMATION TECHNOLOGY SYSTEM OF DEPARTMENT OF VETERANS AFFAIRS TO ASSESS AND IMPROVE THE FAMILY CAREGIVER PROGRAM.**

(a) IMPLEMENTATION OF NEW SYSTEM.—

(1) IN GENERAL.—Not later than October 1, 2018, the Secretary of Veterans Affairs shall implement an information technology system that fully supports the Program and allows for data assessment and comprehensive monitoring of the Program.

(2) ELEMENTS OF SYSTEM.—The information technology system required to be implemented under paragraph (1) shall include the following:

(A) The ability to easily retrieve data that will allow all aspects of the Program (at the medical center and aggregate levels) and the workload trends for the Program to be assessed and comprehensively monitored.

(B) The ability to manage data with respect to a number of caregivers that is more than the number of caregivers that the Secretary expects to apply for the Program.

(C) The ability to integrate the system with other relevant information technology systems of the Veterans Health Administration.

(b) ASSESSMENT OF PROGRAM.—Not later than 180 days after implementing the system described in subsection (a), the Secretary shall, through the Under Secretary for Health, use data from the system and other relevant data to conduct an assessment of how key aspects of the Program are structured and carried out.

(c) ONGOING MONITORING OF AND MODIFICATIONS TO PROGRAM.—

(1) MONITORING.—The Secretary shall use the system implemented under subsection (a) to monitor and assess the workload of the Program, including monitoring and assessment of data on—

(A) the status of applications, appeals, and home visits in connection with the Program; and

(B) the use by caregivers participating in the Program of other support services under the Program such as respite care.

(2) MODIFICATIONS.—Based on the monitoring and assessment conducted under paragraph (1), the Secretary shall identify and implement such modifications to the Program as the Secretary considers necessary to ensure the Program is functioning as intended and providing veterans and caregivers participating in the Program with services in a timely manner.

(d) REPORTS.—

(1) INITIAL REPORT.—

(A) 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, the Committee on Veterans' Affairs of the House of Representatives, and the Comptroller General of the United States a report that includes—

(i) the status of the planning, development, and deployment of the system required to be implemented under subsection (a), including any changes in the timeline for the implementation of the system; and

(ii) an assessment of the needs of family caregivers of veterans described in subparagraph (B), the resources needed for the inclusion of such family caregivers in the Program, and such changes to the Program as the Secretary considers necessary to ensure the successful expansion of the Program to include such family caregivers.

(B) VETERANS DESCRIBED.—Veterans described in this subparagraph are veterans who are eligible for the Program under clause (ii) or (iii) of section 1720G(a)(2)(B) of title 38, United States Code, as amended by section 161(a)(1) of this title, solely due to a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service before September 11, 2001.

(2) NOTIFICATION BY COMPTROLLER GENERAL.—The Comptroller General shall review the report submitted under paragraph (1) and notify the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives with respect to the progress of the Secretary in—

(A) fully implementing the system required under subsection (a); and

(B) implementing a process for using such system to monitor and assess the Program under subsection (c)(1) and modify the Program as considered necessary under subsection (c)(2).

(3) FINAL REPORT.—

(A) IN GENERAL.—Not later than October 1, 2019, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Comptroller General a report on the implementation of subsections (a) through (c).

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

(i) A certification by the Secretary that the information technology system described in subsection (a) has been implemented.

(ii) A description of how the Secretary has implemented such system.

(iii) A description of the modifications to the Program, if any, that were identified and implemented under subsection (c)(2).

(iv) A description of how the Secretary is using such system to monitor the workload of the Program.

(e) DEFINITIONS.—In this section:

(1) ACTIVE MILITARY, NAVAL, OR AIR SERVICE.—The term “active military, naval, or air service” has the meaning given that term in section 101 of title 38, United States Code.

(2) PROGRAM.—The term “Program” means the program of comprehensive assistance for family caregivers under section 1720G(a) of title 38, United States Code, as amended by section 161 of this title.

**SEC. 163. MODIFICATIONS TO ANNUAL EVALUATION REPORT ON CAREGIVER PROGRAM OF DEPARTMENT OF VETERANS AFFAIRS.**

(a) BARRIERS TO CARE AND SERVICES.—Subparagraph (A)(iv) of section 101(c)(2) of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163; 38 U.S.C. 1720G note) is amended by inserting “, including a description of any barriers to accessing and receiving care and services under such programs” before the semicolon.

(b) SUFFICIENCY OF TRAINING FOR FAMILY CAREGIVER PROGRAM.—Subparagraph (B) of such section is amended—

(1) in clause (i), by striking “; and” and inserting a semicolon;

(2) in clause (ii), by striking the period at the end and inserting “; and”;

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

“(iii) an evaluation of the sufficiency and consistency of the training provided to family caregivers under such program in preparing family caregivers to provide care to veterans under such program.”.

**TITLE II—VA ASSET AND INFRASTRUCTURE REVIEW**

**Subtitle A—Asset and Infrastructure Review**

**SEC. 201. SHORT TITLE.**

This subtitle may be cited as the “VA Asset and Infrastructure Review Act of 2018”.

**SEC. 202. THE COMMISSION.**

(a) ESTABLISHMENT.—There is established an independent commission to be known as the “Asset and Infrastructure Review Commission” (in this subtitle referred to as the “Commission”).

(b) DUTIES.—The Commission shall carry out the duties specified for it in this subtitle.

(c) APPOINTMENT.—

(1) IN GENERAL.—

(A) APPOINTMENT.—The Commission shall be composed of 9 members appointed by the President, by and with the advice and consent of the Senate.

(B) TRANSMISSION OF NOMINATIONS.—The President shall transmit to the Senate the nominations for appointment to the Commission not later than May 31, 2021.

(2) CONSULTATION IN SELECTION PROCESS.—In selecting individuals for nominations for appointments to the Commission, the President shall consult with—

(A) the Speaker of the House of Representatives;

(B) the majority leader of the Senate;

(C) the minority leader of the House of Representatives;

(D) the minority leader of the Senate; and

(E) congressionally chartered, membership based veterans service organizations concerning the appointment of three members.

(3) DESIGNATION OF CHAIR.—At the time the President nominates individuals for appointment to the Commission under paragraph (1)(B), the President shall designate one such individual who shall serve as Chair of the Commission and one such individual who shall serve as Vice Chair of the Commission.

(4) MEMBER REPRESENTATION.—In nominating individuals under this subsection, the President shall ensure that—

(A) veterans, reflecting current demographics of veterans enrolled in the system of annual patient enrollment under section 1705 of title 38, United States Code, are adequately represented in the membership of the Commission;

(B) at least one member of the Commission has experience working for a private integrated health care system that has annual gross revenues of more than \$50,000,000;

(C) at least one member has experience as a senior manager for an entity specified in clause (ii), (iii), or (iv) of section 101(a)(1)(B) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 38 U.S.C. 1701 note);

(D) at least one member—

(i) has experience with capital asset management for the Federal Government; and

(ii) is familiar with trades related to building and real property, including construction, engineering, architecture, leasing, and strategic partnerships; and

(E) at least three members represent congressionally chartered, membership-based, veterans service organizations.

(d) MEETINGS.—

(1) IN GENERAL.—The Commission shall meet only during calendar years 2022 and 2023.

(2) PUBLIC NATURE OF MEETINGS AND PROCEEDINGS.—

(A) **PUBLIC MEETINGS.**—Each meeting of the Commission shall be open to the public.

(B) **OPEN PARTICIPATION.**—All the proceedings, information, and deliberations of the Commission shall be available for review by the public.

(e) **VACANCIES.**—A vacancy in the Commission shall be filled in the same manner as the original appointment, but the individual appointed to fill the vacancy shall serve only for the unexpired portion of the term for which the individual's predecessor was appointed.

(f) **PAY.**—

(1) **IN GENERAL.**—Members of the Commission shall serve without pay.

(2) **OFFICERS OR EMPLOYEES OF THE UNITED STATES.**—Each member of the Commission who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

(3) **TRAVEL EXPENSES.**—Members shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(g) **DIRECTOR OF STAFF.**—

(1) **APPOINTMENT.**—The Commission shall appoint a Director who—

(A) has not served as an employee of the Department of Veterans Affairs during the one-year period preceding the date of such appointment; and

(B) is not otherwise barred or prohibited from serving as Director under Federal ethics laws and regulations, by reason of post-employment conflict of interest.

(2) **RATE OF PAY.**—The Director shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(h) **STAFF.**—

(1) **PAY OF PERSONNEL.**—Subject to paragraphs (2) and (3), the Director, with the approval of the Commission, may appoint and fix the pay of additional personnel.

(2) **EXEMPTION FROM CERTAIN REQUIREMENTS.**—The Director may make such appointments without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and any personnel so appointed may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of the annual rate of basic pay payable for GS-15 of the General Schedule.

(3) **DETAILEES.**—

(A) **LIMITATION ON NUMBER.**—Not more than two-thirds of the personnel employed by or detailed to the Commission may be on detail from the Department of Veterans Affairs.

(B) **PROFESSIONAL ANALYSTS.**—Not more than half of the professional analysts of the Commission staff may be persons detailed from the Department of Veterans Affairs to the Commission.

(C) **PROHIBITION ON DETAIL OF CERTAIN PERSONNEL.**—A person may not be detailed from the Department of Veterans Affairs to the Commission if, within 6 months before the detail is to begin, that person participated personally and substantially in any matter within the Department of Veterans Affairs concerning the preparation of recommendations regarding facilities of the Veterans Health Administration.

(4) **AUTHORITY TO REQUEST DETAILED PERSONNEL.**—Subject to paragraph (3), the head of any Federal department or agency, upon the request of the Director, may detail any of the personnel of that department or agency to the Commission to assist the Commission in carrying out its duties under this subtitle.

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

(i) **OTHER AUTHORITY.**—

(1) **TEMPORARY AND INTERMITTENT SERVICES.**—The Commission may procure by contract, to the extent funds are available, the temporary or intermittent services of experts or consultants pursuant to section 3109 of title 5, United States Code.

(2) **LEASING AND ACQUISITION OF PROPERTY.**—To the extent funds are available, the Commission may lease real property and acquire personal property either of its own accord or in consultation with the General Services Administration.

(j) **TERMINATION.**—The Commission shall terminate on December 31, 2023.

(k) **PROHIBITION AGAINST RESTRICTING COMMUNICATIONS.**—

(1) **IN GENERAL.**—Except as provided in paragraph (2), no person may restrict an employee of the Department of Veterans Affairs in communicating with the Commission.

(2) **UNLAWFUL COMMUNICATIONS.**—Paragraph (1) does not apply to a communication that is unlawful.

### SEC. 203. PROCEDURE FOR MAKING RECOMMENDATIONS.

(a) **SELECTION CRITERIA.**—

(1) **PUBLICATION.**—The Secretary shall, not later than February 1, 2021, and after consulting with veterans service organizations, publish in the Federal Register and transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives the criteria proposed to be used by the Department of Veterans Affairs in assessing and making recommendations regarding the modernization or realignment of facilities of the Veterans Health Administration under this subtitle. Such criteria shall include the preferences of veterans regarding health care furnished by the Department.

(2) **PUBLIC COMMENT.**—The Secretary shall provide an opportunity for public comment on the proposed criteria under paragraph (1) for a period of at least 90 days and shall include notice of that opportunity in the publication required under such paragraph.

(3) **PUBLICATION OF FINAL CRITERIA.**—The Secretary shall, not later than May 31, 2021, publish in the Federal Register and transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives the final criteria to be used in making recommendations regarding the closure, modernization, or realignment of facilities of the Veterans Health Administration under this subtitle.

(b) **RECOMMENDATIONS OF THE SECRETARY.**—

(1) **PUBLICATION IN FEDERAL REGISTER.**—The Secretary shall, not later than January 31, 2022, and after consulting with veterans service organizations, publish in the Federal Register and transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives and to the Commission a report detailing the recommendations regarding the modernization or realignment of facilities of the Veterans Health Administration on the basis of the final criteria referred to in subsection (a)(2) that are applicable.

(2) **FACTORS FOR CONSIDERATION.**—In making recommendations under this subsection, the Secretary shall consider each of the following factors:

(A) The degree to which any health care delivery or other site for providing services to veterans reflect the metrics of the Department of Veterans Affairs regarding market area health system planning.

(B) The provision of effective and efficient access to high-quality health care and services for veterans.

(C) The extent to which the real property that no longer meets the needs of the Federal Government could be reconfigured, repurposed, consolidated, realigned, exchanged, outleased, replaced, sold, or disposed.

(D) The need of the Veterans Health Administration to acquire infrastructure or facilities that will be used for the provision of health care and services to veterans.

(E) The extent to which the operating and maintenance costs are reduced through consolidating, col locating, and reconfiguring space, and through realizing other operational efficiencies.

(F) The extent and timing of potential costs and savings, including the number of years such costs or savings will be incurred, beginning with the date of completion of the proposed recommendation.

(G) The extent to which the real property aligns with the mission of the Department of Veterans Affairs.

(H) The extent to which any action would impact other missions of the Department (including education, research, or emergency preparedness).

(I) Local stakeholder inputs and any factors identified through public field hearings.

(J) The assessments under paragraph (3).

(K) The extent to which the Veterans Health Administration has appropriately staffed the medical facility, including determinations whether there has been insufficient resource allocation or deliberate understaffing.

(L) Any other such factors the Secretary determines appropriate.

(3) **CAPACITY AND COMMERCIAL MARKET ASSESSMENTS.**—

(A) **ASSESSMENTS.**—The Secretary shall assess the capacity of each Veterans Integrated Service Network and medical facility of the Department to furnish hospital care or medical services to veterans under chapter 17 of title 38, United States Code. Each such assessment shall—

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

(ii) identify how such gaps can be filled by—  
(I) entering into contracts or agreements with network providers under this section or with entities under other provisions of law;

(II) making changes in the way such care and services are furnished at such Veterans Integrated Service Network or medical facility, including—

(aa) extending hours of operation;

(bb) adding personnel; or

(cc) expanding space through the construction, leasing, or sharing of health care facilities; and

(III) the building or realignment of Department resources or personnel;

(iii) forecast, based on future projections and historical trends, both the short- and long-term demand in furnishing care or services at such Veterans Integrated Service Network or medical facility and assess how such demand affects the needs to use such network providers;

(iv) include a commercial health care market assessment of designated catchment areas in the United States conducted by a non-governmental entity; and

(v) consider the unique ability of the Federal Government to retain a presence in an area otherwise devoid of commercial health care providers or from which such providers are at risk of leaving.

(B) **CONSULTATION.**—In carrying out the assessments under subparagraph (A), the Secretary shall consult with veterans service organizations and veterans served by each such Veterans Integrated Service Network and medical facility.

(C) **SUBMITTAL.**—The Secretary shall submit such assessments to the Committees on Veterans' Affairs of the House of Representatives and the Senate with the recommendations of the Secretary under this subsection and make the assessments publicly available.

(4) **SUMMARY OF SELECTION PROCESS.**—The Secretary shall include, with the list of recommendations published and transmitted pursuant to paragraph (1), a summary of the selection process that resulted in the recommendation for each facility of the Veterans Health Administration, including a justification for each recommendation. The Secretary shall transmit the matters referred to in the preceding sentence not

later than 7 days after the date of the transmittal to the Committees on Veterans' Affairs of the Senate and the House of Representatives and the Commission of the report referred to in paragraph (1).

(5) **TREATMENT OF FACILITIES.**—In assessing facilities of the Veterans Health Administration, the Secretary shall consider all such facilities equally without regard to whether the facility has been previously considered or proposed for reuse, closure, modernization, or realignment by the Department of Veterans Affairs.

(6) **AVAILABILITY OF INFORMATION TO CONGRESS.**—In addition to making all information used by the Secretary to prepare the recommendations under this subsection available to Congress (including any committee or Member of Congress), the Secretary shall also make such information available to the Commission and the Comptroller General of the United States.

(7) **CERTIFICATION OF ACCURACY.**—

(A) **IN GENERAL.**—Each person referred to in subparagraph (B), when submitting information to the Secretary or the Commission concerning the modernization or realignment of a facility of the Veterans Health Administration, shall certify that such information is accurate and complete to the best of that person's knowledge and belief.

(B) **COVERED PERSONS.**—Subparagraph (A) applies to the following persons:

(i) Each Under Secretary of the Department of Veterans Affairs.

(ii) Each director of a Veterans Integrated Service Network.

