To amend title 38, United States Code, to establish a permanent VA Care in the Community Program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 3, 2017

Mr. Roe of Tennessee (for himself, Mr. Coffman, Mr. Wenstrup, Mrs. Radewagen, Mr. Bost, Mr. Poliquin, Mr. Arrington, Mr. Rutherford, Mr. Higgins of Louisiana, Mr. Bergman, Mr. Banks of Indiana, Miss González-Colón of Puerto Rico, Mr. Bilirakis, Mr. Dunn, Mr. Walz, Ms. Kuster of New Hampshire, Miss Rice of New York, Mr. Correa, Mr. Sablan, Ms. Esty of Connecticut, Mr. Peters, Mr. O’Rourke, Mr. Takano, and Ms. Brownley of California) introduced the following bill; which was referred to the Committee on Veterans’ Affairs

A BILL

To amend title 38, United States Code, to establish a permanent VA Care in the Community Program, and for other purposes.

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

2 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

3 (a) Short Title.—This Act may be cited as the “VA Care in the Community Act”.

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(b) Table of Contents.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

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

Sec. 101. Assignment of veterans to primary care providers.
Sec. 102. Establishment of VA Care in the Community Program.
Sec. 103. Veterans Care Agreements.
Sec. 104. Modification of authority to enter into agreements with State homes to provide nursing home care.
Sec. 105. Department of Veterans Affairs electronic interface for processing of medical claims.
Sec. 106. Funding for VA Care in the Community Program.
Sec. 107. Termination of certain provisions authorizing medical care to veterans through non-Department of Veterans Affairs providers.
Sec. 108. Implementation and transition.

TITLE II—OTHER ADMINISTRATIVE MATTERS

Sec. 201. Reimbursement for emergency ambulance services.
Sec. 202. Improvement of care coordination for veterans through exchange of certain medical records.
Sec. 203. Elimination of copayment offset.
Sec. 204. Use of Department of Veterans Affairs Medical Care Collections Fund for certain improvements in collections.
Sec. 205. Department of Veterans Affairs health care productivity improvement.
Sec. 206. Licensure of health care professionals of the Department of Veterans Affairs providing treatment via telemedicine.

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

SEC. 101. ASSIGNMENT OF VETERANS TO PRIMARY CARE PROVIDERS.

Section 1706 of title 38, United States Code, is amended by adding at the end the following new sub-section:
“(d)(1) Except as provided in section 1703A of this title, in furnishing primary care under this chapter, the Secretary shall assign each eligible veteran to—

“(A) a patient-aligned care team of the Department; or

“(B) a dedicated primary care provider of the Department as a part of any other model of providing consistent primary care determined appropriate by the Secretary.

“(2) Each patient-aligned care team of the Department shall consist of a team of health care professionals of the Department who—

“(A) provide to each eligible veteran comprehensive primary care in partnership with the veteran; and

“(B) manage and coordinate comprehensive hospital care and medical services consistent with the goals of care agreed upon by the veteran and team.

“(3) The Secretary shall ensure that an eligible veteran is not simultaneously assigned to more than one patient-aligned care team or dedicated primary care provider under this subsection at a single location, including by establishing procedures in the event a primary care provider retires or is otherwise no longer able to treat the veteran.
In the case of an eligible veteran who resides in more than one location, the Secretary may assign such veteran to a patient-aligned care team or dedicated primary care provider at each such location.

"(4) The term ‘eligible veteran’ means a veteran who—

“(A) is enrolled in the patient enrollment system of the Department established and operated under section 1705(a) of this title; and

“(B) has—

“(i) been furnished hospital care or medical services at or through a Department facility on at least one occasion during the two-year period preceding the date of the determination of eligibility; or

“(ii) requested a first-time appointment for hospital care or medical services at a Department facility.”.

SEC. 102. ESTABLISHMENT OF VA CARE IN THE COMMUNITY PROGRAM.

(a) Establishment of Program.—

(1) In general.—Chapter 17 of title 38, United States Code, is amended by inserting after section 1703 the following new section:
§ 1703A. VA Care in the Community Program

“(a) PROGRAM.—(1) Subject to the availability of appropriations for such purpose, hospital care, medical services, and extended care services under this chapter shall be furnished to an eligible veteran through contracts or agreements authorized under subsection (d), or contracts or agreements, including national contracts or agreements, authorized under section 8153 of this title or any other provision of law administered by the Secretary, with network providers for the furnishing of such care and services to veterans.

“(2) Subject to subsection (b), an eligible veteran may select a provider of such care or services from among network providers.

“(3) The Secretary shall coordinate the furnishing of care and services under this section to eligible veterans.

“(4)(A) In carrying out this section, the Secretary shall establish regional networks of network providers. The Secretary shall determine, and may modify, such regions based on the capacity and market assessments of Veterans Integrated Service Networks conducted under subsection (k) or upon recognized need.

“(B) The Secretary may enter into one or more contracts for the purposes of managing the operations of the regional networks and for the delivery of care pursuant to this section.
“(b) PRIMARY AND SPECIALTY CARE.—(1)(A) If the Secretary is unable to assign an eligible veteran to a patient-aligned care team or dedicated primary care provider under section 1706(d) of this title because the Secretary determines such a care team or provider at a Department facility is not available—

“(i) the Secretary shall consult with the veteran regarding available primary care providers from among network providers that are located in the regional network in which the veteran resides or a regional network that is adjacent to the regional network in which the veteran resides; and

“(ii) the veteran may select one of the available primary care providers to serve as the dedicated primary care provider of the veteran.