(iii) Each director of a medical center of the Department of Veterans Affairs.

(iv) Each director of a program office of the Department of Veterans Affairs.

(v) Each person who is in a position the duties of which include personal and substantial involvement in the preparation and submission of information and recommendations concerning the modernization or realignment of facilities of the Veterans Health Administration.

(c) **REVIEW AND RECOMMENDATIONS BY THE COMMISSION.**—

(1) **PUBLIC HEARINGS.**—

(A) **IN GENERAL.**—After receiving the recommendations from the Secretary pursuant to subsection (b), the Commission shall conduct public hearings on the recommendations.

(B) **LOCATIONS.**—The Commission shall conduct public hearings in regions affected by a recommendation of the Secretary to close a facility of the Veterans Health Administration. To the greatest extent practicable, the Commission shall conduct public hearings in regions affected by a recommendation of the Secretary to modernize or realign such a facility.

(C) **REQUIRED WITNESSES.**—Witnesses at each public hearing shall include at a minimum—

(i) a veteran—

(I) enrolled under section 1705 of title 38, United States Code; and

(II) identified by a local veterans service organization; and

(ii) a local elected official.

(2) **TRANSMITTAL TO PRESIDENT.**—

(A) **IN GENERAL.**—The Commission shall, not later than January 31, 2023, transmit to the President a report containing the Commission's findings and conclusions based on a review and analysis of the recommendations made by the Secretary, together with the Commission's recommendations, for modernizations and realignments of facilities of the Veterans Health Administration.

(B) **AUTHORITY TO MAKE CHANGES TO RECOMMENDATIONS.**—Subject to subparagraph (C), in making its recommendations, the Commission may change any recommendation made by the Secretary if the Commission—

(i) determines that the Secretary deviated substantially from the final criteria referred to in subsection (a)(2) in making such recommendation;

(ii) determines that the change is consistent with the final criteria referred to in subsection (a)(2);

(iii) publishes a notice of the proposed change in the Federal Register not less than 45 days before transmitting its recommendations to the President pursuant to subparagraph (A); and

(iv) conducts public hearings on the proposed change.

(3) **JUSTIFICATION FOR CHANGES.**—The Commission shall explain and justify in its report submitted to the President pursuant to paragraph (2) any recommendation made by the Commission that is different from the recommendations made by the Secretary pursuant to subsection (b). The Commission shall transmit a copy of such report to the Committees on Veterans' Affairs of the Senate and the House of Representatives on the same date on which it transmits its recommendations to the President under paragraph (2).

(4) **PROVISION OF INFORMATION TO CONGRESS.**—After the Commission transmits its report to the President, the Commission shall promptly provide, upon request, to any Member of Congress, information used by the Commission in making its recommendations.

(d) **REVIEW BY THE PRESIDENT.**—

(1) **REPORT.**—The President shall, not later than February 15, 2023, transmit to the Commission and to the Congress a report containing the President's approval or disapproval of the Commission's recommendations.

(2) **PRESIDENTIAL APPROVAL.**—If the President approves all the recommendations of the Commission, the President shall transmit a copy of such recommendations to the Congress, together with a certification of such approval.

(3) **PRESIDENTIAL DISAPPROVAL.**—If the President disapproves the recommendations of the Commission, in whole or in part, the President shall transmit to the Commission and the Congress, not later than March 1, 2023, the reasons for that disapproval. The Commission, after consideration of the President's reasons for disapproval, shall then transmit to the President, not later than March 15, 2023, a report containing—

(A) the Commission's findings and conclusions based on a review and analysis of those reasons for disapproval provided by the President; and

(B) recommendations that the Commission determines are appropriate for modernizations and realignments of facilities of the Veterans Health Administration.

(4) **TRANSMITTAL OF RECOMMENDATIONS TO CONGRESS.**—If the President approves all recommendations of the Commission transmitted to the President under paragraph (3), the President shall transmit a copy of such recommendations to the Congress, together with a certification of such approval.

(5) **FAILURE TO TRANSMIT.**—If the President does not transmit to the Congress an approval and certification described in paragraph (2) or (4) by March 30, 2023, the process by which facilities of the Veterans Health Administration may be selected for modernization or realignment under this subtitle shall be terminated.

**SEC. 204. ACTIONS REGARDING INFRASTRUCTURE AND FACILITIES OF THE VETERANS HEALTH ADMINISTRATION.**

(a) **IN GENERAL.**—Subject to subsection (b), the Secretary shall begin to implement the recommended modernizations and realignments in the report under section 203(d) not later than three years after the date on which the President transmits such report to Congress. In any fiscal year, such implementation includes—

(1) the planning of modernizations and realignments of facilities of the Veterans Health Administration as recommended in such report; and

(2) providing detailed information on the budget for such modernizations or realignments in documents submitted to Congress by the Secretary in support of the President's budget for that fiscal year.

(b) **CONGRESSIONAL DISAPPROVAL.**—

(1) **IN GENERAL.**—The Secretary may not carry out any modernization or realignment rec-

ommended by the Commission in a report transmitted from the President pursuant to section 203(d) if a joint resolution is enacted, in accordance with the provisions of section 207, disapproving such recommendations of the Commission before the earlier of—

(A) the end of the 45-day period beginning on the date on which the President transmits such report; or

(B) the adjournment of Congress sine die for the session during which such report is transmitted.

(2) **COMPUTATION OF PERIOD.**—For purposes of paragraph (1) and subsections (a) and (c) of section 207, the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

**SEC. 205. IMPLEMENTATION.**

(a) **IN GENERAL.**—

(1) **MODERNIZING AND REALIGNING FACILITIES.**—In modernizing or realigning any facility of the Veterans Health Administration under this subtitle, the Secretary may—

(A) take such actions as may be necessary to modernize or realign any such facility, including the alteration of such facilities, the acquisition of such land, the leasing or construction of such replacement facilities, the disposition of such land or facilities, the performance of such activities, and the conduct of such advance planning and design as may be required to transfer functions from a facility of the Veterans Health Administration to another such facility, and may use for such purpose funds in the Account or funds appropriated to the Department of Veterans Affairs for such purposes;

(B) carry out activities for the purposes of environmental mitigation, abatement, or restoration at any such facility, and shall use for such purposes funds in the Account;

(C) reimburse other Federal agencies for actions performed at the request of the Secretary with respect to any such closure or realignment, and may use for such purpose funds in the Account or funds appropriated to the Department of Veterans Affairs and available for such purpose; and

(D) exercise the authority of the Secretary under subchapter V of chapter 81 of title 38, United States Code.

(2) **ENVIRONMENTAL RESTORATION; HISTORIC PRESERVATION.**—In carrying out any closure or realignment under this subtitle, the Secretary, with regards to any property made excess to the needs of the Department of Veterans Affairs as a result of such closure or realignment, shall carry out, as soon as possible with funds available for such purpose, any of the following for which the Secretary is responsible:

(A) Environmental mitigation.

(B) Environmental abatement.

(C) Environmental restoration.

(D) Compliance with historic preservation requirements.

(b) **MANAGEMENT AND DISPOSAL OF PROPERTY.**—

(1) **EXISTING DISPOSAL AUTHORITIES.**—To transfer or dispose of surplus real property or infrastructure located at any facility of the Veterans Health Administration that is modernized or realigned under this title, the Secretary may exercise the authorities of the Secretary under subchapters I and II of chapter 81 of title 38, United States Code, or the authorities delegated to the Secretary by the Administrator of General Services under subchapter III of chapter 5 of title 40, United States Code.

(2) **EFFECTS ON LOCAL COMMUNITIES.**—

(A) **CONSULTATION WITH STATE AND LOCAL GOVERNMENT.**—Before any action may be taken with respect to the disposal of any surplus real property or infrastructure located at any facility of the Veterans Health Administration to be closed or realigned under this subtitle, the Secretary of Veterans Affairs shall consult with the

Governor of the State and the heads of the local governments concerned for the purpose of considering any plan for the use of such property by the local community concerned.

(B) TREATMENT OF ROADS.—If infrastructure or a facility of the Veterans Health Administration to be closed or realigned under this subtitle includes a road used for public access through, into, or around the facility, the Secretary—

(i) shall consult with the Government of the State and the heads of the local governments concerned for the purpose of considering the continued availability of the road for public use after the recommended action is complete; and

(ii) may exercise the authority of the Secretary under section 8108 of title 38, United States Code.

(3) LEASES; CERCLA.—

(A) LEASE AUTHORITY.—

(i) TRANSFER TO REDEVELOPMENT AUTHORITY FOR LEASE.—The Secretary may transfer title to a facility of the Veterans Health Administration approved for closure or realignment under this subtitle (including property at a facility of the Veterans Health Administration approved for realignment which will be retained by the Department of Veterans Affairs or another Federal agency after realignment) to the redevelopment authority for the facility if the redevelopment authority agrees to lease, directly upon transfer, one or more portions of the property transferred under this subparagraph to the Secretary or to the head of another department or agency of the Federal Government.

(ii) TERM OF LEASE.—A lease under clause (i) shall be for a term of not to exceed 50 years, but may provide for options for renewal or extension of the term by the department or agency concerned.

(iii) LIMITATION.—A lease under clause (i) may not require rental payments by the United States.

(iv) TREATMENT OF REMAINDER LEASE TERMS.—A lease under clause (i) shall include a provision specifying that if the department or agency concerned ceases requiring the use of the leased property before the expiration of the term of the lease, the remainder of the lease term may be satisfied by the same or another department or agency of the Federal Government using the property for a use similar to the use under the lease. Exercise of the authority provided by this clause shall be made in consultation with the redevelopment authority concerned.

(v) FACILITY SERVICES.—Notwithstanding clause (iii), if a lease under clause (i) involves a substantial portion of the facility, the department or agency concerned may obtain facility services for the leased property and common area maintenance from the redevelopment authority or the redevelopment authority's assignee as a provision of the lease. The facility services and common area maintenance shall be provided at a rate no higher than the rate charged to non-Federal tenants of the transferred property. Facility services and common area maintenance covered by the lease shall not include—

(I) municipal services that a State or local government is required by law to provide to all landowners in its jurisdiction without direct charge; or

(II) firefighting or security-guard functions.

(B) APPLICATION OF CERCLA.—The provisions of section 120(h) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9620(h)) shall apply to any transfer of real property under this paragraph.

(C) ADDITIONAL TERMS AND CONDITIONS.—The Secretary may require any additional terms and conditions in connection with a transfer under this paragraph as such Secretary considers appropriate to protect the interests of the United States.

(4) APPLICATION OF MCKINNEY-VENTO HOMELESS ASSISTANCE ACT.—Nothing in this subtitle shall limit or otherwise affect the application of

the provisions of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11301 et seq.) to facilities of the Veterans Health Administration closed under this subtitle.

(c) APPLICABILITY OF NATIONAL ENVIRONMENTAL POLICY ACT OF 1969.—

(1) IN GENERAL.—The provisions of the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.) shall not apply to the actions of the President, the Commission, and, except as provided in paragraph (2), the Department of Veterans Affairs in carrying out this subtitle.

(2) DEPARTMENT OF VETERANS AFFAIRS.—

(A) COVERED ACTIVITIES.—The provisions of the National Environmental Policy Act of 1969 shall apply to actions of the Department of Veterans Affairs under this subtitle—

(i) during the process of property disposal; and

(ii) during the process of relocating functions from a facility of the Veterans Health Administration being closed or realigned to another facility after the receiving facility has been selected but before the functions are relocated.

(B) OTHER ACTIVITIES.—In applying the provisions of the National Environmental Policy Act of 1969 to the processes referred to in subparagraph (A), the Secretary shall not have to consider—

(i) the need for closing or realigning the facility of the Veterans Health Administration as recommended by the Commission;

(ii) the need for transferring functions to any facility of the Veterans Health Administration which has been selected as the receiving facility; or

(iii) facilities of the Veterans Health Administration alternative to those recommended or selected.

(d) WAIVER.—

(1) RESTRICTIONS ON USE OF FUNDS.—The Secretary may close or realign facilities of the Veterans Health Administration under this subtitle without regard to any provision of law restricting the use of funds for closing or realigning facilities of the Veterans Health Administration included in any appropriation or authorization Act.

(2) RESTRICTIONS ON AUTHORITIES.—The Secretary may close or realign facilities of the Veterans Health Administration under this subtitle without regard to the restrictions of section 8110 of title 38, United States Code.

(e) TRANSFER AUTHORITY IN CONNECTION WITH PAYMENT OF ENVIRONMENTAL REMEDIATION COSTS.—

(1) IN GENERAL.—

(A) TRANSFER BY DEED.—Subject to paragraph (2) of this subsection and section 120(h) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9620(h)), the Secretary may enter into an agreement to transfer by deed a facility of the Veterans Health Administration with any person who agrees to perform all environmental restoration, waste management, and environmental compliance activities that are required for the property or facilities under Federal and State laws, administrative decisions, agreements (including schedules and milestones), and concurrences.

(B) ADDITIONAL TERMS OR CONDITIONS.—The Secretary may require any additional terms and conditions in connection with an agreement authorized by subparagraph (A) as the Secretary considers appropriate to protect the interests of the United States.

(2) LIMITATION.—A transfer of a facility of the Veterans Health Administration may be made under paragraph (1) only if the Secretary certifies to Congress that—

(A) the costs of all environmental restoration, waste management, and environmental compliance activities otherwise to be paid by the Secretary with respect to the facility of the Veterans Health Administration are equal to or greater than the fair market value of the prop-

erty or facilities to be transferred, as determined by the Secretary; or

(B) if such costs are lower than the fair market value of the facility of the Veterans Health Administration, the recipient of such transfer agrees to pay the difference between the fair market value and such costs.

(3) PAYMENT BY THE SECRETARY FOR CERTAIN TRANSFERS.—In the case of a facility of the Veterans Health Administration covered by a certification under paragraph (2)(A), the Secretary may pay the recipient of such facility an amount equal to the lesser of—

(A) the amount by which the costs incurred by the recipient of the facility of the Veterans Health Administration for all environmental restoration, waste, management, and environmental compliance activities with respect to such facility exceed the fair market value of such property as specified in such certification; or

(B) the amount by which the costs (as determined by the Secretary) that would otherwise have been incurred by the Secretary for such restoration, management, and activities with respect to such facility of the Veterans Health Administration exceed the fair market value of property as so specified.

(4) DISCLOSURE.—As part of an agreement under paragraph (1), the Secretary shall disclose to the person to whom the facility of the Veterans Health Administration will be transferred any information of the Secretary regarding the environmental restoration, waste management, and environmental compliance activities described in paragraph (1) that relate to the facility of the Veterans Health Administration. The Secretary shall provide such information before entering into the agreement.

(5) APPLICABILITY OF CERTAIN ENVIRONMENTAL LAWS.—Nothing in this subsection shall be construed to modify, alter, or amend the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9601 et seq.) or the Solid Waste Disposal Act (42 U.S.C. 6901 et seq.).

#### SEC. 206. DEPARTMENT OF VETERANS AFFAIRS ASSET AND INFRASTRUCTURE REVIEW ACCOUNT.

(a) ESTABLISHMENT.—There is hereby established in the ledgers of the Treasury an account to be known as the "Department of Veterans Affairs Asset and Infrastructure Review Account" which shall be administered by the Secretary as a single account.

(b) CREDITS TO ACCOUNT.—There shall be credited to the Account the following:

(1) Funds authorized for and appropriated to the Account.

(2) Proceeds received from the lease, transfer, or disposal of any property at a facility of the Veterans Health Administration closed or realigned under this subtitle.

(c) USE OF ACCOUNT.—The Secretary may use the funds in the Account only for the following purposes:

(1) To carry out this subtitle.

(2) To cover property management and disposal costs incurred at facilities of the Veterans Health Administration closed, modernized, or realigned under this subtitle.

(3) To cover costs associated with supervision, inspection, overhead, engineering, and design of construction projects undertaken under this subtitle, and subsequent claims, if any, related to such activities.

(4) Other purposes that the Secretary determines support the mission and operations of the Department of Veterans Affairs.

(d) CONSOLIDATED BUDGET JUSTIFICATION DISPLAY FOR ACCOUNT.—

(1) CONSOLIDATED BUDGET INFORMATION REQUIRED.—The Secretary shall establish a consolidated budget justification display in support of the Account that for each fiscal year—

(A) details the amount and nature of credits to, and expenditures from, the Account during the preceding fiscal year;

(B) separately details the environmental remediation costs associated with facility of the Veterans Health Administration for which a budget request is made;

(C) specifies the transfers into the Account and the purposes for which these transferred funds will be further obligated, to include caretaker and environment remediation costs associated with each facility of the Veterans Health Administration; and

(D) details any intra-budget activity transfers within the Account that exceeded \$1,000,000 during the preceding fiscal year or that are proposed for the next fiscal year and will exceed \$1,000,000.

(2) **SUBMISSION.**—The Secretary shall include the information required by paragraph (1) in the materials that the Secretary submits to Congress in support of the budget for a fiscal year submitted by the President pursuant to section 1105 of title 31, United States Code.

(e) **CLOSURE OF ACCOUNT; TREATMENT OF REMAINING FUNDS.**—

(1) **CLOSURE.**—The Account shall be closed at the time and in the manner provided for appropriation accounts under section 1555 of title 31, United States Code, except that unobligated funds which remain in the Account upon closure shall be held by the Secretary of the Treasury until transferred to the Secretary of Veterans Affairs by law after the Committees on Veterans Affairs of the Senate and the House of Representatives receive the final report transmitted under paragraph (2).

(2) **FINAL REPORT.**—No later than 60 days after the closure of the Account under paragraph (1), the Secretary shall transmit to the Committees on Veterans Affairs of the Senate and the House of Representatives and the Committees on Appropriations of the House of Representatives and the Senate a report containing an accounting of—

(A) all the funds credited to and expended from the Account or otherwise expended under this subtitle; and

(B) any funds remaining in the Account.

**SEC. 207. CONGRESSIONAL CONSIDERATION OF COMMISSION REPORT.**

(a) **DISAPPROVAL RESOLUTION.**—For purposes of this subtitle, the term “joint resolution” means only a joint resolution which is introduced within the 5-day period beginning on the date on which the President transmits the report to the Congress under section 203(d), and—

(1) which does not have a preamble;

(2) the matter after the resolving clause of which is as follows: “that Congress disapproves the recommendations of the VHA Asset and Infrastructure Review Commission as submitted by the President on \_\_\_\_\_”, the blank space being filled with the appropriate date; and

(3) the title of which is as follows: “Joint resolution disapproving the recommendations of the VHA Asset and Infrastructure Review Commission.”

(b) **CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.**—

(1) **REPORTING AND DISCHARGE.**—Any committee of the House of Representatives to which a joint resolution is referred shall report it to the House without amendment not later than 15 legislative days after the date of introduction thereof. If a committee fails to report the joint resolution within that period, the committee shall be discharged from further consideration of the joint resolution.

(2) **PROCEEDING TO CONSIDERATION.**—It shall be in order at any time after the third legislative day after each committee authorized to consider a joint resolution has reported or has been discharged from consideration of a joint resolution, to move to proceed to consider the joint resolution in the House. All points of order against the motion are waived. Such a motion shall not be in order after the House has disposed of a motion to proceed on a joint resolution addressing a particular submission. The previous question shall be considered as ordered on the mo-

tion to its adoption without intervening motion. The motion shall not be debatable. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(3) **CONSIDERATION.**—The joint resolution shall be considered as read. All points of order against the joint resolution and against its consideration are waived. The previous question shall be considered as ordered on the joint resolution to its passage without intervening motion except two hours of debate equally divided and controlled by the proponent and an opponent. A motion to reconsider the vote on passage of the joint resolution shall not be in order.

(c) **CONSIDERATION IN THE SENATE.**—

(1) **REFERRAL.**—A joint resolution introduced in the Senate shall be referred to the Committee on Veterans Affairs.

(2) **REPORTING AND DISCHARGE.**—Any committee of the Senate to which a joint resolution is referred shall report it to the Senate without amendment not later than 15 session days after the date of introduction of a joint resolution described in subsection (a). If a committee fails to report the joint resolution within that period, the committee shall be discharged from further consideration of the joint resolution and the joint resolution shall be placed on the calendar.

(3) **FLOOR CONSIDERATION.**—

(A) **IN GENERAL.**—Notwithstanding Rule XXII of the Standing Rules of the Senate, it is in order at any time after the third session day on which the Committee on Veterans Affairs has reported or has been discharged from consideration of a joint resolution described in subsection (a) (even though a previous motion to the same effect has been disagreed to) to move to proceed to the consideration of the joint resolution, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived. The motion to proceed is not debatable. The motion is not subject to a motion to postpone. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the resolution is agreed to, the joint resolution shall remain the unfinished business until disposed of.

(B) **CONSIDERATION.**—Consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 2 hours, which shall be divided equally between the majority and minority leaders or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

(C) **VOTE ON PASSAGE.**—If the Senate has voted to proceed to a joint resolution, the vote on passage of the joint resolution shall occur immediately following the conclusion of consideration of the joint resolution, and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate.

(D) **RULINGS OF THE CHAIR ON PROCEDURE.**—Appeals from the decisions of the Chair relating to the application of the rules of the Senate, as the case may be, to the procedure relating to a joint resolution shall be decided without debate.

(d) **AMENDMENT NOT IN ORDER.**—A joint resolution of disapproval considered pursuant to this section shall not be subject to amendment in either the House of Representatives or the Senate.

(e) **COORDINATION WITH ACTION BY OTHER HOUSE.**—

“(1) **IN GENERAL.**—If, before the passage by one House of the joint resolution of that House, that House receives the joint resolution from the other House, then the following procedures shall apply:

“(A) The joint resolution of the other House shall not be referred to a committee.

“(B) With respect to the joint resolution of the House receiving the joint resolution—

“(i) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

(ii) the vote on passage shall be on the joint resolution of the other House.”

(2) **TREATMENT OF JOINT RESOLUTION OF OTHER HOUSE.**—If the Senate fails to introduce or consider a joint resolution under this section, the joint resolution of the House shall be entitled to expedited floor procedures under this section.

(3) **TREATMENT OF COMPANION MEASURES.**—If, following passage of the joint resolution in the Senate, the Senate then receives the companion measure from the House of Representatives, the companion measure shall not be debatable.

(f) **RULES OF THE HOUSE OF REPRESENTATIVES AND SENATE.**—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a joint resolution, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

**SEC. 208. OTHER MATTERS.**

(a) **ONLINE PUBLICATION OF COMMUNICATIONS.**—

(1) **IN GENERAL.**—Not later than 24 hours after the transmission or receipt of any communication under this subtitle that is transmitted or received by a party specified in paragraph (2), the Secretary of Veterans Affairs shall publish such communication online.

(2) **PARTIES SPECIFIED.**—The parties specified under this paragraph are the following:

(A) The Secretary of Veterans Affairs.

(B) The Commission.

(C) The President.

(b) **CONTINUATION OF EXISTING CONSTRUCTION PROJECTS AND PLANNING.**—During activities that the Commission, President, or Congress carry out under this subtitle, the Secretary of Veterans Affairs may not stop, solely because of such activities—

(1) a construction or leasing project of the Veterans Health Administration;

(2) long term planning regarding infrastructure and assets of the Veterans Health Administration; or

(3) budgetary processes for the Veterans Health Administration.

(c) **RECOMMENDATIONS FOR FUTURE ASSET REVIEWS.**—The Secretary of Veterans Affairs may, after consulting with veterans service organizations, include in budget submissions the Secretary submits after the termination of the Commission recommendations for future such commissions or other capital asset realignment and management processes.

**SEC. 209. DEFINITIONS.**

In this subtitle:

(1) The term “Account” means the Department of Veterans Affairs Asset and Infrastructure Review Account established by section 206(a).

(2) The term “Commission” means the Commission established by section 202.

(3) The term “date of approval”, with respect to a modernization or realignment of a facility of the Veterans Health Administration, means the date on which the authority of Congress to disapprove a recommendation of modernization or realignment, as the case may be, of such facility under this subtitle expires.

(4) The term “facility of the Veterans Health Administration”—

(A) means any land, building, structure, or infrastructure (including any medical center,

nursing home, domiciliary facility, outpatient clinic, center that provides readjustment counseling, or leased facility) that is—

(i) under the jurisdiction of the Department of Veterans Affairs;

(ii) under the control of the Veterans Health Administration; and

(iii) not under the control of the General Services Administration; or

(B) with respect to a collocated facility of the Department of Veterans Affairs, includes any land, building, or structure—

(i) under the jurisdiction of the Department of Veterans Affairs;

(ii) under the control of another administration of the Department of Veterans Affairs; and

(iii) not under the control of the General Services Administration.

(5) The term “infrastructure” means improvements to land other than buildings or structures.

(6) The term “modernization” includes—

(A) any action, including closure, required to align the form and function of a facility of the Veterans Health Administration to the provision of modern day health care, including utilities and environmental control systems;

(B) the construction, purchase, lease, or sharing of a facility of the Veterans Health Administration; and

(C) realignments, disposals, exchanges, collaborations between the Department of Veterans Affairs and other Federal entities, and strategic collaborations between the Department and non-Federal entities, including tribal organizations.

(7) The term “realignment”, with respect to a facility of the Veterans Health Administration, includes—

(A) any action that changes the numbers of or relocates services, functions, and personnel positions;

(B) disposals or exchanges between the Department of Veterans Affairs and other Federal entities, including the Department of Defense; and

(C) strategic collaborations between the Department of Veterans Affairs and non-Federal entities, including tribal organizations.

(8) The term “redevelopment authority”, in the case of a facility of the Veterans Health Administration closed or modernized under this subtitle, means any entity (including an entity established by a State or local government) recognized by the Secretary of Veterans Affairs as the entity responsible for developing the redevelopment plan with respect to the facility or for directing the implementation of such plan.

(9) The term “redevelopment plan” in the case of a facility of the Veterans Health Administration to be closed or realigned under this subtitle, means a plan that—

(A) is agreed to by the local redevelopment authority with respect to the facility; and

(B) provides for the reuse or redevelopment of the real property and personal property of the facility that is available for such reuse and redevelopment as a result of the closure or realignment of the facility.

(10) The term “Secretary” means the Secretary of Veterans Affairs.

(11) The term “tribal organization” has the meaning given such term in section 3765 of title 38, United States Code.

#### **Subtitle B—Other Infrastructure Matters**

#### **SEC. 211. IMPROVEMENT TO TRAINING OF CONSTRUCTION PERSONNEL.**

Subsection (g) of section 8103 of title 38, United States Code, is amended to read as follows:

“(g)(1)(A) Not later than September 30 of the fiscal year following the fiscal year during which the VA Asset and Infrastructure Review Act of 2018 is enacted, the Secretary shall implement the covered training curriculum and the covered certification program.

“(B) In designing and implementing the covered training curriculum and the covered certifi-

cation program under paragraph (1), the Secretary shall use as models existing training curricula and certification programs that have been established under chapter 87 of title 10, United States Code, as determined relevant by the Secretary.

“(2) The Secretary may develop the training curriculum under paragraph (1)(A) in a manner that provides such training in any combination of—

“(A) training provided in person;

“(B) training provided over an internet website; or

“(C) training provided by another department or agency of the Federal Government.

“(3) The Secretary may develop the certification program under paragraph (1)(A) in a manner that uses—

“(A) one level of certification; or

“(B) more than one level of certification, as determined appropriate by the Secretary with respect to the level of certification for different grades of the General Schedule.

“(4) The Secretary may enter into a contract with an appropriate entity to provide the covered training curriculum and the covered certification program under paragraph (1)(A).

“(5)(A) Not later than September 30 of the second fiscal year following the fiscal year during which the VA Asset and Infrastructure Review Act of 2018 is enacted, the Secretary shall ensure that the majority of employees subject to the covered certification program achieve the certification or the appropriate level of certification pursuant to paragraph (3), as the case may be.

“(B) After carrying out subparagraph (A), the Secretary shall ensure that each employee subject to the covered certification program achieves the certification or the appropriate level of certification pursuant to paragraph (3), as the case may be, as quickly as practicable.

“(6) In this subsection:

“(A) The term ‘covered certification program’ means, with respect to employees of the Department of Veterans Affairs who are members of occupational series relating to construction or facilities management, or employees of the Department who award or administer contracts for major construction, minor construction, or non-recurring maintenance, including as contract specialists or contracting officers’ representatives, a program to certify knowledge and skills relating to construction or facilities management and to ensure that such employees maintain adequate expertise relating to industry standards and best practices for the acquisition of design and construction services.

“(B) The term ‘covered training curriculum’ means, with respect to employees specified in subparagraph (A), a training curriculum relating to construction or facilities management.”

#### **SEC. 212. REVIEW OF ENHANCED USE LEASES.**

Section 8162(b)(6) is amended to read as follows:

“(6) The Office of Management and Budget shall review each enhanced-use lease before the lease goes into effect to determine whether the lease is in compliance with paragraph (5).”

#### **SEC. 213. ASSESSMENT OF HEALTH CARE FURNISHED BY THE DEPARTMENT TO VETERANS WHO LIVE IN THE PACIFIC TERRITORIES.**

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committees on Veterans’ Affairs of the Senate and the House of Representatives a report regarding health care furnished by the Department of Veterans Affairs to veterans who live in the Pacific territories.

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

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

(A) Hospital care.

(B) Medical services.

(C) Mental health services.

(D) Geriatric services.

(2) The feasibility of establishing a community-based outpatient clinic of the Department in any Pacific territory that does not contain such a facility.

(c) DEFINITION.—In this section, the term “Pacific territories” means American Samoa, Guam, and the Northern Mariana Islands.

#### **TITLE III—IMPROVEMENTS TO RECRUITMENT OF HEALTH CARE PROFESSIONALS**

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

(a) SCHOLARSHIPS FOR PHYSICIANS AND DENTISTS.—Section 7612(b) of title 38, United States Code, is amended by adding at the end the following new paragraph:

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

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

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

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

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

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

“(E) On an annual basis, the Secretary shall provide to appropriate educational institutions informational material about the availability of scholarships under this paragraph.”

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

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

(2) by inserting after paragraph (3) the following new paragraph (4):

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

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

#### **SEC. 302. INCREASE IN MAXIMUM AMOUNT OF DEBT THAT MAY BE REDUCED UNDER EDUCATION DEBT REDUCTION PROGRAM OF DEPARTMENT OF VETERANS AFFAIRS.**

(a) INCREASE IN AMOUNT.—Section 7683(d)(1) is amended—

(1) by striking “\$120,000” and inserting “\$200,000”; and

(2) by striking “\$24,000” and inserting “\$40,000”.

(b) STUDY.—

(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall—

(A) conduct a study on the demand for education debt reduction under subchapter VII of chapter 76 of title 38, United States Code; and

(B) submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the findings of the Secretary with respect to the study carried out under subparagraph (A).

(2) CONSIDERATIONS.—In carrying out the study required by paragraph (1)(A), the Secretary shall consider the following:

(A) The total number of vacancies within the Veterans Health Administration whose applicants are eligible to participate in the Education Debt Reduction Program pursuant to section 7682(a) of such title.

(B) The types of medical professionals in greatest demand in the United States.

(C) Projections by the Secretary of the numbers and types of medical professions that meet the needs of veterans.

**SEC. 303. ESTABLISHING THE DEPARTMENT OF VETERANS AFFAIRS SPECIALTY EDUCATION LOAN REPAYMENT PROGRAM.**

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

**“SUBCHAPTER VIII—SPECIALTY EDUCATION LOAN REPAYMENT PROGRAM**

**“§ 7691. Establishment**

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

**“§ 7692. Purpose**

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

**“§ 7693. Eligibility; preferences; covered costs**

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

“(1) is hired under section 7401 of this title to work in an occupation described in section 7692 of this title;

“(2) owes any amount of principal or interest under a loan, the proceeds of which were used by or on behalf of that individual to pay costs relating to a course of education or training which led to a degree that qualified the individual for the position referred to in paragraph (1); and

“(3) is—

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

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

“(b) PREFERENCES.—In selecting individuals for participation in the Specialty Education Loan Repayment Program under this subchapter, the Secretary may give preference to the following:

“(1) Individuals who are, or will be, participating in residency programs in health care facilities—

“(A) located in rural areas;

“(B) operated by Indian tribes, tribal organizations, or the Indian Health Service; or

“(C) affiliated with underserved health care facilities of the Department.

“(2) Veterans.

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

“(1) tuition expenses;

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

“(3) reasonable living expenses.