“(B) In determining whether a patient-aligned care team or dedicated provider under section 1706(d) of this title is available for assignment to a veteran, the Secretary shall take into consideration each of the following:

“(i) Whether the veteran faces an unusual or excessive burden in accessing such patient-aligned care team or dedicated provider at a medical facility of the Department including with respect to—

“(I) geographical challenges;
“(II) environmental factors, including roads that are not accessible to the general public, traffic, or hazardous weather;

“(III) a medical condition of the veteran;

or

“(IV) such other factors as determined by the Secretary.

“(ii) Whether the veteran reasonably believes that the assignment of a particular care team or provider to the veteran would detrimentally affect the patient-provider relationship and result in sub-optimal care to the veteran.

“(iii) Whether the panel size of the care team or provider is at such a number that it would result in difficulty for the veteran in accessing timely care or in sub-optimal care to the veteran.

“(C) If the Secretary determines that a patient-aligned care team or dedicated primary care provider at a Department facility has become available for assignment to an eligible veteran who had been assigned to a network provider under subparagraph (A), the Secretary shall provide the veteran with the option of reassignment to the team or provider at the Department facility.

“(D) In the case of an eligible veteran who is assigned to a network provider under subparagraph (A), the
Secretary shall reevaluate such assignment not earlier than one year after a veteran makes a selection under sub-
paragraph (A)(ii), and on an annual basis thereafter, to—

“(i) determine whether the Secretary is able to assign to the veteran a patient-aligned care team or dedicated primary care provider under section 1706(d) of this title; and

“(ii) in consultation with and upon approval of the veteran, make such assignment if able.

“(2)(A)(i) Except as provided in clause (ii), the Sec-
cretary may only furnish specialty hospital care, medical services, or extended care services to an eligible veteran under this section pursuant to a referral for such specialty care or services made by the primary care provider of the veteran.

“(ii) The Secretary may designate specialties which shall be exempt from the requirement under clause (i).

“(B) The Secretary shall determine whether to fur-
nish specialty hospital care, medical services, or extended care services to an eligible veteran pursuant to subpara-
graph (A)—

“(i) at a medical facility of the Department that is within a reasonable distance of the residence of the veteran, as determined by the Secretary;
“(ii) by a network provider that, to the greatest extent practicable, is located in the regional network in which the veteran resides or a regional network that is adjacent to the regional network in which the veteran resides; or

“(iii) pursuant to an agreement described in subparagraph (C).

“(C) An agreement described in this subparagraph is an agreement entered into by the Secretary with a network provider under which—

“(i) specialty hospital care, medical services, or extended care services are furnished to an eligible veteran pursuant to subparagraph (A)—

“(I) at a medical facility of the Department by a network provider possessing the appropriate credentials, as determined by the Secretary; or

“(II) at a facility of a network provider by a health care provider of the Department; and

“(ii) such specialty care or services are so furnished either—

“(I) in accordance with this section with respect to fees and payments for care and services furnished under subsection (a); or

“(II) at no cost to the United States.
“(D) In making the determination under subparagraph (B), the Secretary shall give priority to medical facilities and health care providers of the Department but shall take into account—

“(i) whether the veteran faces an unusual or excessive burden in accessing such specialty hospital care, medical services, or extended care services at a medical facility of the Department, including with respect to—

“(I) geographical challenges;

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

“(III) a medical condition of the veteran; or

“(IV) such other factors as determined by the Secretary; and

“(ii) whether the primary care provider of the veteran recommends that such specialty hospital care, medical services, or extended care services should be furnished by a network provider.

“(E) The Secretary shall ensure that each medical facility of the Department processes referrals for specialty hospital care, medical services, or extended care services in a standardized manner, including with respect to the
organization of the program office responsible for such re-
ferrals.

“(F) In carrying out this section, the Secretary shall
establish a process to review any disagreement between an
eligible veteran and the Department, or between an eligi-
ble veteran and a health care provider of the Department,
regarding the eligibility of the veteran to receive care or
services from a network provider under this section or the
assignment of a primary care provider of the Department
to the veteran. In reviewing a disagreement under such
process with respect to the availability of and assignment
to a patient aligned care team or dedicated primary care
provider, the Secretary shall give deference to the veteran
with respect to any determination under subsection
(b)(1)(B)(ii).

“(c) EPISODES OF CARE.—(1) The Secretary shall
ensure that, at the election of an eligible veteran who re-
ceives hospital care, medical services, or extended care
services from a network provider in an episode of care
under this section, the veteran receives such care or serv-
ices from that network provider, another network provider
selected by the veteran, or a health care provider of the
Department, through the completion of the episode of
care, including all specialty and ancillary services deter-
mined necessary by the provider as part of the treatment
recommended in the course of such care or services. In
making such determination with respect to necessary spe-
cialty and ancillary services provided by a network pro-
vider, the network provider shall consult with the Sec-
retary, acting through the program office of the appro-
priate medical facility.

“(2) In cases of episodes of care that the Secretary
determines case management to be appropriate, the Sec-
retary shall provide case management to an eligible vet-
eran who receives hospital care, medical services, or ex-
tended care services from a network provider for such epi-
sodes of care. The Secretary may provide such case man-
agement through the Veterans Health Administration or
through an entity that manages the operations of the re-
gional networks pursuant to subsection (a)(4)(B).

“(d) CARE AND SERVICES THROUGH CONTRACTS
AND AGREEMENTS.—(1) The Secretary shall enter into
contracts or agreements, including national contracts or
agreements for, but not limited to, dialysis, for furnishing
care and services to eligible veterans under this section
with network providers.