**“§ 7694. Specialty education loan repayment**

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

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

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

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

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

**“§ 7695. Choice of location**

“Each participant in the Specialty Education Loan Repayment Program who completes residency may select, from a list of medical facilities of the Veterans Health Administration provided by the Secretary, at which such facility the participant will work in a medical specialty described in section 7692 of this title.

**“§ 7696. Term of obligated service**

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

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

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

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

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

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

case later than 60 days after completion of such fellowship.

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

“(2) In the formula in paragraph (1):

“(A) ‘A’ is the amount the employee owes the Federal Government.

“(B) ‘B’ is the sum of all payments to or for the participant under the Specialty Education Loan Repayment Program.

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

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

**“§ 7697. Relationship to Educational Assistance Program**

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

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) CONFORMING AMENDMENTS.—

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

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

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

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

“(6) the specialty education loan repayment program provided for in subchapter VIII of this chapter.”.

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

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

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

(i) in subsection (a)(1)—

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

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

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

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

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

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

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

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

“SUBCHAPTER VIII—SPECIALTY EDUCATION LOAN REPAYMENT PROGRAM

“7691. Establishment.

“7692. Purpose.

“7693. Eligibility; preferences; covered costs.

“7694. Specialty education loan repayment.

“7695. Choice of location.

“7696. Term of obligated service.  
“7697. Relationship to Educational Assistance Program.”.

(c) **NEEDS OF THE VHA.**—In making determinations each year under section 7692 of title 38, United States Code, as enacted by subsection (a), the Secretary of Veterans Affairs shall consider the anticipated needs of the Veterans Health Administration during the period two to six years in the future.

(d) **PREFERENCE.**—In granting preference under section 7693 of title 38, United States Code, as enacted by subsection (a), the Secretary of Veterans Affairs shall determine whether a facility of the Department is underserved based on the criteria developed under section 401 of this Act.

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

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

(2) such match is published.

(f) **PUBLICITY.**—The Secretary of Veterans Affairs shall take such steps as the Secretary determines are appropriate to publicize the Specialty Education Loan Repayment Program established under subchapter VIII of chapter 76 of title 38, United States Code, as enacted by subsection (a).

**SEC. 304. VETERANS HEALING VETERANS MEDICAL ACCESS AND SCHOLARSHIP PROGRAM.**

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

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

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

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

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

(4) indicate on such application for admission that the veteran would like to be considered for an award of funding under this section;

(5) meet the minimum admissions criteria for the covered medical school to which the veteran applies; and

(6) enter into an agreement described in subsection (e).

(c) **AWARD OF FUNDING.**—

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

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

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

(B) books, fees, and technical equipment;

(C) fees associated with the National Residency Match Program;

(D) two away rotations performed during the fourth year at a Department of Veterans Affairs medical facility; and

(E) a monthly stipend for the four-year period during which the veteran is enrolled in medical school in an amount to be determined by the Secretary.

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

(d) **AGREEMENT.**—

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

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

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

(C) to complete post-graduate training leading to eligibility for board certification in a specialty applicable to the Department of Veterans Affairs, as determined by the Secretary;

(D) after completion of medical school, to obtain a license to practice medicine in a State; and

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

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

(e) **RULE OF CONSTRUCTION.**—Nothing in this section shall be construed to prevent any covered medical school from accepting more than two eligible veterans for the entering class of 2019.

(f) **REPORT TO CONGRESS.**—Not later than December 31, 2020, and annually thereafter for the subsequent three years, the Secretary shall submit to Congress a report on the pilot program under this section. Such report shall include the evaluation of the Secretary of the success of the pilot program, including the number of veterans who received funding under the program who matriculated and an evaluation of the academic progress of such veterans.

(g) **COVERED MEDICAL SCHOOLS.**—In this section, the term “covered medical school” means any of the following.

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

(A) Texas A&M College of Medicine;

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

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

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

(E) University of South Carolina School of Medicine.

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

(3) Howard University College of Medicine.

(4) Meharry Medical College.

(5) Morehouse School of Medicine.

**SEC. 305. BONUSES FOR RECRUITMENT, RELOCATION, AND RETENTION.**

Section 705(a) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 38 U.S.C. 703 note) is amended—

(1) in paragraph (1), by striking “\$230,000,000” and inserting “\$250,000,000, of which not less than \$20,000,000 shall be for recruitment, relocation, and retention bonuses”; and

(2) in paragraph (2), by striking “\$225,000,000” and inserting “\$290,000,000, of which not less than \$20,000,000 shall be for recruitment, relocation, and retention bonuses”.

**SEC. 306. INCLUSION OF VET CENTER EMPLOYEES IN EDUCATION DEBT REDUCTION PROGRAM OF DEPARTMENT OF VETERANS AFFAIRS.**

(a) **IN GENERAL.**—The Secretary of Veterans Affairs shall ensure that clinical staff working at Vet Centers are eligible to participate in the Education Debt Reduction Program of the Department of Veterans Affairs under subchapter VII of chapter 76 of title 38, United States Code.

(b) **REPORT.**—Not later than one year 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 number of participants in the Education Debt Reduction Program of the Department under such subchapter who work at Vet Centers.

(c) **VET CENTER DEFINED.**—In this section, the term “Vet Center” has the meaning given that term in section 1712A(h) of title 38, United States Code.

**TITLE IV—HEALTH CARE IN UNDERSERVED AREAS**

**SEC. 401. DEVELOPMENT OF CRITERIA FOR DESIGNATION OF CERTAIN MEDICAL FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS AS UNDERSERVED FACILITIES AND PLAN TO ADDRESS PROBLEM OF UNDERSERVED FACILITIES.**

(a) **IN GENERAL.**—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall develop criteria to designate medical centers, ambulatory care facilities, and community based outpatient clinics of the Department of Veterans Affairs as underserved facilities.

(b) **CONSIDERATION.**—Criteria developed under subsection (a) shall include consideration of the following with respect to a facility:

(1) The ratio of veterans to health care providers of the Department of Veterans Affairs for a standardized geographic area surrounding the facility, including a separate ratio for general practitioners and specialists.

(2) The range of clinical specialties covered by such providers in such area.

(3) Whether the local community is medically underserved.

(4) The type, number, and age of open consults.

(5) Whether the facility is meeting the wait-time goals of the Department.

(6) Such other criteria as the Secretary considers important in determining which facilities are not adequately serving area veterans.

(c) **ANALYSIS OF FACILITIES.**—Not less frequently than annually, directors of Veterans Integrated Service Networks of the Department shall perform an analysis to determine which facilities within that Veterans Integrated Service Network qualify as underserved facilities pursuant to criteria developed under subsection (a).

(d) **ANNUAL PLAN TO ADDRESS UNDERSERVED FACILITIES.**—

(1) **PLAN REQUIRED.**—Not later than one year after the date of the enactment of this Act and not less frequently than once each year, the Secretary shall submit to Congress a plan to address the problem of underserved facilities of the Department, as designated pursuant to criteria developed under subsection (a).

(2) **CONTENTS.**—Each plan submitted under paragraph (1) shall address the following:

(A) Increasing personnel or temporary personnel assistance, including mobile deployment teams furnished under section 407 of this Act.

(B) Providing special hiring incentives, including under the Education Debt Reduction Program under subchapter VII of chapter 76 of title 38, United States Code, and recruitment, relocation, and retention incentives.

(C) Using direct hiring authority.

(D) Improving training opportunities for staff.

(E) Such other actions as the Secretary considers appropriate.

**SEC. 402. PILOT PROGRAM TO FURNISH MOBILE DEPLOYMENT TEAMS TO UNDERSERVED FACILITIES.**

(a) **IN GENERAL.**—The Secretary of Veterans Affairs shall carry out a pilot program to furnish mobile deployment teams of medical personnel to underserved facilities.

(b) **ELEMENTS.**—In furnishing mobile deployment teams under subsection (a), the Secretary shall consider the following elements:

(1) The medical positions of greatest need at underserved facilities.

(2) The size and composition of teams to be deployed.

(3) Such other elements as the Secretary considers necessary for effective oversight of the program established under subsection (a).

(c) **USE OF ANNUAL ANALYSIS.**—The Secretary shall use the results of the annual analysis conducted under section 401(c) of this Act to form mobile deployment teams under subsection (a) that are composed of the most needed medical personnel for underserved facilities.

(d) **REPORTING.**—

(1) **PROGRESS REPORT.**—Not later than one year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the implementation of the pilot program under this section.

(2) **FINAL REPORT.**—Not later than the termination of the pilot program under this section, the Secretary shall submit a final report to Congress that contains the recommendations of the Secretary regarding the feasibility and advisability of—

(A) extending or expanding the pilot program; and

(B) making the pilot program (or any aspect thereof) permanent.

(e) **DURATION.**—The pilot program under this section shall terminate three years after the date of the enactment of this Act.

(f) **UNDERSERVED FACILITY DEFINED.**—In this section, the term “underserved facility” means a medical center, ambulatory care facility, or community based outpatient clinic of the Department of Veterans Affairs designated by the Secretary of Veterans Affairs as underserved pursuant to criteria developed under section 401 of this Act.

**SEC. 403. PILOT PROGRAM ON GRADUATE MEDICAL EDUCATION AND RESIDENCY.**

(a) **ESTABLISHMENT.**—

(1) **IN GENERAL.**—Subject to paragraph (5), the Secretary of Veterans Affairs shall establish a pilot program to establish medical residency positions authorized under section 301(b)(2) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 7302 note) at covered facilities.

(2) **COVERED FACILITIES.**—For purposes of this section, a covered facility is any of the following:

(A) A health care facility of the Department of Veterans Affairs.

(B) A health care facility operated by an Indian tribe or a tribal organization, as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

(C) A health care facility operated by the Indian Health Service.

(D) 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)).

(E) A health care facility operated by the Department of Defense.

(F) Such other health care facility as the Secretary considers appropriate for purposes of this section.

(3) **AGREEMENTS.**—To carry out the pilot program under this section, the Secretary may enter into agreements with entities that operate covered facilities in which the Secretary places residents under paragraph (1).

(4) **PARAMETERS FOR LOCATION, AFFILIATE SPONSOR, AND DURATION.**—When determining in which covered facilities to place residents under paragraph (1), the Secretary shall consider the extent to which there is a clinical need for providers in an area, as determined by the following:

(A) The ratio of veterans to health care providers of the Department for a standardized geographic area surrounding a facility, including a separate ratio for general practitioners and specialists.

(B) The range of clinical specialties of providers in standardized geographic areas surrounding a facility.

(C) Whether the specialty of a provider is included in the most recent staffing shortage determination of the Department under section 7412 of title 38, United States Code.

(D) Whether the local community is designated by the Secretary of Veterans Affairs as underserved pursuant to criteria developed under section 401 of this Act.

(E) Whether the facility is located in a community that is designated by the Secretary of Health and Human Services as a health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(F) Whether the facility is located in a rural or remote area.

(G) Such other criteria as the Secretary considers important in determining which facilities are not adequately serving area veterans.

(5) **PRIORITY IN PLACEMENTS.**—During the pilot program under this section, the Secretary shall place no fewer than 100 residents in covered facilities—

(A) operated by the Indian Health Service;

(B) operated by an Indian tribe;

(C) operated by a tribal organization; or

(D) located in communities designated by the Secretary as underserved pursuant to criteria developed under section 401 of this Act.

(6) **STIPENDS AND BENEFITS.**—The Secretary may pay stipends and provide benefits for residents in positions under paragraph (1), regardless of whether they have been assigned in a Department facility.

(b) **REIMBURSEMENT.**—If a covered facility establishes a new residency program in which the Secretary places a resident under the pilot program, the Secretary shall reimburse that covered facility for costs of the following:

(1) Curriculum development.

(2) Recruitment and retention of faculty.

(3) Accreditation of the program by the Accreditation Council for Graduate Medical Education.

(4) The portion of faculty salaries attributable to duties under an agreement subsection (a)(3).

(5) Expenses relating to educating a resident under the pilot program.

(c) **REPORTING.**—

(1) **IN GENERAL.**—Not later than one year after the date of the enactment of this Act and not less frequently than once each year thereafter until the termination of the pilot program, the Secretary shall submit to Congress a report on the implementation of the pilot program.

(2) **ELEMENTS.**—Each report submitted under paragraph (1) shall include the following with regard to the immediately preceding year, and in comparison to the year immediately preceding that year:

(A) The number of veterans who received care from residents under the pilot program.

(B) The number of veterans who received care from each resident per position described in subsection (a)(1) under the pilot program.

(C) The number of veterans who received care from residents under the pilot program expressed as a percentage of all individuals who received care from such residents.

(D) The number of clinical appointments for veterans conducted by each resident under the pilot program.

(E) The number of clinical appointments for veterans conducted by residents per position de-

scribed in subsection (a)(1) under the pilot program.

(F) The number of clinical appointments for veterans expressed as a percentage of all clinical appointments conducted by residents under the pilot program.

(G) The number of positions described in subsection (a)(1) at each covered facility under the pilot program.

(H) For each position described in subsection (a)(1) in a residency program affiliated with a health care facility of the Department, the time a resident under the pilot program spent training at that facility of the Department, expressed as a percentage of the total training time for that resident position.

(I) For each residency program affiliated with a health care facility of the Department, the time all residents under the pilot program spent training at that facility of the Department, expressed as a percentage of the total training time for those residents.

(J) The time that all residents under the pilot program who are assigned to programs affiliated with health care facilities of the Department spent training at facilities of the Department, expressed as a percentage of the total training time for those residents.

(K) The cost to the Department of Veterans Affairs under the pilot program in the year immediately preceding the report and since the beginning of the pilot program.

(L) The cost to the Department of Veterans Affairs per resident placed under the pilot program at each covered facility.

(M) The number of residents under the pilot program hired by the Secretary to work in the Veterans Health Administration after completion of residency in the year immediately preceding the report and since the beginning of the pilot program.

(N) The medical specialties pursued by residents under the pilot program.

(d) **DURATION.**—The pilot program under this section shall terminate on August 7, 2024.

**TITLE V—OTHER MATTERS**

**SEC. 501. ANNUAL REPORT ON PERFORMANCE AWARDS AND BONUSES AWARDED TO CERTAIN HIGH-LEVEL EMPLOYEES OF THE DEPARTMENT.**

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

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

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

“(1) Regional Office Director of the Department.

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

“(3) Director of a Veterans Integrated Service Network.

“(4) Senior executive of the Department.

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

“(1) The amount of each award or bonus.

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

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

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

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

“(2) The term ‘senior executive’ means—

“(A) a career appointee; or

“(B) an individual—

“(i) in an administrative or executive position; and

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

“(3) The term ‘career appointee’ has the meaning given that term in section 3132(a) of title 5, United States Code.”

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 725 the following new item:

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

**SEC. 502. ROLE OF PODIATRISTS IN DEPARTMENT OF VETERANS AFFAIRS.**

(a) INCLUSION AS PHYSICIAN.—

(1) IN GENERAL.—Subchapter I of chapter 74 is amended by adding at the end the following new section:

**“§7413. Treatment of podiatrists; clinical oversight standards**

“(a) PODIATRISTS.—Except as provided by subsection (b), a doctor of podiatric medicine who is appointed as a podiatrist under section 7401(1) of this title is eligible for any supervisory position in the Veterans Health Administration to the same degree that a physician appointed under such section is eligible for the position.

“(b) ESTABLISHMENT OF CLINICAL OVERSIGHT STANDARDS.—The Secretary, in consultation with appropriate stakeholders, shall establish standards to ensure that specialists appointed in the Veterans Health Administration to supervisory positions do not provide direct clinical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties.”

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 is amended by inserting after the item relating to section 7412 the following new item:

“7413. Treatment of podiatrists; clinical oversight standards.”

(b) MODIFICATION AND CLARIFICATION OF PAY GRADE.—

(1) GRADE.—The list in section 7404(b) of such title is amended—

(A) by striking “PHYSICIAN AND DENTIST SCHEDULE” and inserting “PHYSICIAN AND SURGEON (MD/DO), PODIATRIC SURGEON (DPM), AND DENTIST AND ORAL SURGEON (DDS, DMD) SCHEDULE”;

(B) by striking “Physician grade” and inserting “Physician and surgeon grade”; and

(C) by striking “PODIATRIST, CHIROPRACTOR, AND” and inserting “CHIROPRACTOR AND”.

(2) APPLICATION.—The amendments made by paragraph (1) shall apply with respect to a pay period of the Department of Veterans Affairs beginning on or after the date that is 30 days after the date of the enactment of this Act.

**SEC. 503. DEFINITION OF MAJOR MEDICAL FACILITY PROJECT.**

(a) MODIFICATION OF DEFINITION OF MEDICAL FACILITY.—Section 8101(3) is amended by striking “Secretary” and all that follows through “nursing home,” and inserting “Secretary, or as otherwise authorized by law, for the provision of health-care services (including hospital, outpatient clinic, nursing home,”.

(b) MODIFICATION OF DEFINITION OF MAJOR MEDICAL FACILITY PROJECT.—Paragraph (3) of section 8104(a) is amended to read as follows:

“(3) For purposes of this subsection, the term ‘major medical facility project’ means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than \$20,000,000, but such term does not include an acquisition by exchange, non-recurring maintenance projects of the Department, or the construction, alteration, or acquisition of a shared Federal medical facility for

which the Department’s estimated share of the project costs does not exceed \$20,000,000.”

**SEC. 504. AUTHORIZATION OF CERTAIN MAJOR MEDICAL FACILITY PROJECTS OF THE DEPARTMENT OF VETERANS AFFAIRS.**

(a) AUTHORIZATION.—The Secretary of Veterans Affairs may carry out the following major medical facility project, to be carried out in an amount not to exceed the amount specified for that project: Construction of the new East Bay Community Based Outpatient Clinic and all associated site work, utilities, parking, and landscaping, construction of the Central Valley Engineering and Logistics support facility, and enhanced flood plain mitigation at the Central Valley and East Bay Community Based Outpatient Clinics as part of the realignment of medical facilities in Livermore, California, in an amount not to exceed \$117,300,000.

(b) AUTHORIZATION OF APPROPRIATIONS FOR CONSTRUCTION.—There is authorized to be appropriated to the Secretary of Veterans Affairs for fiscal year 2018 or the year in which funds are appropriated for the Construction, Major Projects account, \$117,300,000 for the project authorized in subsection (a).

(c) SUBMITTAL OF INFORMATION.—Not later than 90 days after the date of the enactment of this Act, for the project authorized in subsection (a), 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 the following information:

(1) A line item accounting of expenditures relating to construction management carried out by the Department of Veterans Affairs for such project.

(2) The future amounts that are budgeted to be obligated for construction management carried out by the Department for such project.

(3) A justification for the expenditures described in paragraph (1) and the future amounts described in paragraph (2).

(4) Any agreement entered into by the Secretary regarding a non-Department of Veterans Affairs Federal entity providing management services relating to such project, including reimbursement agreements and the costs to the Department for such services.

**SEC. 505. DEPARTMENT OF VETERANS AFFAIRS PERSONNEL TRANSPARENCY.**

(a) PUBLICATION OF STAFFING AND VACANCIES.—

(1) WEBSITE REQUIRED.—Subject to paragraph (2) and not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall make publicly available on an Internet website of the Department of Veterans Affairs the following information, which shall, subject to subparagraph (D), be displayed by departmental component or, in the case of information relating to Veterans Health Administration positions, by medical facility:

(A) The number of personnel encumbering positions.

(B) The number of accessions and separation actions processed during the quarter preceding the date of the publication of the information.

(C) The number of vacancies, by occupation.

(D) The percentage of new hires for the Department who were hired within the time-to-hire target of the Office of Personnel Management, disaggregated by administration.

(2) EXCEPTIONS.—The Secretary may withhold from publication under paragraph (1) information relating to law enforcement, information security, or such positions in the Department that the Secretary determines to be sensitive.

(3) UPDATE OF INFORMATION.—The Secretary shall update the information on the website required under paragraph (1) on a quarterly basis.

(4) TREATMENT OF CONTRACTOR POSITIONS.—Any Department of Veterans Affairs position that is filled with a contractor may not be treated as a Department position for purposes of the information required to be published under paragraph (1).

(5) INSPECTOR GENERAL REVIEW.—On a semi-annual basis, the Inspector General of the Department shall review the administration of the website required under paragraph (1) and make recommendations relating to the improvement of such administration.

(b) REPORT TO CONGRESS.—The Secretary of Veterans Affairs shall submit to Congress an annual report on the steps the Department is taking to achieve full staffing capacity. Each such report shall include the amount of additional funds necessary to enable the Department to reach full staffing capacity.

**SEC. 506. PROGRAM ON ESTABLISHMENT OF PEER SPECIALISTS IN PATIENT ALIGNED CARE TEAM SETTINGS WITHIN MEDICAL CENTERS OF DEPARTMENT OF VETERANS AFFAIRS.**

(a) PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a program to establish not fewer than two peer specialists in patient aligned care teams at medical centers of the Department of Veterans Affairs to promote the use and integration of services for mental health, substance use disorder, and behavioral health in a primary care setting.

(b) TIMEFRAME FOR ESTABLISHMENT OF PROGRAM.—The Secretary shall carry out the program at medical centers of the Department as follows:

(1) Not later than May 31, 2019, at not fewer than 15 medical centers of the Department.

(2) Not later than May 31, 2020, at not fewer than 30 medical centers of the Department.

(c) SELECTION OF LOCATIONS.—

(1) IN GENERAL.—The Secretary shall select medical centers for the program as follows:

(A) Not fewer than five shall be medical centers of the Department that are designated by the Secretary as polytrauma centers.

(B) Not fewer than ten shall be medical centers of the Department that are not designated by the Secretary as polytrauma centers.

(2) CONSIDERATIONS.—In selecting medical centers for the program under paragraph (1), the Secretary shall consider the feasibility and advisability of selecting medical centers in the following areas:

(A) Rural areas and other areas that are underserved by the Department.

(B) Areas that are not in close proximity to an active duty military installation.

(C) Areas representing different geographic locations, such as census tracts established by the Bureau of the Census.

(d) GENDER-SPECIFIC SERVICES.—In carrying out the program at each location selected under subsection (c), the Secretary shall ensure that—

(1) the needs of female veterans are specifically considered and addressed; and

(2) female peer specialists are made available to female veterans who are treated at each location.

(e) ENGAGEMENT WITH COMMUNITY PROVIDERS.—At each location selected under subsection (c), the Secretary shall consider ways in which peer specialists can conduct outreach to health care providers in the community who are known to be serving veterans to engage with those providers and veterans served by those providers.

(f) REPORTS.—

(1) PERIODIC REPORTS.—

(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, and not less frequently than once every 180 days thereafter until the Secretary determines that the program is being carried out at the last location to be selected under subsection (c), the Secretary shall submit to Congress a report on the program.

(B) ELEMENTS.—Each report required by subparagraph (A) shall, with respect to the 180-day period preceding the submittal of the report, include the following:

(i) The findings and conclusions of the Secretary with respect to the program.

(ii) An assessment of the benefits of the program to veterans and family members of veterans.

(iii) An assessment of the effectiveness of peer specialists in engaging under subsection (e) with health care providers in the community and veterans served by those providers.

(2) **FINAL REPORT.**—Not later than 180 days after the Secretary determines that the program is being carried out at the last location to be selected under subsection (c), the Secretary shall submit to Congress a report detailing the recommendations of the Secretary as to the feasibility and advisability of expanding the program to additional locations.

**SEC. 507. DEPARTMENT OF VETERANS AFFAIRS MEDICAL SCRIBE PILOT PROGRAM.**

(a) **IN GENERAL.**—The Secretary of Veterans Affairs shall carry out a two-year pilot program under which the Secretary shall increase the use of medical scribes at Department of Veterans Affairs medical centers.

(b) **LOCATIONS.**—The Secretary shall carry out the pilot program at the 10 medical centers of the Department as follows:

(1) At least four such medical centers located in rural areas.

(2) At least four such medical centers located in urban areas.

(3) Two such medical centers located in areas with need for increased access or increased efficiency, as determine by the Secretary.

(c) **MEDICAL SCRIBES.**—

(1) **HIRING.**—Under the pilot program the Secretary shall—

(A) hire 20 new Department of Veterans Affairs term employees as medical scribes; and

(B) seek to enter into contracts with appropriate entities for the employment of 20 additional medical scribes.

(2) **DISTRIBUTION.**—The Secretary shall assign four medical scribes to each of the 10 medical centers of the Department where the Secretary carries out the pilot program as follows:

(A) Two scribes shall be assigned to each of two physicians.

(B) Thirty percent of the scribes shall be employed in the provision of emergency care.

(C) Seventy percent of the scribes shall be employed in the provision of specialty care in specialties with the longest patient wait times or lowest efficiency ratings, as determined by the Secretary.

(d) **REPORTS.**—

(1) **REPORTS TO CONGRESS.**—Not later than 180 days after the commencement of the pilot program required under this section, and every 180 days thereafter for the duration of the pilot program, the Secretary of Veterans Affairs shall submit to Congress a report on the pilot program. Each such report shall include each of the following:

(A) A separate analysis of each the following with respect to medical scribes employed by the Department of Veterans Affairs and medical scribes performing Department of Veterans Affairs functions under a contract:

(i) Provider efficiency.

(ii) Patient satisfaction.

(iii) Average wait time.

(iv) The number of patients seen per day by each physician or practitioner.

(v) The amount of time required to hire and train an employee to perform medical scribe functions under the pilot program.

(B) Metrics and data for analyzing the effects of the pilot program, including an evaluation of the each of the elements under clauses (i) through (iv) of subparagraph (A) at medical centers who employed scribes under the pilot program for an appropriate period preceding the hiring of such scribes.

(2) **COMPTROLLER GENERAL REPORT.**—Not later than 90 days after the termination of the pilot program under this section, the Comptroller General of the United States shall submit to Congress a report on the pilot program. Such report shall include a comparison of the pilot program with similar programs carried out in the private sector.

(e) **DEFINITIONS.**—In this section:

(1) The term “medical scribe” means an unlicensed individual hired to enter information into the electronic health record or chart at the direction of a physician or licensed independent practitioner whose responsibilities include the following:

(A) Assisting the physician or practitioner in navigating the electronic health record.

(B) Responding to various messages as directed by the physician or practitioner.

(C) Entering information into the electronic health record, as directed by the physician or practitioner.

(2) The terms “urban” and “rural” have the meanings given such terms under the rural-urban commuting codes developed by the Secretary of Agriculture and the Secretary of Health and Human Services.

(f) **FUNDING.**—The pilot program under this section shall be carried out using amounts otherwise authorized to be appropriated for the Department of Veterans Affairs. No additional amounts are authorized to be appropriated to carry out such program.

**SEC. 508. EXTENSION OF REQUIREMENT TO COLLECT FEES FOR HOUSING LOANS GUARANTEED BY SECRETARY OF VETERANS AFFAIRS.**

Section 3729(b)(2) of title 38, United States Code, is amended by striking “2027” each place it appears and inserting “2028”.

**SEC. 509. EXTENSION OF REDUCTION IN AMOUNT OF PENSION FURNISHED BY DEPARTMENT OF VETERANS AFFAIRS FOR CERTAIN VETERANS COVERED BY MEDICAID PLANS FOR SERVICES FURNISHED BY NURSING FACILITIES.**

Section 5503(d)(7) of title 38, United States Code, is amended by striking “September 30, 2027” and inserting “September 30, 2028”.

**SEC. 510. APPROPRIATION OF AMOUNTS.**

(a) **VETERANS CHOICE PROGRAM.**—There is authorized to be appropriated, and is appropriated, to the Secretary of Veterans Affairs, out of any funds in the Treasury not otherwise appropriated, \$5,200,000,000 to be deposited in the Veterans Choice Fund under section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 38 U.S.C. 1701 note).

(b) **AVAILABILITY OF AMOUNTS.**—The amounts appropriated under subsection (a) shall not be available for obligation or expenditure without fiscal year limitation.

**SEC. 511. TECHNICAL CORRECTION.**

Section 1712I of title 38, United States Code, is redesignated as section 1720I of such title.

**SEC. 512. BUDGETARY EFFECTS.**

(a) **STATUTORY PAY-AS-YOU-GO SCORECARDS.**—The budgetary effects of this Act shall not be entered on either PAYGO scorecard maintained pursuant to section 4(d) of the Statutory Pay-As-You-Go Act of 2010.

(b) **SENATE PAYGO SCORECARDS.**—The budgetary effects of this Act shall not be entered on any PAYGO scorecard maintained for purposes of section 4106 of H. Con. Res. 71 (115th Congress).

The SPEAKER pro tempore. The bill, as amended, shall be debatable for 1 hour equally divided and controlled by the chair and ranking minority member of the Committee on Veterans' Affairs.

The gentleman from Tennessee (Mr. ROE) and the gentleman from Minnesota (Mr. WALZ) each will control 30 minutes.

The Chair recognizes the gentleman from Tennessee.

**GENERAL LEAVE**

Mr. ROE of Tennessee. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to

revise and extend their remarks and insert extraneous material in the RECORD on S. 2372, as amended.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Tennessee?

There was no objection.

Mr. ROE of Tennessee. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of my bill, the John S. McCain III; the Daniel K. Akaka; and with great honor, the Samuel R. Johnson Department of Veterans Affairs Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the VA MISSION Act.

This bill exemplifies exactly how Congress should work. It is a bipartisan, bicameral compromise agreement between the House and Senate Veterans' Affairs Committees that was crafted over the last year and a half through regular order and in close coordination with stakeholders and advocates in VA, the White House, the military and veterans service organizations, and the broader health community.

It is also aptly named after Senator MCCAIN, late Senator Akaka, and Congressman SAM JOHNSON, three great Americans whose lives and work exemplify service and statesmanship. The MISSION Act is also aptly named in that it would address and reaffirm Congress' commitment to VA's core and most important mission: caring for, as President Lincoln said, those who have borne the battle.

There are five main components of the MISSION Act. Each of these components on their own would be noteworthy and significant. Together, they are transformational.

The first component of the MISSION Act would consolidate and improve VA's community care programs. VA uses several different methods to refer veterans to community providers today. The most recent and notable method is the Choice Program, which Congress created following the nationwide access and accountability crisis in 2014. All of those methods serve different purposes and employ different business processes, reimbursement rates, and eligibility criteria. That creates a tremendous and increasing amount of confusion and consternation from VA employees, community providers, and VA patients.

The MISSION Act would consolidate all of those methods into a single, streamlined VA community care program that is easier to understand, administer, and deliver to veterans who need it. This would increase access to timely quality care in every community across the country and, in doing so, expand VA's reach and veterans' choice. It would also return all VA community care funding to the discretionary side of the ledger, thereby increasing transparency and accountability for the hard-earned taxpayer dollars that VA receives.

The second component of the MISSION Act would address the pending shortfall in the Choice fund. When Congress created the Choice Program 4 years ago, it also created the Choice fund and stipulated that the program would end when the fund ran dry. Congress has acted time and time again to prevent that from happening in recognition of the millions of veterans who rely on the Choice Program despite its imperfections.

However, Acting VA Secretary Wilkie sent a letter just last week declaring that the remaining funds in the Choice fund will be exhausted as early as May 31, just 2 weeks from today. The consequences of that have the potential to be catastrophic for veterans, with Acting Secretary Wilkie warning that wait times will increase, access to care will decrease, continuity of care will be disrupted, and valuable community partnerships will be damaged.

To prevent that, the MISSION Act would authorize and appropriate \$5.2 billion to the Choice fund. This would prevent an access-to-care crisis from occurring in the immediate future and provide sufficient funding to allow the Choice Program to continue serving veteran patients over the next year until the new, consolidated community care program is implemented.

The third component of the MISSION Act would address VA's massive and misaligned physical footprint. VA is one of the largest property-holding entities in the Federal Government with a capital asset portfolio that includes thousands of medical facilities spanning hundreds of millions of square feet.

The average VA medical facility building is more than five times older than the average building in the not-for-profit system in this country, with some VA facilities being much older than that. For example, the VA medical center in my hometown of Johnson City, Tennessee, was built in 1903 to care for Civil War veterans. It is still seeing patients today.

Since being named chairman of the Committee on Veterans' Affairs a year and a half ago, I have made it a priority to travel to VA facilities across the country. While many of them are doing great work, they are operating out of facilities that were designed and built to meet antiquated healthcare needs and delivery models.

Those facilities are increasingly impossible to manage and maintain in accordance with modern standards and the ever-changing shifts in the veteran population, not to mention that demand for care is growing progressively more costly and complex in Tennessee and across the country.

The Asset and Infrastructure Review, or AIR, Act process that the MISSION Act would create is based on a recommendation from the bipartisan Commission on Care that was put together by President Obama. It would create an open, objective, politically insulated process to recommend how

VA's massive physical footprint can be realigned and brought up to date. This would transform the VA healthcare system that we know today into one that is stronger, more efficient, and better able to meet the healthcare needs of veterans, now and for generations of veterans to come.