“(2)(A) In entering into a contract or agreement
under paragraph (1) with a network provider, the Sec-
retary shall—
“(i) negotiate rates for the furnishing of care and services under this section; and

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

“(B)(i) Except as provided in paragraph (3), rates negotiated under subparagraph (A)(i) shall not be more than the rates paid by the United States to a provider of services (as defined in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u))) or a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d))) under the Medicare Program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for the same care or services.

“(ii) In determining the rates under the Medicare Program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for purposes of clause (i), in the case of care or services furnished by a provider of services with respect to which such rates are determined under a fee schedule to which the area wage index under section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) applies, such area wage index so applied to such provider of services may not be less than 1.00.
“(C) In carrying out paragraph (2), the Secretary may incorporate the use of value-based reimbursement models to promote the provision of high-quality care.

“(3)(A) With respect to the furnishing of care or services under this section to an eligible veteran who resides in a highly rural area (as defined under the rural-urban commuting area codes developed by the Secretary of Agriculture and the Secretary of Health and Human Services), the Secretary of Veterans Affairs may negotiate a rate that is more than the rate paid by the United States as described in paragraph (2)(B).

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

“(C) With respect to furnishing care or services under this section in a State with an All-Payer Model Agreement under the Social Security Act that became effective on or after January 1, 2014, the Medicare payment rates under paragraph (2)(B) shall be calculated based on the payment rates under such agreement, or any such successor agreement.

“(D) With respect to furnishing care or services under this section in a location in which the Secretary de-
termines that adjusting the rate paid by the United States as described in paragraph (2)(B) is appropriate, the Secretary may negotiate such an adjusted rate.

“(E) With respect to furnishing care or services under this section in a location or in a situation in which an exception to the rates paid by the United States under the Medicare Program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for the same care or services applies, the Secretary may follow such exception.

“(F) With respect to furnishing care or services under this section for care or services not covered under the Medicare Program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Secretary shall establish a schedule of fees for such care or services.

“(G) With respect to furnishing care or services under this section pursuant to an agreement with a tribal or Federal entity, the Secretary may negotiate a rate that is more than the rate paid by the United States as described in paragraph (2)(B).

“(4) For the furnishing of care or services pursuant to a contract or agreement under paragraph (1), a network provider may not collect any amount that is greater than the rate negotiated pursuant to paragraph (2)(A).

“(5)(A) If, in the course of an episode of care under this section, any part of care or services is furnished by
a medical provider who is not a network provider, the Secretary may compensate such provider for furnishing such care or services.

“(B) The Secretary shall make reasonable efforts to enter into a contract or agreement under this section with any provider who is compensated pursuant to subparagraph (A).

“(e) PROMPT PAYMENT STANDARD.—(1) The Secretary shall ensure that claims for payments for hospital care, medical services, or extended care services furnished under this section are processed in accordance with this subsection, regardless of whether such claims are—

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

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

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

“(2) A covered claimant that seeks payment for hospital care, medical services, or extended care services furnished under this section shall submit to the covered payer a claim for payment not later than—
“(A) with respect to a claim by a network provider, 180 days after the date on which the network provider furnishes such care or services; or

“(B) with respect to a claim by a regional network operated by a contractor, 180 days after the date on which the contractor pays the network provider for furnishing such care or services.

“(3) Notwithstanding chapter 39 of title 31 or any other provision of law, the covered payer shall pay a covered claimant for hospital care, medical services, or extended care services furnished under this section—

“(A) in the case of a clean claim submitted to the covered payer on paper, not later than 45 calendar days after receiving the claim; or

“(B) in the case of a clean claim submitted to the covered payer electronically, not later than 30 calendar days after receiving the claim.

“(4)(A) If the covered payer denies a claim submitted by a covered claimant under paragraph (1), the covered payer shall notify the covered claimant of the reason for denying the claim and the additional information, if any, that may be required to process the claim—

“(i) in the case of a clean claim submitted to the covered payer on paper, not later than 45 calendar days after receiving the claim; or
“(ii) in the case of a clean claim submitted to
the covered payer electronically, not later than 30
calendar days after receiving the claim.
“(B) Upon receipt by the covered payer of additional
information specified under subparagraph (A) relating to
a claim, the covered payer shall pay, deny, or otherwise
adjudicate the claim, as appropriate, not later than 30 cal-
endar days after receiving such information.
“(5)(A) If the covered payer has not paid a covered
claimant or denied a clean claim for payment by the cov-
ered claimant under this subsection during the appro-
priate period specified in this subsection, such clean claim
shall be considered overdue.
“(B) If a clean claim for payment by a covered claim-
ant is considered overdue under subparagraph (A), in ad-
dition to the amount the covered payer owes the covered
claimant under the claim, the covered payer shall owe the
covered claimant an interest penalty amount that shall—
“(i) be prorated daily;
“(ii) accrue from the date the payment was
overdue;
“(iii) be payable at the time the claim is paid;
and
“(iv) be computed at the rate of interest estab-
lished by the Secretary of the Treasury, and pub-
lished in the Federal Register, for interest payments
under subsections (a)(1) and (b) of section 7109 of
title 41 that is in effect at the time the covered
payer accrues the obligation to pay the interest pen-
alty amount.

“(6)(A) If the covered payer overpays a covered
claimant for hospital care, medical services, or extended
care services furnished under this section—

“(i) the covered payer shall deduct the amount
of any overpayment from payments due to the cov-
ered claimant after the date of such overpayment; or

“(ii) if the covered payer determines that there
are no such payments due after the date of the over-
payment, the covered claimant shall refund the
amount of such overpayment not later than 30 days
after such determination.