None of us who are lucky enough to have a VA facility in their backyard, as I do, want to contemplate a future where that facility may change or disappear. But without action as bold, brave, and potentially transformative as the AIR Act is, the long-term success and sustainability of the VA healthcare system is in serious question, and veterans will suffer the consequences.

I want to assure those who may still be concerned about AIR that they will have nothing to fear from it. I worked closely with a wide variety of veteran service organizations to ensure that the AIR process takes and includes a high level of veteran, VSO, stakeholder, and community involvement—both locally and nationally—and to make sure no AIR recommendation would occur behind closed doors without an open discussion and a review of all the relevant facts, with every option and opportunity left on the table.

It is my firm belief that AIR will result in a modern, streamlined VA healthcare system but not necessarily a markedly smaller one. VA is going to remain a presence in communities large and small, and no facility that is needed to care for veteran patients or that has a worthy service to provide them will be negatively impacted.

The fourth component of the MISSION Act will be to expand the Family Caregiver Program to the caregivers of pre-9/11 veterans. Congress created the Family Caregiver Program in 2010 to provide services and supports, including a monthly stipend payment and healthcare coverage, if needed, to caregivers of post-9/11 veterans.

Caregivers provide an invaluable service, often at great personal sacrifice, to those veterans who have been seriously injured in the line of duty. Caregivers know no age or era, but for far too long the Family Caregiver Program has been restricted to an inequality based on era of service. The MISSION Act would correct that serious inequity and finally give pre-9/11 caregivers the recognition they deserve.

The fifth and the final component of the MISSION Act would be to enhance the internal capacity of the VA healthcare system to care for veteran patients internally. Opponents of this bill will tell you falsely that it is aimed at eventual privatization of the VA healthcare system. That misconception is based on nothing but fear and rhetoric, I think.

The MISSION Act contains numerous provisions that would make it easier for VA to attract high-quality commissions and other professionals and put them to work in VA medical facilities, just as I have done. It also contains nu-

merous provisions that would make it easier for the providers already working in VA hospitals and clinics to see more veteran patients and to be recognized and rewarded for their great work.

Together, these provisions would fortify the VA healthcare system and make sure it stays strong and able to provide the care that it is meant to provide.

Before closing, I want to take a moment to recognize some people: Chairman JOHNNY ISAKSON and Ranking Member TESTER of the Senate Committee on Veterans' Affairs. Chairman ISAKSON and Ranking Member TESTER have been steadfast partners over the last year and over the last several weeks, in particular. The MISSION Act would not be a reality without their good-faith efforts to work hand in hand with me and with our veteran service organization partners to overcome our differences and craft a bipartisan, bicameral compromise bill that veterans and their families can be proud of. Mr. Speaker, I want to thank them for their leadership and for their friendship.

I am also grateful for the many members of the committee from both sides of the aisle and both sides of the Capitol, including Ranking Member WALZ, and to our VSO partners in the community, the VA, and in the White House who have worked hard over the last year and a half to craft and consider many of the provisions that make up the MISSION Act.

Finally, I want to thank President Trump for his leadership and steadfast commitment to veterans since taking office. This bill would not have been possible without his vocal leadership. This may well be the most impactful vote that any of us will ever take for our Nation's veterans.

And before I finish, I also want to thank the staffs on both sides of the aisle, both in the Senate and in the House, both Republican and Democrat, for their incredible hard work, the many hours behind the scenes that you never see, that the public never sees, that I certainly appreciate and I believe Ranking Member WALZ does too, the hard work of our staffs.

A "yes" vote is a vote for access, for quality, for choice, for the long-term success and sustainability of the VA healthcare system, for caregivers and for veterans. And for that I would recommend a positive "yes" vote.

The MISSION Act is supported by every major military and veteran service organization that rightfully recognizes this as a monumental and historic opportunity to support a bill that will positively impact the daily lives and well-being of millions of veterans and their families and fundamentally shape and improve the second largest agency in the Federal Government.

□ 1600

I urge every single one of my colleagues to stand today with me and

these organizations dedicated to the service of veterans, servicemembers, and their families, and, most importantly, our Nation's veterans, and support the VA MISSION Act.

Mr. Speaker, I include in the RECORD a letter from the VSO in support of the MISSION Act.

MAY 7, 2018.

Hon. PHIL ROE,  
*Chairman, House Veterans' Affairs Committee,*  
*Washington, DC.*

Hon. JOHNNY ISAKSON,  
*Chairman, Senate Veterans Affairs Committee,*  
*Washington, DC.*

Hon. TIM WALZ,  
*Ranking Member, House Veterans' Affairs Com-*  
*mittee, Washington, DC.*

Hon. JON TESTER,  
*Ranking Member, Senate Veterans' Affairs Com-*  
*mittee, Washington, DC.*

DEAR CHAIRMAN ROE, RANKING MEMBER WALZ, CHAIRMAN ISAKSON AND RANKING MEMBER TESTER: On behalf of the millions of veterans, service members and family members we represent and advocate for, we offer our strong support for the "VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018," also known as the "VA MISSION Act of 2018." This historic veterans legislation would consolidate and reform VA's community care programs; extend funding for the current Veterans Choice Program for one year; strengthen VA's ability to recruit, hire and retain quality medical personnel; review, realign and modernize VA's health care infrastructure; and extend eligibility to VA's comprehensive caregiver assistance program to aging and disabled veterans injured before September 11, 2001.

Our organizations strongly support expanding eligibility for VA's comprehensive caregiver program to all generations of seriously disabled veterans, while maintaining the caregiver benefits that are currently available. Today, this program provides full comprehensive caregiver assistance only to veterans injured on or after September 11, 2001, leaving family caregivers and veterans injured during World War II, the Korean, Vietnam and Gulf Wars ineligible for this critical support. The legislation will help to correct this injustice and we—along with millions of members in our organizations—applaud you for taking this action and look forward to working in the future to ensure that both injured and ill veterans from all eras are eligible for this benefit.

The legislation would consolidate VA's community care programs and develop integrated networks of VA and community providers to supplement, not supplant VA health care, so that all enrolled veterans have timely access to quality medical care. The bill includes funding to continue the current Choice Program for an additional year until the new community care program is implemented as well as important workforce improvement provisions to strengthen VA's internal capacity to deliver care. This carefully crafted compromise represents a balanced approach to ensuring timely access to care while continuing to strengthen the VA health care system that millions of veterans choose and rely on.

The legislation also includes a new Asset and Infrastructure Review (AIR) process intended to design and implement a comprehensive plan to optimize and modernize VA's medical care facilities. The AIR process would provide meaningful stakeholder involvement, transparency and other safeguards during the review process to help ensure the final result leads to a stronger and better aligned VA infrastructure able to deliver care to veterans when and where they need it.

Since the access and waiting list crisis exploded in 2014, Congress, VA and veterans leaders have debated how best to strengthen and reform the delivery of veterans health care to ensure timely and seamless access for enrolled veterans. The legislation before the Committee would take a major step towards that goal by making improvements to and investments in the VA health care system, creating integrated networks so that veterans have access to care when and where they need it, and providing the further recognition and assistance to family caregivers of severely disabled veterans deserve.

As leaders of the nation's veterans and military service organizations, we thank you for your steadfast leadership in crafting this important bipartisan bill and call on all members of Congress to seize this historic opportunity to improve the lives of veterans, their families and caregivers by swiftly passing the "VA MISSION Act of 2018." The men and women who have served, are serving and will serve in the future are counting on Congress' support.

Respectfully,

Garry J. Augustine, Washington Executive Director, DAV (Disabled American Veterans); Verna L Jones, Executive Director, The American Legion; Joseph R. Chenelly, Executive Director, AMVETS; Dana T. Atkins, Lieutenant General, U.S. Air Force (Ret.), President, Military Officers Association of America; Robert E. Wallace, Executive Director, Veterans of Foreign Wars of the United States; Carl Blake, Executive Director, Paralyzed Veterans of America; Rick Weidman, Executive Director of Policy, Vietnam Veterans of America; Rene Bardof, Senior Vice President, Government & Community Relations, Wounded warrior Project; Paul Rieckhoff, Founder and CEO, Iraq and Afghanistan Veterans of America; Joseph C. Bogart MA, Executive Director, Blinded Veterans Association; Thomas J. Snee, National Executive Director, Fleet Reserve Association; Kristina Kaufmann, Executive director, Code of Support Foundation.

Paul K. Hopper, Colonel, USMC (Ret.), National President, Marine Corps Reserve Association; James T. (Jim) Currie, Ph.D., Colonel, USA (Ret.), Executive Director, Commissioned Officers Association of the U.S. Public Health Service; Neil Van Ess, National Commander, Military Order of the Purple Heart; Steve Schwab, Executive Director, Elizabeth Dole Foundation; Bonnie Carroll, President and Founder, Tragedy Assistance Program for Survivors; Jon Ostrowski, Senior Chief USCGR, Retired, Director, Government Affairs, Non Commissioned Officers Association; Michael Cowan MD, VADM USN (Ret), Executive Director, AMSUS; Randy Reid, Executive Director, U.S. Coast Guard Chief Petty Officers, Association; Deirdre Park Holleman, Esq. Washington Executive Director, The Retired Enlisted Association; John H. Madigan, Jr, Vice President and Chief Public Policy Officer, American Foundation for Suicide Prevention; CW4 (Ret.) Jack Du Teil, Executive Director, United States Army Warrant Officers, Association; Jim Lorraine, President & CEO, America's Warrior Partnership.

Mr. ROE of Tennessee. Mr. Speaker, I reserve the balance of my time.

Mr. WALZ. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would like to say the chairman's description of how this

process was done was absolutely 100 percent accurate. The sense of bipartisanship that went into the writing of this bill, the sense of purpose in shared values on caring for our veterans, the sense of dignity and respect that was given to the minority side in dissenting opinions both from the chairman and his staff was exemplary and what we should all expect out of our leadership.

This is a piece of legislation that has components of it that have literally been with me or been on my mind or things that I have tried to effect for literally two-thirds of my life—22 years in that uniform and 12 years here.

Much of this, I am proud to have been part of the original authors with the chairman in writing that, and it brings me to a strange position today. I am rising personally in opposition, and I say that this will be my last opportunity to vote on the Choice Act.

I will be leaving this Congress after this term, and after many positive things—and I have said it time and time again. The leadership that the gentleman from Tennessee (Mr. ROE) is showing will probably not be parallel in terms of care for veterans in the way that he has approached this. This piece of legislation is critically important—the caregivers piece in it, the piece on dealing with VA assets and how we look at capacity going forward, and, of course, Choice.

And I would like to say—and especially to my friend, SAM JOHNSON—very few words need to be said about SAM JOHNSON. We served on the POW/MIA Commission in dealing with finding the lost remains of our warriors and dealing directly with the Russian Government. And when SAM JOHNSON's name is mentioned anywhere around the world, people stop and listen. So it is appropriate. I thank the chairman for naming that, and, of course, with Senators AKAKA and MCCAIN.

My concerns on this. This is not a symptom of the VA Committee. The VA Committee did exactly what it was supposed to do. The chairman did exactly what he was supposed to do. The VSOs did exactly what they were supposed to do. But I think this is my last chance to voice, how do we ever get to the point where we look at long-term stability. How do we ever get to the point—three times we had to do—and the chairman is right. I have no doubt that this body, because of the care for veterans on both sides, will do whatever is necessary when we run short, and we will.

And next May, when we hit the discretionary spending caps and things had to be made, I have no doubt, under the chairman's leadership, we will find a fix, or whoever sits in that chair will try and find that fix. I thought, and still believe to this day, this was our opportunity to look at that long-term care—the issue that was going to be the stability of VA care.

The Congressional Budget Office estimates this bill is going to cost \$47 billion over 5 years. There is not an

American taxpayer that would not pay every penny of that to go to care of veterans. This is not about trying to figure that piece of it out. Paying for veterans care in the community is going to cost \$22 billion on that.

I agree that reforming Choice Programs, consolidating the VA's seven other community care programs is needed. And I agree transferring this funding of the Choice Program to discretionary funding so the VA can budget for the increased cost and all healthcare is paid by that fund. We must ensure the high cost of community care, though, does not force the VA to cut other critical veterans services.

It is unfortunate that we have chosen to solve this problem on the mandatory side by exempting VA care from statutory PAYGO, but we are not going to do that in the future on the care in the community. It is not a problem that is going to occur years from now. Everybody in here who is coming back—and the voters will tell you if you are or not—is coming. The cost of community care is so expensive, we will not get through fiscal year 2019 without a similar exemption on the discretionary side.

This bill fails to address how VA will fund all of its other programs once this transfer occurs. The Bipartisan Budget Act deal raised VA's caps by \$4 billion to improve VA infrastructure. This increased discretionary funding responsibility for community care is going to undermine that deal, forcing VA to cut its own programs and use money designated for VA infrastructure to fund community care.

That is a choice we can make, and it is a choice that has to be made. I am just suggesting today that with the good will, the smart policies, the leadership that was here, maybe we should have gone for the whole one on this.

I will take the critique that looking for the perfect and throwing away the good is a fair critique. I am just not sure, in a Congress with a \$21 trillion deficit and a discretionary spending budget that could be eaten up across there, when is that hard decision ever going to be made?

It could mean that care provided in VA hospitals and clinics, construction and maintenance of those facilities, veterans homelessness programs, and VA research will have to see cuts under the way the law is made to make sure community care is funded. It could cause cuts to programs across the Federal Government, including programs that help veterans with job training, employment assistance, or veterans treatment courts. Even the expansion of eligibility for caregiver assistance for all veterans of all generations—a key part of this bill supported by everyone here—could face cuts if VA hits those spending caps.

Now, all of us here, it is the job of this committee to be the authorizing committee, so don't get me wrong. I am not going to put the pressure where

the White House was or to the appropriators, but the fact of the matter is, after this vote, the Caregiver Support Program has zero dollars in it. No dollars in it. They are going to have to come from somewhere, and a budget that the chairman has rightfully told us has increased fourfold in the last 10 years, we are going to have to come to grips with that.

I am not suggesting you cut it. I am just suggesting that we budget honestly on this so we don't run into this nightmare scenario that is coming in May of 2019. There are concerns over long-term sustainability without qualified leadership in place to successfully implement the program.

Here is what I am worried about. If this committee and even this Congress were responsible for implementation, but once it leaves here, it goes to the executive branch, I, as the ranking member of the House VA Committee, am not quite sure who to call up there right now in this transition. We have been 40 days without a VA Secretary. We don't have one, that I know of, scheduled to go in front of the Senate for confirmation at this point in time.

So we are willing to capitulate the authority, the ability to give this over there, and decisions that are going to affect generational care in the VA to somebody yet to be placed. That leadership piece scares me. But again, some of it is relieved because I know you have got leadership in this House. I know you have got a chairman who cares, wants to get this right, I trust, to carry that oversight out.

The problem is, administrations come and go; secretaries come and go; Members of Congress come and go. That is why we do statutory requirements on spending. That is why this is now discretionary spending. That is why there are caps in place that cannot be violated, and decisions will be made where that is going to come from.

Also, a shortage of 33,000 health providers in the VA and a \$10 billion backlog to fix needed facilities that have "D" or "F" life conditions, that we should be doing more to address that internal care. I agree. These reforms are needed. I agree that these programs were debated in a logical, a fair, and open manner. We got much of what needed to be done in this. We got much of what is good.

The chairman took this process—exactly what should be expected of us. My responsibility, as the final time that I will stand here to talk about how we fund Choice and how we get going for long-term sustainability, is to ask us to just put in—and we had a couple of amendments that could do this—ask us with some capacity to be able to fix that cap piece in this and look for that long-term sustainability.

Mr. Speaker, I reserve the balance of my time.

Mr. ROE of Tennessee. Mr. Speaker, I yield 4 minutes to the gentleman from Texas (Mr. SAM JOHNSON), one of my personal heroes. One of the greatest

privileges I have had in the 9½ years I have served in this U.S. Congress is to serve with SAM JOHNSON.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I first want to thank Chairman ROE for his strong support of our veterans and for the incredible honor he does Senators Akaka, McCAIN, and myself with the bipartisan bill before us. I am truly humbled by this gesture, and I am sure it also means a lot to my buddy JOHN, his family, and Senator Akaka's family as well. Both of these men served during wartime.