“(B)(i) Before deducting any amount from a pay-
ment to a covered claimant under subparagraph (A), the
covered payer shall ensure that the covered claimant is
provided an opportunity—

“(I) to dispute the existence or amount of any
overpayment owed to the covered payer; and

“(II) to request a compromise with respect to
any such overpayment.
“(ii) The covered payer may not make any deduction from a payment to a covered claimant under subparagraph (A) unless the covered payer has made reasonable efforts to notify the covered claimant of the rights of the covered claimant under subclauses (I) and (II) of clause (i).

“(iii) Upon receiving a dispute under subclause (I) of clause (i) or a request under subclause (II) of such clause, the covered payer shall make a determination with respect to such dispute or request before making any deduction under subparagraph (A) unless the time required to make such a determination would jeopardize the ability of the covered payer to recover the full amount owed to the covered payer.

“(7) Notwithstanding any other provision of law, the Secretary may, except in the case of a fraudulent claim, false claim, or misrepresented claim, compromise any claim of an amount owed to the United States under this section.

“(8) This subsection shall apply only to payments made on a claims basis and not to capitation or other forms of periodic payments to network providers.

“(9) A network provider that provides hospital care, medical services, or extended care services to an eligible veteran under this section may not seek any payment for such care or services from the eligible veteran.
“(10) With respect to making a payment for hospital care or medical services furnished to an eligible veteran by a network provider under this section—

“(A) the Secretary may not require receipt by the veteran or the Department of a medical record under subsection (g) detailing such care or services before a covered payer makes a payment for such care or services; and

“(B) the Secretary may require that the network provider attests to such care or services so provided before a covered payer makes a payment for such care or services.

“(f) COST-SHARING.—(1) The Secretary shall require an eligible veteran to pay a copayment for the receipt of care or services under this section only if such eligible veteran would be required to pay a copayment for the receipt of such care or services at a medical facility of the Department or from a health care provider of the Department under this chapter.

“(2) The amount of a copayment charged under paragraph (1) may not exceed the amount of the copayment that would be payable by such eligible veteran for the receipt of such care or services at a medical facility of the Department or from a health care provider of the Department under this chapter.
“(3) In any case in which an eligible veteran is furnished hospital care or medical services under this section for a non-service-connected disability described in subsection (a)(2) of section 1729 of this title, the Secretary shall recover or collect reasonable charges for such care or services from a health-plan contract described in section 1705A in accordance with such section 1729.

“(g) MEDICAL RECORDS.—(1) The Secretary shall ensure that any network provider that furnishes care or services under this section to an eligible veteran—

“(A) upon the request of the veteran, provides to the veteran the medical records related to such care or services; and

“(B) upon the completion of the provision of such care or services to such veteran, provides to the Department the medical records for the veteran furnished care or services under this section in a time-frame and format specified by the Secretary for purposes of this section, except the Secretary may not require that any payment by the Secretary to the eligible provider be contingent on such provision of medical records.

“(2) To the extent practicable, the Secretary shall submit to a network provider that furnishes care or services under this section to an eligible veteran the medical
records of such eligible veteran that are maintained by the
Department and are relevant to such care or services.

“(3) To the extent practicable, the Secretary shall—

“(A) ensure that the medical records shared
under paragraphs (1) and (2) are shared in an elec-
tronic format accessible by network providers and
the Department through an Internet website; and

“(B) provide to network providers access to the
electronic patient health record system of the De-
partment, or successor system, for the purpose of
furnishing care or services under this section.

“(h) USE OF CARD.—The Secretary shall ensure that
the veteran health identification card, or such successor
identification card, includes sufficient information to act
as an identification card for an eligible entity or other non-
Department facility. The Secretary may not use any
amounts made available to the Secretary to issue separate
identification cards solely for the purpose of carrying out
this section.

“(i) PRESCRIPTION MEDICATIONS.—(1) With respect
to requirements relating to the licensing or credentialing
of a network provider, the Secretary shall ensure that the
network provider is able to submit prescriptions for phar-
maceutical agents on the formulary of the Department to
pharmacies of the Department in a manner that is sub-
substantially similar to the manner in which the network provider submits prescriptions to retail pharmacies.

“(2) Nothing in this section shall be construed to affect the process of the Department for filling and paying for prescription medications.

“(j) QUALITY OF CARE.—In carrying out this section, the Secretary shall use the quality of care standards set forth or used by the Centers for Medicare & Medicaid Services or other quality of care standards, as determined by the Secretary.

“(k) CAPACITY AND COMMERCIAL MARKET ASSESSMENTS.—(1) On a periodic basis, but not less often than once every three years, the Secretary shall conduct an assessment of the capacity of each Veterans Integrated Service Network and medical facility of the Department to furnish care or services under this chapter. Each such assessment shall—

“(A) identify gaps in furnishing such care or services at such Veterans Integrated Service Network or medical facility;

“(B) identify how such gaps can be filled by—

“(i) entering into contracts or agreements with network providers under this section or with entities under other provisions of law;
“(ii) making changes in the way such care and services are furnished at such Veterans Integrated Service Network or medical facility, including but not limited to—

“(I) extending hours of operation;

“(II) adding personnel; or

“(III) expanding space through construction, leasing, or sharing of health care facilities; and

“(iii) the building or realignment of Department resources or personnel;

“(C) forecast, based on future projections and historical trends, both the short- and long-term demand in furnishing care or services at such Veterans Integrated Service Network or medical facility and assess how such demand affects the needs to use such network providers;

“(D) include a commercial health care market assessment of designated catchment areas in the United States conducted by a nongovernmental entity; and

“(E) consider the unique ability of the Federal Government to retain a presence in an area otherwise devoid of commercial health care providers or from which such providers are at a risk of leaving.
“(2) The Secretary shall submit each assessment under paragraph (1) to the Committees on Veterans’ Affairs of the House of Representatives and the Senate and shall make each such assessment publicly available.

“(l) ALLOCATION OF FUNDS.—The Secretary shall develop a plan for the allocation of funds in the Medical Community Care account.

“(m) REPORTS ON RATES.—Not later than December 31, 2019, and annually thereafter during each of the subsequent three years, the Secretary shall submit to the Committees on Veterans’ Affairs of the House of Representatives and the Senate a report detailing, for the fiscal year preceding the fiscal year during which the report is submitted, the rates paid by the Secretary for hospital care, medical services, or extended care services under this section that, pursuant to subsection (d)(3), are more than the rates described in subsection (d)(2)(B) for the same care or services.

“(n) DEFINITIONS.—In this section:

“(1) The term ‘clean claim’ means a claim submitted—

“(A) to the covered payer by a covered claimant for purposes of payment by the covered payer of expenses for hospital care or medical services furnished under this section;
“(B) that contains substantially all of the required elements necessary for accurate adjudication, without requiring additional information from the network provider; and

“(C) in such a nationally recognized format as may be prescribed by the Secretary for purposes of paying claims for hospital care or medical services furnished under this section.

“(2) The term ‘covered claimant’ means—

“(A) a network provider that submits a claim to the Secretary for purposes of payment by the Secretary of expenses for hospital care or medical services furnished under this section; or

“(B) a regional network operated by a contractor pursuant to subsection (a)(4)(B) that submits a claim to the Secretary for purposes of reimbursement for a payment made by the contractor to a network provider for hospital care or medical services furnished under this section.

“(3) The term ‘covered payer’ means—

“(A) a regional network operated by a contractor pursuant to subsection (a)(4)(B) with respect to a claim made by a network provider...
to the contractor for purposes of payment by
the contractor of expenses for hospital care or
medical services furnished under this section; or

“(B) the Secretary with respect to—

“(i) a claim made by a network pro-
vider to the Secretary for purposes of pay-
ment by the Secretary of expenses for hos-
pital care or medical services furnished
under this section; and

“(ii) a claim made by a regional net-
work operated by a contractor pursuant to
subsection (a)(4)(B) for purposes of reim-
bursement for a payment described by sub-
paragraph (A).

“(4) The term ‘eligible veteran’ means a vet-

eran who—

“(A) is enrolled in the patient enrollment
system of the Department established and oper-
ated under section 1705(a) of this title; and

“(B) has—

“(i) been furnished hospital care or
medical services at or through a Depart-
ment facility on at least one occasion dur-
ing the two-year period preceding the date
of the determination of eligibility; or
“(ii) requested a first-time appointment for hospital care or medical services at a Department facility.

“(5) The term ‘fraudulent claim’ means a claim by a network provider for reimbursement under this section that includes an intentional and deliberate misrepresentation of a material fact or facts that is intended to induce the Secretary to pay an amount that was not legally owed to the provider.”.

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

“1703A. VA Care in the Community Program.”.

(b) CONFORMING AMENDMENTS.—The Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146) is amended—

(1) in section 101(p)(1) (38 U.S.C. 1701 note), by inserting before the period at the end the following: “or the date on which the Secretary certifies to the Committees on Veterans’ Affairs of the House of Representatives and the Senate that the Secretary is fully implementing section 1703A of title 38, United States Code, whichever occurs first”; and
(2) in section 208(1), by striking “section 101” and inserting “section 1703A of title 38, United States Code”.

(c) Definitions.—Section 1701 of title 38, United States Code, is amended by adding at the end the following new paragraphs:

“(11) The term ‘network provider’ means any of the following health care providers that have entered into a contract or agreement under which the provider agrees to furnish care and services to eligible veterans under section 1703A of this title:

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

“(B) Any provider of items and services receiving payment under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or a waiver of such a plan.

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

“(D) The Department of Defense.

“(E) The Indian Health Service.
“(F) Any health care provider that is an academic affiliate of the Department.

“(G) Any health care provider not otherwise covered under any of subparagraphs (A) through (F) that meets criteria established by the Secretary for purposes of such section.

“(12) The term ‘VA Care in the Community Program’ means the program under which the Secretary furnishes hospital care or medical services to veterans through network providers pursuant to section 1703A of this title.”.

(d) TRANSITION OF PROVISION OF CARE.—This Act, and the amendments made by this Act, may not be construed to affect the obligations of the Secretary of Veterans Affairs under contracts and agreements for the provision of hospital care, medical services, and extended care services entered into before the date of the enactment of this Act at the terms and rates contained in such contracts and agreements.

SEC. 103. VETERANS CARE AGREEMENTS.

(a) IN GENERAL.—Subchapter I of chapter 17 of title 38, United States Code, is further amended by inserting after section 1703A, as added by section 102, the following new section:
§ 1703B. Veterans Care Agreements with non-network providers

(a) Veterans Care Agreements.—(1) In addition to furnishing hospital care, medical services, or extended care services under this chapter at facilities of the Department or under contracts or agreements entered into pursuant to section 1703A of this title or any other provision of law other than this section, the Secretary may furnish such care and services to eligible veterans through the use of agreements, to be known as ‘Veterans Care Agreements’, entered into under this section by the Secretary with eligible non-network providers.