Many folks know that JOHN and I were POWs at Hanoi Hilton, and I will always admire his courage in rejecting the North Vietnamese offer to go home early. They, of course, did this in an effort to break the spirit of other POWs. No one but another POW knows the strength and heartbreak it takes to deny yourself the hope of home when your future and life are uncertain. I say this as a fellow POW who spent nearly 7 years in that hellhole Earth.

Mr. Speaker, I served 29 years in the United States Air Force and fought in both the Korean and Vietnam wars, so I understand the sacrifices our servicemembers make to protect the freedom of every American. It is only right that in return for their faithful service, our veterans get the quality healthcare they need and deserve when they return home. That is why one of my proudest accomplishments is the establishment of a VA community-based outpatient clinic in my hometown of Plano, Texas. This facility was much needed in our community, and I am proud to report it is expanding services for our veterans all the time.

But as important as a VA facility is, they are not always convenient for our veterans to visit. To address the fact that some veterans live far from VA facilities or face longer wait times to see doctors, Congress created the Choice Program.

Today's bill makes the Choice Program even better by bringing it fully into the VA health system. That means all veterans actively enrolled in the VA can go to a doctor in their community. You know that is the right thing to do in the spirit, and I think this bill is something we should all support.

Politics aside, may we all be mindful that our veterans have answered the call to duty. They put their lives on the line on our behalf, and their families serve alongside them as well. At the very least, they deserve to be treated with respect and appreciation for their service and their sacrifice.

To all our veterans: God bless you and God bless America. I salute you.

Mr. WALZ. Mr. Speaker, I thank the gentleman from Texas for bringing inspiration to everybody in this body and across the country.

Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. TAKANO), the vice ranking member of the House Committee on Veterans' Affairs.

Mr. TAKANO. Mr. Speaker, I thank Ranking Member WALZ for yielding me

the time and his steadfast leadership on the Veterans' Affairs Committee. He has been tireless in his support of veterans and their families. I am, likewise, inspired by the gentleman from Texas' service to our country. I thank him for his service.

Mr. Speaker, the bill before us today is the culmination of years of ongoing discussion about how to guarantee veterans have timely access to quality care. It streamlines existing programs that allow veterans to get care in the community, creates a process for aligning VA facilities to meet the changing needs of the veteran population, and it expands the Caregiver Support Program to all veterans.

□ 1615

It should come as no surprise that I have serious concerns with this bill. I voted against it when it was reported out of committee to signal that it is not a perfect bill and that there are still improvements to be made.

One of my biggest concerns has to do with funding. In that regard, I share the concern of the ranking member. While previous funding for Choice came from emergency mandatory funding, moving forward, the program will receive discretionary funding and could break the budget caps that trigger sequestration.

That is why I offered an amendment at the Rules Committee last night that guaranteed that moving community care funding to the discretionary side wouldn't count against the bipartisan budget caps we agreed to just a few short months ago. It would help guarantee that we continue to keep our promises to veterans by funding the full range of supports and benefits that they are owed.

Unfortunately, that amendment was not made in order for us to consider on the floor today. Without this critical amendment, I am concerned we will be facing difficult choices, and I fear that veterans will ultimately pay the price, and I mean that in a literal sense.

I have concerns about the process that brought us here today. I think this bill needs a greater emphasis on building the VA's capacity, its internal capacity, to provide veterans the specialized care that many of them need. We need to do more to recruit and retain the best providers to care for our veterans.

I wish that there were more guardrails in place as we begin asset realignment, and I wish that we had a strong VA leadership in place before moving forward with sweeping reforms. But, at the end of the day, Mr. Speaker, I realize we can't keep doing emergency patches to fund community care. We can't continue to look veterans in the eye when we don't offer caregiver support services just because they served in an era before 9/11. That is why I will reluctantly vote in favor of this bill today.

The SPEAKER pro tempore (Mr. MITCHELL). The time of the gentleman has expired.

Mr. WALZ. Mr. Speaker, I yield an additional 30 seconds to the gentleman from California.

Mr. TAKANO. I will reluctantly vote for this bill today.

Mr. ROE of Tennessee. Mr. Speaker, just for clarification, we have been under cap since 2011. The VA budget has grown exponentially since then. We have always done the right thing for our Nation's heroes and will continue to do that.

Mr. Speaker, it is my privilege to yield 2 minutes to the gentleman from Ohio (Mr. WENSTRUP), my good friend. He served until he recently moved to a different committee, as chairman of the Health Subcommittee. He has been an active member of the Veterans' Affairs Committee and has been a very valued member.

Mr. WENSTRUP. Mr. Speaker, I am humbled to follow SAM JOHNSON here at this podium. I have been in Congress 6 years, and to think that he spent 7 years incarcerated as a POW.

Mr. Speaker, I rise in support of the VA MISSION Act. This legislation is about keeping our promises to those who safeguard our freedoms.

As a member of the Army Reserve and a doctor in the Army, I am all too familiar with the challenges plaguing the VA today. In 2014, America witnessed the heartbreaking results of hidden VA wait lists, and Congress quickly responded with the Veterans Choice Program to ensure that no veteran was kept from care. Now, with the leadership of Chairman ROE, we are delivering a lasting solution to get our deserving veterans the care that they have earned and enacting real reforms for the VA to succeed in the 21st century.

This bill will improve and streamline the VA's community care programs, those outside the walls of the VA, into one cohesive program and give a patient and their doctor more say in the process. This will create a nonpartisan, transparent process to review the VA's infrastructure assets, in line with the recommendation from the Commission on Care.

This bill will expand the VA's post-9/11 caregiver program to all eras of veterans.

The VA MISSION Act also includes my legislation, the VA Provider Equity Act, which aims to enhance the ability of the VA to recruit and retain in-demand surgical specialists, due, in part, to increased use of IEDs in the last decade of war.

Mr. Speaker, if we don't act by May 31, 2018, the funding for the Veterans Choice Program will run out, and veterans across America will be unable to access healthcare.

Finally, I want to extend my sincere thanks and gratitude for the tireless work of the entire VA Committee staff, and specifically Christine Hill and Samantha Gonzalez, for the countless hours that they have put in to getting this across the finish line.

Mr. Speaker, I am proud to sponsor the John McCain, Daniel Akaka, and

Samuel Johnson VA MISSION Act, named in honor of three American veteran heroes, and I urge my colleagues to vote "yes."

Mr. WALZ. Mr. Speaker, I yield 4 minutes to the gentlewoman from California (Ms. BROWNLEY), my good friend, the ranking member of the Subcommittee on Health.

Ms. BROWNLEY of California. Mr. Speaker, I thank the gentleman from Minnesota for yielding, and I thank him, also, for his leadership on the committee.

Mr. Speaker, I rise today in support of the VA MISSION Act because it makes significant improvements to the VA that our Nation's veterans have long been asking for, which will help deliver better care to the 9 million veterans enrolled in the VA.

While I recognize that this bill is not a perfect one, my mission and the Veterans' Affairs Committee's mission has always been to provide better access to high-quality care for our Nation's veterans, and this bill advances that goal in a few very important ways.

First, the VA MISSION Act consolidates the various community care programs, which will make it easier for veterans to use and for providers to participate in.

The bill also expands the caregiver program, which is critical for improving outcomes and quality of life for our veterans. This has been a key priority for our Nation's veterans service organizations for years.

Community nursing homes are five times more expensive than the average cost of the caregiver program. Expanding the caregiver program will save the VA and taxpayers money in the long run, all the while allowing veterans to receive quality care and better care at home from the people they trust the most.

The bill also makes important improvements to community care eligibility, which are more closely aligned with the veterans' needs rather than the arbitrary criteria currently in place.

Finally, I am planning to vote "yes" because time is of the essence. As you may know, the acting VA Secretary recently informed Congress that the Choice account will run out of funds by the beginning of June, meaning tens of thousands of veterans could lose access to community care in a few short weeks. The VA MISSION Act will ensure that this does not happen, which is another reason why the legislation is supported by 39 veterans service organizations.

With that said, I fully recognize that the bill's approach to realigning facilities, in my opinion, is flawed.

I also share the ranking member's concerns about the budget caps. Reimposing the sequester would be devastating for the VA and for other Federal discretionary programs. This is a real issue that must be addressed.

Since I have been in Congress, we have raised budget caps three times in

a bipartisan manner. We can and we must do so again in order to avoid devastating cuts to programs our constituents depend on.

As the ranking member noted, during the committee markup, Democrats tried to fix this issue, but his amendment was voted down. Today, our new colleague from Pennsylvania also has offered legislation to address this issue, which I supported, but the House did not adopt it.

While I am disappointed that the budget cap issue has not yet been fully addressed, I plan to vote for the VA MISSION Act today. It is past that time. Congress must take action to consolidate the community care programs and to expand the caregiver program.

Mr. Speaker, I urge my colleagues to also support the bill.

Mr. ROE of Tennessee. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), the vice chair of the committee and a tireless worker on the Veterans' Affairs Committee.

Mr. BILIRAKIS. Mr. Speaker, what an honor it is, an honor and a privilege, to serve with Mr. SAM JOHNSON, a true American hero.

Mr. Speaker, I rise today in support of S. 2372, the VA MISSION Act, which will provide significant reforms and improvements to the Veterans Choice Program.

Since its implementation, the Veterans Choice Program has served over 1.7 million unique veterans seeking timely and high-quality healthcare for their physical and invisible wounds. Although progress has been made, there is more work to be done to ensure we balance resources from community care and the VA healthcare system.

The VA MISSION Act will streamline and consolidate the Veterans Choice Program with the other duplicative VA community care programs to create one new cohesive Veterans Community Care Program. This new program allows eligible veterans to seek care from non-VA providers in the community if the VA is not providing the quality care the veterans deserve, and timely care. It also requires access to community providers if the veteran and doctor believe it is in the veteran's best medical interest to seek such care.

Mr. Speaker, I thank Chairman ROE, who did an outstanding job with this bill, for his hard work on this bicameral, bipartisan piece of legislation, which is the result of a long negotiation process, where both sides of the aisle put aside differences and compromised to strike a balance between each stakeholder. This is how Congress should work. I am proud of the work that we have done on this committee.

I want to thank the staff, as well. The committee ensured that we have a great work product for our true American heroes. Again, I want to thank the sponsors of the bill.

Mr. Speaker, let's have a great vote for our true American heroes. Let's pass this VA MISSION Act and get it to the Senate as soon as possible.

Mr. WALZ. Mr. Speaker, could I inquire how much time I have remaining.

The SPEAKER pro tempore. The gentleman from Minnesota has 15½ minutes remaining. The gentleman from Tennessee has 10¼ minutes remaining.

Mr. WALZ. Mr. Speaker, I yield 3 minutes to the gentlewoman from New Hampshire (Ms. KUSTER), my good friend, the ranking member of the Subcommittee of Oversight and Investigations.

Ms. KUSTER of New Hampshire. Mr. Speaker, today I rise to speak as a cosponsor of the VA MISSION Act. I appreciate the work of Chairman ROE and Ranking Member WALZ in putting this bill together. This bill is almost unanimously supported by the veterans service organization community.

I am proud to cosponsor this legislation because it will enact needed reforms to the Veterans Choice Program and finally extend benefits to family caregivers for veterans of all eras.

I am pleased that the committee retained provisions that Senator SULLIVAN of Alaska and I fought for that would recognize the unique access issues for States that lack a full-service VA hospital. While I will continue to fight for improved and expanded facilities at our Manchester, New Hampshire, VA Medical Center, it is important to recognize that we have unique challenges in New Hampshire where we do not have a full-service hospital.

I also want to speak to this: the provisions that expand the caregiver benefits provided to post-9/11 veterans to veterans of all eras are necessary and long overdue.

I have heard repeatedly from Granite State veterans of eras prior to the global war on terror that the differences and benefits are simply unfair. The way these benefits are currently structured essentially pits veterans against veterans. That is unacceptable.

I thank Chairman ROE for working with us on finding a way forward for family caregiver benefits. I am sure thousands of Granite State veterans will agree.

While this bill embodies the kind of bipartisanship for which our committee is well known, it is not perfect. As the ranking member of the Oversight and Investigations Subcommittee, I believe it is important to acknowledge parts of the bill that will need continued oversight. I remain committed to ensuring that the VA follows through in a manner that befits the veterans they serve.

Number one, the asset infrastructure review portion of the bill is promising, but I have concerns that it will be insufficient to accomplish its goals. The VA is in desperate need of improved facilities and a realignment of facilities to better serve veterans' needs.

In my own State of New Hampshire, the veterans of the North Country must rely on the Veterans Choice Program, rather than have ease of access to services they would prefer. I am encouraged by the continued work to im-

prove our existing facilities, but Granite State veterans need more, and I hope this bill will further empower the VA to expand services in Manchester and across our State.

Recent experiences has shown that the VA's ability to accurately assess the needs of the veterans' population is in doubt. I remain committed to ensuring that the VA can paint an accurate picture of veterans' needs, especially veterans living in rural America. Too often, our veterans in rural America have seen promised infrastructure expansion stripped away from them. I urge the veterans service organizations community to continue to work with us to keep the VA honest.

□ 1630

Mr. ROE of Tennessee. Mr. Speaker, it is my great honor to welcome Ms. KUSTER back. She has been out for a little bit due to some work, and I am glad to see her back on the floor.

Mr. Speaker, I yield 2 minutes to the gentleman from Maine (Mr. POLIQUIN), my good friend and a very active member of the Veterans' Affairs Committee.

Mr. POLIQUIN. Mr. Speaker, I thank the chairman for yielding.

Mr. Speaker, this is a great day, a great week for America. Here we are celebrating not only our great veterans, who have given us our freedom and our way of life, but also our great police officers, who stand between ourselves and a more chaotic environment. We are grateful for everybody that steps up, not only our men and women in uniform who have represented us, but also our men and women in blue.

Mr. Speaker, I represent the Second Congressional District of the great State of Maine. This is the largest geographic district east of the Mississippi River. We have an 8-hour drive if you go from Fryeburg to Van Buren over beautiful country roads, all kinds of critters in the roads, including moose, so you have got to be careful when you are driving, but let me tell you, we also have 125,000 veterans in the State of Maine, more than half of which, Mr. Speaker, are in the Second District.

We love our veterans in the State of Maine. We absolutely love our veterans. We honor them, but we only have, Mr. Speaker, one veterans hospital in the State of Maine. It is in Togus, the first VA Hospital in America to take care of our veterans coming back from the Civil War. But, you know, if you live in Frenchville, Maine, or you live in Van Buren, you might have a 3-, 4-, or 5-hour drive to Togus at 2 o'clock in the morning when the snow is blowing sideways in February.

We need to make sure we give folks an opportunity—who served our country—to get healthcare closer to them. It just makes sense.

Now, a lot of people, Mr. Speaker, say, "Well, we don't want to privatize the VA." Neither do I, and nobody wants to, but it makes sense to make sure we augment what they can do so our veterans can get healthcare closer

to home, and that is exactly what this program does.

Now, one thing I have to mention to you, Mr. Speaker, is that some of our rural hospitals who have contracted with the VA and provided great services to our veterans have not been getting paid on time. This is a real problem when you have got a small hospital that might not have bills paid for 1 to 2 years.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. ROE of Tennessee. Mr. Speaker, I yield an additional 15 seconds to the gentleman.

Mr. POLIQUIN. Mr. Speaker, we need to make sure all of our rural hospitals in the State of Maine and throughout the country get paid, and this bill says if they are not paid within 30 days, then interest starts accruing on that.

This is a great win for our veterans, for our small community hospitals that need to stay open for everybody, and for this country.

Mr. WALZ. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. CORREA), my good friend and a member of the House Committee on Veterans' Affairs, who also served a very long time in the California Senate serving veterans there.

Mr. CORREA. Mr. Speaker, I rise today in support of S. 2372, the VA MISSION Act.

Mr. Speaker, I support the VA MISSION Act because it will improve access to timely care for all our veterans through consolidation and reform of the various care and community programs and through expansion of the caregiver program.

Like my colleague from Maine said, in California, we are the proud home to the largest number of veterans in the United States, and we want more of them in California.

Let me say that I know there may be some issues with this legislation, but at the end of the day, I have got to ask myself, is this about Wall Street or is this about the beltway? No. This is about Main Street, Main Street Santa Ana, Anaheim, Orange County, California.

This VA MISSION Act is supported by 38 veteran and military service groups, including The American Legion.