(2) The Secretary may enter into a Veterans Care Agreement under this section with an eligible non-network provider if the Secretary determines that—

(A) the provision of the hospital care, medical services, or extended care services at a Department facility is impracticable or inadvisable because of the medical condition of the veteran, the travel involved, or the nature of the care or services required, or a combination of such factors; and

(B) such care or services are not available to be furnished by a non-Department health care provider under a contract or agreement entered into pursuant to a provision of law other than this section.
“(3)(A) In accordance with subparagraphs (C) and (D), the Secretary shall review each Veterans Care Agreement with a non-network provider to determine whether it is practical or advisable to, instead of carrying out such agreement—

“(i) provide at a Department facility the hospital care, medical services, or extended care services covered by such agreement; or

“(ii) enter into an agreement with the provider under section 1703A of this title to provide such care or services.

“(B) If the Secretary determines pursuant to a review of a Veterans Care Agreement under subparagraph (A) that it is practical or advisable to provide hospital care, medical services, or extended care services at a Department facility, or enter into an agreement under section 1703A of this title to provide such care or services, as the case may be, the Secretary—

“(i) may not renew the Veterans Care Agreement; and

“(ii) shall take such actions as are necessary to implement such determination.

“(C) This paragraph shall apply with respect to Veterans Care Agreements entered into with a non-network
provider whose gross annual revenue, as determined under subsection (b)(1), exceeds—

“(i) $3,000,000, in the case of a provider that furnishes homemaker or home health aide services; or

“(ii) $1,000,000, in the case of any other provider.

“(D) The Secretary shall conduct each review of a Veterans Care Agreement under subparagraph (A) as follows:

“(i) Once during the 18-month period beginning on the date that is six months after date on which the agreement is entered into.

“(ii) Not less than once during each four-year period beginning on the date on which the review under subparagraph (A) is conducted.

“(b) ELIGIBLE NON-NETWORK PROVIDERS.—A provider of hospital care, medical services, or extended care services is eligible to enter into a Veterans Care Agreement under this section if the Secretary determines that the provider meets the following criteria:

“(1) The gross annual revenue of the provider under contracts or agreements entered into with the Secretary in the year preceding the year in which
the provider enters into the Veterans Care Agree-
ment does not exceed—

“(A) $5,000,000 (as adjusted in a manner
similar to amounts adjusted pursuant to section
5312 of this title), in the case of a provider
that furnishes homemaker or home health aide
services; or

“(B) $2,000,000 (as so adjusted), in the
case of any other provider.

“(2) The provider is not a network provider and
does not otherwise provide hospital care, medical
services, or extended care services to patients pursu-
ant to a contract entered into with the Department.

“(3) The provider is—

“(A) a provider of services that has en-
rolled and entered into a provider agreement
under section 1866(a) of the Social Security
Act (42 U.S.C. 1395ce(a));

“(B) a physician or supplier that has en-
rolled and entered into a participation agree-
ment under section 1842(h) of such Act (42
U.S.C. 1395u(h));

“(C) a provider of items and services re-
ceiving payment under a State plan under title
XIX of such Act (42 U.S.C. 1396 et seq.) or  
a waiver of such a plan;  

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

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

“(4) The provider is certified pursuant to the  
process established under subsection (c)(1).  

“(5) Any additional criteria determined appro-  
priate by the Secretary.  

“(c) PROVIDER CERTIFICATION.—(1) The Secretary  
shall establish a process for the certification of eligible  
providers to enter into Veterans Care Agreements under  
this section that shall, at a minimum, set forth the fol-  
lowing:  

“(A) Procedures for the submission of applica-  
tions for certification and deadlines for actions taken  
by the Secretary with respect to such applications.  

“(B) Standards and procedures for the ap-  
proval and denial of certifications and the revocation  
of certifications.

“(D) Requirement for denial or revocation of certification if the Secretary determines that the otherwise eligible provider is—

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

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

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

“(2) To the extent practicable, the Secretary shall establish the procedures under paragraph (1) in a manner that takes into account any certification process administered by another department or agency of the Federal Government that an eligible provider has completed by reason of being a provider described in any of subparagraphs (A) through (E) of subsection (b)(4).

“(d) TERMS OF AGREEMENTS.—Subsections (d), (e), (f), and (g) of section 1703A of this title shall apply with respect to a Veterans Care Agreement in the same manner such subsections apply to contracts and agreements entered into under such section.

“(e) EXCLUSION OF CERTAIN FEDERAL CONTRACTING PROVISIONS.—(1) Notwithstanding any other provision of law, the Secretary may enter into a Veterans Care Agreement using procedures other than competitive procedures.

“(2)(A) Except as provided in subparagraph (B) and unless otherwise provided in this section, an eligible non-network provider that enters into a Veterans Care Agreement under this section is not subject to, in the carrying out of the agreement, any provision of law that providers of services and suppliers under the original Medicare fee-

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for-service program under parts A and B of title XVIII
of the Social Security Act (42 U.S.C. 1395 et seq.) or the
Medicaid program under title XIX of such Act (42 U.S.C.
1396 et seq.) are not subject to.

“(B) In addition to the provisions of laws covered by
subparagraph (A), an eligible non-network provider shall
be subject to the following provisions of law:

“(i) Any applicable law regarding integrity, eth-

ics, or fraud, or that subject a person to civil or
criminal penalties.

“(ii) Section 1352 of title 31, except for the fil-
ing requirements under subsection (b) of such sec-
tion.

“(iii) Section 4705 or 4712 of title 41, and any
other applicable law regarding the protection of
whistleblowers.

“(iv) Section 4706(d) of title 41.

“(v) Title VII of the Civil Rights Act of 1964
(42 U.S.C. 2000e et seq.) to the same extent as
such title applies with respect to the eligible non-net-
work provider in providing care or services through
an agreement or arrangement other than under a
Veterans Care Agreement.

“(f) Termination of a Veterans Care Agree-
ment.—(1) An eligible non-network provider may termi-
nate a Veterans Care Agreement with the Secretary under this section at such time and upon such notice to the Secretary as the Secretary may specify for purposes of this section.

“(2) The Secretary may terminate a Veterans Care Agreement with an eligible non-network provider under this section at such time and upon such notice to the provider as the Secretary may specify for the purposes of this section, if the Secretary determines necessary.

“(g) DISPUTES.—(1) The Secretary shall establish administrative procedures for providers with which the Secretary has entered into a Veterans Care Agreement to present any dispute arising under or related to the agreement.

“(2) Before using any dispute resolution mechanism under chapter 71 of title 41 with respect to a dispute arising under a Veterans Care Agreement under this section, a provider must first exhaust the administrative procedures established by the Secretary under paragraph (1).

“(h) AUTHORITY TO PAY FOR OTHER AUTHORIZED SERVICES.—(1) If, in the course of an episode of care for which hospital care, medical services, or extended care services are furnished to an eligible veteran pursuant to a Veterans Care Agreement, any part of such care or services is furnished by a medical provider who is not an eligi-
ble non-network provider or a network provider, the Secretary may compensate such provider for furnishing such care or services.

“(2) The Secretary shall make reasonable efforts to enter into a Veterans Care Agreement with any provider who is compensated pursuant to paragraph (1).

“(i) Annual Reports.—(1) Not later than December 31 of the year following the fiscal year in which the Secretary first enters into a Veterans Care Agreement under this section, and each year thereafter, the Secretary shall submit to the appropriate congressional committees an annual report that includes a list of all Veterans Care Agreements entered into as of the date of the report.

“(2) The requirement to submit a report under paragraph (1) shall terminate on the date that is five years after the date of the enactment of this section.

“(j) Quality of Care.—In carrying out this section, the Secretary shall use the quality of care standards set forth or used by the Centers for Medicare & Medicaid Services or other quality of care standards, as determined by the Secretary.

“(k) Delegation.—The Secretary may delegate the authority to enter into or terminate a Veterans Care Agreement to an official of the Department at a level not
below the Director of a Veterans Integrated Service Network or the Director of a Network Contracting Office.

“(l) DEFINITIONS.—In this section:

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

“(A) the Committees on Veterans’ Affairs of the House of Representatives and the Senate; and

“(B) the Committees on Appropriations of the House of Representatives and the Senate.

“(2) The term ‘eligible veteran’ has the meaning given such term in section 1703A(m) of this title.”.

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

“1703B. Veterans Care Agreements with non-network providers.”.

SEC. 104. MODIFICATION OF AUTHORITY TO ENTER INTO AGREEMENTS WITH STATE HOMES TO PROVIDE NURSING HOME CARE.

(a) USE OF AGREEMENTS.—

(1) IN GENERAL.—Paragraph (1) of section 1745(a) of title 38, United States Code, is amended, in the matter preceding subparagraph (A), by striking “a contract (or agreement under section
1720(c)(1) of this title)” and inserting “an agree-
ment”.

(2) PAYMENT.—Paragraph (2) of such section
is amended by striking “contract (or agreement)”
each place it appears and inserting “agreement”.

(b) TREATMENT OF CERTAIN LAWS.—Such section
is amended by adding at the end the following new para-
graph:

“(4)(A) An agreement under this section may be en-
tered into without regard to any law that would require
the Secretary to use competitive procedures in selecting
the party with which to enter into the agreement.

“(B)(i) Except as provided in clause (ii) and unless
otherwise provided in this section or in regulations pre-
scribed pursuant to this section, a State home that enters
into an agreement under this section is not subject to, in
the carrying out of the agreement, any law to which pro-
viders of services and suppliers are not subject under the
original Medicare fee-for-service program under parts A
and B of title XVIII of the Social Security Act (42 U.S.C.
1395 et seq.) or the Medicaid program under title XIX
of such Act (42 U.S.C. 1396 et seq.).

“(ii) The exclusion under clause (i) does not apply
to laws regarding integrity, ethics, fraud, or that subject
a person to civil or criminal penalties.
“(C) Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.) shall apply with respect to a State home that enters into an agreement under this section to the same extent as such title applies with respect to the State home in providing care or services through an agreement or arrangement other than under this section.”.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to agreements entered into under section 1745 of such title on and after the date on which the regulations prescribed by the Secretary of Veterans Affairs to implement such amendments take effect.

(2) PUBLICATION.—The Secretary shall publish the date described in paragraph (1) in the Federal Register not later than 30 days before such date.

SEC. 105. DEPARTMENT OF VETERANS AFFAIRS ELECTRONIC INTERFACE FOR PROCESSING OF MEDICAL CLAIMS.

(a) ELECTRONIC INTERFACE.—Not later than the implementation date specified in section 108(a), the Chief Information Officer of the Department of Veterans Affairs shall ensure that the information technology system used by the Department to receive, process, and pay claims under the VA Care in the Community Program estab-
lished in section 1703A of title 38, United States Code, as added by section 102, and under Veterans Care Agreements established in section 1703B of such title, as added by section 103, includes the following:

1. A function through which a covered non-Department health care provider may submit all required data and supporting information required for claims reimbursement through electronic data exchanges.

2. An ability to automatically adjudicate claims.

3. A centralized claims database that is accessible nationwide.

4. Integration with the relevant eligibility and authorization information technology systems of the Department.

5. Ability for a covered non-Department health care provider to ascertain the status of a pending claim submitted by the provider, receive information regarding missing documentation or discrepancies that may impede claim processing timelines or result in rejection, and receive notification when such claim is accepted for reimbursement or rejected.