One of my constituents, Ken George, the District 29 Commander of the Department of California American Legion, represents more than 8,000 American Legion members in Orange County, he called me and he said: If Congress wants to help veterans and caregivers, there is no better way than to support this legislation.

As Ken said, the bill will help veterans and caregivers through expansion of benefits available to our caregivers of veterans of all eras.

Mr. Speaker, I urge passage of this legislation. Yes, there are some issues there, but at the end of the day, if you listen to our veterans, our friends, and neighbors, the folks we represent, this is an "aye" vote.

Mr. ROE of Tennessee. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. DUNN), my good friend, a U.S. Army veteran, and an active member of the Veterans' Affairs Committee.

Mr. DUNN. Mr. Speaker, I thank the chairman for yielding.

Mr. Speaker, I rise today in support of the VA MISSION Act of 2018. This important legislation secures veterans' ability to access quality healthcare and ensures that we are fulfilling our promise to care for them following their service to our Nation.

It builds on the success of the Choice Program by streamlining community care programs so a veteran can access care from a provider outside of the VA when they need to. It also expands caregiver benefits for seriously injured pre-9/11 veterans and for their families.

The VA MISSION Act includes two healthcare initiatives from legislation that I have introduced that protects our veterans receiving organ transplants and also helps with the opioid crisis.

Currently, there are only 13 facilities in the Nation where a veteran may receive a transplant in the VA healthcare system, and none of these facilities performs all types of transplants. Timely organ transplants are often the difference between life and death.

The transplant language from my bill included in the VA MISSION Act eliminates the roadblocks that veterans face and increases the access to care for our veterans, the care that they have earned by their service to our Nation.

We are also fighting the opioid epidemic among veterans. My legislative initiative increases transparency in opioid prescribing at the VA by allowing doctors to identify high users of controlled drugs who are therefore at risk for addiction. My language in the VA MISSION Act instructs the VA to do what most private doctors already do: connect to the prescription drug monitoring databases nationwide so that no one slips through the cracks.

Mr. Speaker, we are standing up and fighting for those who fought for our freedoms. As a surgeon and a veteran, I believe the VA MISSION Act is good medicine and good public policy.

Mr. Speaker, I urge all of my colleagues to support this important legislation.

Mr. WALZ. Mr. Speaker, I yield 4 minutes to the gentlewoman from Connecticut (Ms. ESTY), my good friend, the ranking member of the Subcommittee on Disability Assistance and Memorial Affairs.

Ms. ESTY of Connecticut. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of the VA MISSION Act of 2018. I am proud to support the VA MISSION Act of 2018, especially because of its important expansion of support for family caregivers of veterans of all service eras.

Since my first days in Congress, I have heard from veterans and their caregivers about the important support

provided through the VA's Program of Comprehensive Assistance for Family Caregivers.

Family caregivers provide loving and essential care at home for our injured veterans, from bathing and dressing, housework and transportation, to administering physical and medical therapies.

Caregivers are true partners in the delivery of healthcare to our veterans, and it is important that we recognize their tremendous service and their worth.

In 2010, Congress wisely stepped up to offer the family caregivers of veterans support in performing these vital tasks, but the program was only made available to the family caregivers of post-9/11 veterans.

Clearly, those who served in World War II, Korea, and Vietnam, and their families are deserving of the same respect and support.

That is why, since being elected to Congress, I have authored legislation in every session to expand this assistance for family caregivers to pre-9/11 veterans.

Today, this Congress has the opportunity to honor and support veterans of all service eras by voting for this excellent bill.

Mr. Speaker, I thank Congressman RYAN COSTELLO for leading with me on these important caregiver issues. I thank the chairman and the ranking member for their hard work on including this vital provision in the VA MISSION Act.

Mr. Speaker, it is time that we treat our injured veterans of all eras equally by expanding the VA caregivers program to all injured veterans.

I do want to note that I share the ranking member's concerns with the long-term sustainability of this program. Congress will have to work closely with the VA as this expanded community care program is implemented to ensure that this program is sustainable without cuts to other veterans or other important domestic programs.

The bill we are considering today will ensure that our veterans are getting the care they need when they need it, but in addition to timely care, we must ensure that veterans have access to quality care. As we send veterans outside the VA system to private medical providers, we need to ensure that these doctors and other healthcare professionals are capable of delivering the quality care that each and every one of our veterans deserves.

So, while I applaud the expansion of care in this bill, I am concerned about the potential for fraud, waste, and abuse as VA begins to send many more veterans outside the VA system to private medical providers. That is why it is vital that Congress remain engaged with the implementation of this program to make sure that our veterans are receiving high-quality healthcare from qualified providers and that we in Congress are being careful stewards of the taxpayer dollars.

Mr. Speaker, I again thank the gentleman for yielding, and I thank the chairman and ranking member for their leadership.

Mr. Speaker, I am proud to serve on this committee with such extraordinary public servants who share a commitment to serving those who have been willing to put their lives on the line to defend our freedom. It has been a pleasure and an honor serving with them.

Mr. Speaker, I congratulate everyone on their hard work in bringing this bill, admittedly not perfect but very important, forward for our consideration, and I urge my colleagues to adopt it when we have the opportunity to vote later today.

Mr. ROE of Tennessee. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. RUTHERFORD), a very active member of the Veterans' Affairs Committee.

Mr. RUTHERFORD. Mr. Speaker, I thank the chairman for this opportunity, and I thank Ranking Member WALZ for such bipartisan support and work on this bill. I am very proud to serve on this committee because of the kind of work that goes on here under the leadership of Chairman ROE.

Mr. Speaker, I am proud to cosponsor this bill. I can tell you, since coming to Congress, I have had the distinct honor of serving with Dr. ROE, our chairman, and colleagues on the House Veterans' Affairs Committee, and during this time, we on the committee have heard from veterans services organizations, from the Veterans Administration, and from veterans themselves about the challenges in the VA healthcare system.

We have learned about the barriers to timely care, the troubling provider shortage, also the lack of prompt payment to our community providers, and so many other issues.

I am proud to say that I believe this is, in the words of 38 VSOs who wrote in strong support of this legislation, truly a "historic opportunity to improve the lives of veterans, their families, and their caregivers."

That is one reason I am very proud to be on this committee. I think this is a historic move.

It is our duty as legislators and as Americans to ensure that our veterans receive the best care possible. This bill accomplishes that by streamlining community care programs; improving access to timely care; funding the Choice Program; and, until this new program can be implemented, creating a fair access review process, greatly expanding the VA caregiver program, and improving VA's own in-house capacity.

One item that I would like to thank the leaders in both Chambers for, but especially Dr. ROE and his staff and the White House, is including in this language on provider recruitment and retention within the VA, sections 301, 303, and 304 of this bill, which is language that I had asked to have placed in there.

These provisions expand the tools the VA can use to recruit and retain quality providers by requiring the use of scholarships and improving and expanding the loan repayment system that targets newly graduated medical students.

Mr. WALZ. Mr. Speaker, I reserve the balance of my time.

Mr. ROE of Tennessee. Mr. Speaker, I yield 3 minutes to the gentleman from Michigan (Mr. BERGMAN), a lieutenant general and an incredibly valued member of our committee.

Mr. BERGMAN. Mr. Speaker, I thank the chairman for his tireless effort, along with the committee staff, to highlight that the House Veterans' Affairs Committee is truly how a congressional committee is supposed to operate: together.

□ 1645

The name of the act is the VA MISSION Act. Any member of the military understands that mission accomplishment is always first, and with this VA MISSION Act of 2018, what you are going to see is some extremely important elements in accomplishing that long-term mission of providing results for the veterans.

The community care improvement consolidates seven duplicative community care programs into one cohesive program. It removes arbitrary one-size-fits-all parameters in the Choice Program.

Previously, the Choice Program limited accessing care to convenient and affordable. It wasn't good enough. The VA MISSION Act provides Choice funding shortfalls, ensuring that the 1-year funding bridge is complete so that the veterans have a continuity of care during the implementation of the new program.

It also provides for the Asset and Infrastructure Review. This transforms the VA from relying on outdated inpatient facilities to more modern facilities meant for outpatient care of the future that includes delivery through telehealth, through different and unique circumstances that our veterans expect and deserve today.

The VA is one of the Federal Government's largest property holders and needs to make sure that its resources aren't wasted keeping lights on in unused buildings. Those limited resources need to be focused on the veterans.

And finally, the caregiver expansion, this VA MISSION Act expands caregiver support to both pre- and post-9/11 veterans. That is essential and long overdue.

When you reform the VA and allow for greater veteran choices but do not—and I repeat, do not—privatize, this is making the VA the best it needs to be going forward in support of our veterans.

Mr. Speaker, I again thank the chairman for his efforts.

Mr. WALZ. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, again, to the chairman, I am not writing his eulogy here, but I

would say that is a pretty impressive resume of accomplishments, going back to the Forever GI Bill, appeals reform, Clay Hunt Suicide, as just a few, and then this piece of legislation. The gentleman's work and tenacity for veterans, Mr. Speaker, is second to none. His dignity and respect for all Members of this House in the process is legendary.

And for giving this space today for us to talk about and debate on this floor our shared values, compromise disagreements, but always with the goal that we are in this together, that is created by an atmosphere of leadership. It is created by an atmosphere of respecting our democratic process. It is understanding that this is not about gotcha, who is this and who is that. It is about looking at what is possible.

So I congratulate the gentleman for putting together a piece of legislation that serves so many veterans. It has the support of so many folks, and allowing me on this last opportunity to express those long-term concerns to make sure we don't undermine that, I am forever grateful for that.

I appreciate the comments and the gentleman from Michigan talking about the capacity inside the VA, too. We have got incredible providers there serving veterans every day, and many of them veterans themselves. I know his commitment to making sure they have the resources necessary to do their job. It is a priority.

I think the concern that I am showing on the budget gap is just to make sure that we don't pick one over the other or where veterans care is. And, as I said, again, if it were left on the shoulders of the chairman to ensure that would happen, I would sleep well at night. I just worry that when we don't codify these things, when we have the uncertainty in the VA right now, that is where my concern came from, but not from this process, not from an openness, not from a commitment, and not from the gentleman's willingness to get this thing across the finish line.

Mr. Speaker, I yield back the balance of my time.

Mr. ROE of Tennessee. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I want to thank everyone who was involved in this process, beginning with the staff, who have been heavily involved in this. Both the Republican side and Democratic side worked for the last, really, almost 18 months.

I want to thank our Senate colleagues on the other side of this Capitol who worked very hard and the hours that went into this. The real winners here are our Nation's heroes, the veterans.

This VA MISSION Act does a community care where veterans can get high-quality care both inside the VA and out when the VA can't do that. We have heard speakers down here from areas that don't have a VA hospital. They absolutely rely on that.

I was in Oregon a few months ago and realized that some veterans had to drive 5 hours to a VA facility. They need the community care bill in their community. We provide the funding for that bill to bridge us over until the new Secretary implements that.

We have a caregiver. I am a Vietnam-era veteran, and I have seen many catastrophically injured Vietnam veterans whose families struggled for decades. 520-plus Vietnam veterans are dying every day. It is time we implement this bill and get these needed benefits to those World War II and veterans up to 9/11.

We need to rightsize the VA. Healthcare is not provided like it used to be. It has become much more sophisticated and streamlined. And outpatient, the VA needs to get to be able to do that also. That is what the AIR Act is about. We are increasing the internal capacity so we can train and get new clinicians and providers in.

The speaker, SAM JOHNSON, who spoke a minute ago, said it all. We should be able to look at that hero, who is a true American hero, and listen to his speech, which brought tears to my eyes, and vote for this bill.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. RUTHERFORD). All time for debate has expired.

Pursuant to House Resolution 891, the previous question is ordered on the bill, as amended.

The question is on the third reading of the bill.

The bill was ordered to be read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. ROE of Tennessee. Mr. Speaker, I demand a recorded vote.

The Speaker pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

#### AGRICULTURE AND NUTRITION ACT OF 2018

##### GENERAL LEAVE

Mr. CONAWAY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 2.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

The SPEAKER pro tempore. Pursuant to House Resolution 891 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the state of the Union for the consideration of the bill, H.R. 2.

The Chair appoints the gentleman from Michigan (Mr. MITCHELL) to preside over the Committee of the Whole.

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##### IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the state of the Union for the consideration of the bill (H.R. 2) to provide for the reform and continuation of agricultural and other programs of the Department of Agriculture through fiscal year 2023, and for other purposes, with Mr. MITCHELL in the chair.

The Clerk read the title of the bill.

The CHAIR. Pursuant to the rule, the bill is considered read the first time.

The gentleman from Texas (Mr. CONAWAY) and the gentleman from Minnesota (Mr. PETERSON) each will control 30 minutes.

The Chair recognizes the gentleman from Texas.

Mr. CONAWAY. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise today in strong support of H.R. 2, the Agriculture and Nutrition Act of 2018, more commonly known as the farm bill. I do so, proudly, because I still believe that rural America and our farm and ranch families are the backbone of this country.

Our farmers and ranchers ensure that Americans across this great country pay the lowest grocery bills in the world. They also hand us a rare trade surplus, while creating 21 million American jobs.

In the heartland, agriculture is the lifeblood of the economy. When agriculture does well, Main Street does well; and when agriculture is suffering, so is Main Street.

But beyond the economic contributions, rural America and our Nation's farmers and ranchers are imbued with the values that I cherish deeply: the values of faith, family, God, country, and duty; of neighbor helping neighbor, hard work, and personal responsibility.

In short, Mr. Chairman, rural America and our Nation's farmers and ranchers make America great. I expect that is why the President of the United States strongly supports this farm bill and urges passage.

Times are not good right now in the heartland. Our Nation's farmers and ranchers are struggling in the midst of a 5-year recession, with no end in sight. Net farm income has been cut in half over this period of time. As a result, rural America is not partaking in the economic recovery that urban counterparts are experiencing.

There are many reasons behind the hard times in farm and ranch country. I will briefly discuss two.

In my hometown of Midland, Texas, we have received 1 inch of rain over the last 195 days. Drought is ravaging my State. Last year, we saw record losses due to hurricanes and wildfires. And to the north, in the ranking member's home State, farmers are struggling to get into the fields to plant, although it is the middle of May. The fact is the men and women who clothe and feed us in a manner that is absolutely

unrivaled in world history are the ones hit hardest and first by Mother Nature.

A second reason for the current condition is another factor totally beyond the control of our farm and ranch families: the predatory trade practices of foreign countries. For the sake of brevity, I will offer just one example.

In just 1 year, China oversubsidized just three crops by more than \$1 billion. To put that in perspective, the entire safety net for all of our farmers and ranchers under this farm bill is expected to cost just 64 percent of the amount China spent on illegal subsidies in just 1 year on just three crops.

Mr. Chairman, the global market is awash with high and rising foreign subsidies, tariffs, and nontariff trade barriers, and these are hurting American farmers and ranchers.

So what do we do about that? We heed the call of the President of the United States and the Secretary of Agriculture to pass this farm bill.

No, this farm bill is not a cure for all that ails rural America and our farmers and ranchers, but this farm bill does provide a safety net to see them through the hard times.

For my colleagues interested in the budgetary impacts of this farm bill, H.R. 2 keeps faith with taxpayers, with CBO now projecting more than \$112 billion in savings, nearly five times what was pledged back in 2014.

There are many other aspects of this farm bill, but I will just briefly touch on three.

First, Secretary Perdue has shown great leadership on two particular issues that are extremely important to rural America: the opioid epidemic that is ravaging rural America needs an aggressive, effective response, and the lack of broadband in many parts of rural America puts farmers and ranchers in rural communities at a terrible disadvantage. The Secretary is determined to tackle these problems and has asked for the tools he needs to make it happen. This farm bill provides those tools.

Second, it is no secret that we do not have a bipartisan farm bill process at this moment, and that I deeply regret. Ultimately, Democrats and Republicans chose to agree to disagree on the question of whether work-capable adults should work or get free job training for 20 hours per week in order to be eligible for SNAP.

I respect my colleagues on the other side of the aisle, but I do want to be clear about something: This farm bill in no way, shape, or form disrespects Americans who depend on SNAP. To the contrary, the farm bill keeps faith with SNAP beneficiaries, providing needed benefits and something more—the dignity that comes with work and the promise of a better life that a job brings. I want these Americans to realize the American Dream.

Finally, in closing, I want to note that there is a cottage industry in this town that is determined to defeat this farm bill. They want this House to ignore the realities of Mother Nature and