6. A claim review system similar to that used by the Centers for Medicare & Medicaid Services, as
of the date of the enactment of this Act, to deter-
mine the appropriateness and accuracy of payments
to providers and to ensure program integrity and
oversight.

(b) SECURITY AND PRIVACY.—The Chief Information
Officer shall also ensure that the information technology
system covered under subsection (a) meets the following
criteria:

(1) Such system shall be developed and imple-
mented in compliance with all applicable laws, regu-
lations and Federal Government standards regarding
information security, privacy, and accessibility.

(2) Such system shall provide for the elicitation,
analysis, and prioritization of functional and non-
functional information security and privacy require-
ments for such system, including security and pri-
vacy services and architectural requirements relating
to security and privacy based on a thorough risk as-
essment of all reasonably anticipated cyber and
noncyber threats to the security and privacy of elec-
tronic protected health information made available
through such interface.

(3) Such system shall provide for the elicitation,
analysis, and prioritization of secure development re-
quirements relating to such system.
(4) Such system shall provide assurance that
the prioritized information security and privacy re-
quirements of such system—

(A) are correctly implemented in the de-
sign and implementation of such system
through the systems development lifecycle; and

(B) satisfy the information objectives of
such system relating to security and privacy
throughout the systems development lifecycle.

(c) CONTRACT AUTHORITY.—The Chief Information
Officer may enter into a contract for purposes of carrying
out this section.

(d) DEFINITIONS.—In this section:

(1) The term “electronic protected health infor-
mation” has the meaning given that term in section
160.103 of title 45, Code of Federal Regulations, as
in effect on the date of the enactment of this Act.

(2) The term “covered non-Department health
care provider” means—

(A) a network provider (as defined by sec-
tion 1701(11) of title 38, United States Code,
as added by section 102);

(B) a non-network provider with which the
Secretary has entered into a Veterans Care
Agreement under section 1703B of such title, as added by section 103; or

(C) any other non-Department eligible provider or non-Department health care provider that furnishes hospital care or medical services pursuant to chapter 17 of such title.

(3) The term “secure development requirements” means, with respect to the information technology system established under subsection (a), activities that are required to be completed during the system development lifecycle of such interface, such as secure coding principles and test methodologies.

(4) The term “VA Care in the Community Program” has the meaning given that term in section 1701(12) of title 38, United States Code, as added by section 102.

SEC. 106. FUNDING FOR VA CARE IN THE COMMUNITY PROGRAM.

(a) IN GENERAL.—All amounts required to carry out the VA Care in the Community Program and Veterans Care Agreements under section 1703B of title 38, United States Code, shall be derived from the Veterans Health Administration, Medical Community Care account.

(b) TRANSFER OF AMOUNTS.—
(1) IN GENERAL.—Any unobligated amounts in the Veterans Choice Fund under section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note) shall be transferred to the Veterans Health Administration, Medical Community Care account on the later of the following dates:

(A) The date that is one year after the date of the enactment of this Act.

(B) The date on which the Secretary of Veterans Affairs submits to the Committees on Veterans’ Affairs of the Senate and the House of Representatives the certification required by section 107(c).

(2) CONFORMING REPEAL.—

(A) IN GENERAL.—Effective immediately following the transfer of amounts under paragraph (1), section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note) is repealed.

(B) CONFORMING AMENDMENT.—Section 4003 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (Public Law 114–41; 38 U.S.C. 1701...
note) is amended by striking “for non-Department provider programs (as defined in section 2(d))” and all that follows through “1802)” and inserting the following: “for the VA Care in the Community Program (as defined in section 1701(12) of title 38, United States Code) and Veterans Care Agreements under section 1703B of title 38, United States Code”.

(e) VA Care in the Community Program Defined.—In this section, the term “VA Care in the Community Program” has the meaning given that term in section 1701(12) of title 38, United States Code, as added by section 102.

SEC. 107. TERMINATION OF CERTAIN PROVISIONS AUTHORIZING MEDICAL CARE TO VETERANS THROUGH NON-DEPARTMENT OF VETERANS AFFAIRS PROVIDERS.

(a) Termination of Authority To Contract for Care in Non-Department Facilities.—

(1) In general.—Section 1703 of title 38, United States Code, is amended by adding at the end the following new subsection:

“(e) The authority of the Secretary to carry out this section terminates on the date on which the Secretary certifies to the Committees on Veterans’ Affairs of the House
of Representatives and the Senate that the Secretary is
fully implementing section 1703A of this title.”.

(2) CONFORMING AMENDMENTS.—

(A) DENTAL CARE.—Section 1712(a) of
such title is amended—

(i) in paragraph (3), by striking
“under clause (1), (2), or (5) of section
1703(a) of this title” and inserting “under
the VA Care in the Community Program”;

and

(ii) in paragraph (4)(A), in the first
sentence—

(I) by striking “and section 1703
of this title” and inserting “and the
VA Care in the Community Program
(with respect to such a year beginning
on or after the date on which the Sec-
retary commences implementation of
the VA Care in the Community Pro-
gram)”; and

(II) by striking “in section 1703
of this title” and inserting “under the
VA Care in the Community Pro-
gram”.

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(B) Readjustment Counseling.—Section 1712A(e)(1) of such title is amended by striking “(under sections 1703(a)(2) and 1710(a)(1)(B) of this title)” and inserting “(under the VA Care in the Community Program)”.

(C) Death in Department Facility.—Section 2303(a)(2)(B)(i) of such title is amended by striking “in accordance with section 1703 of this title” and inserting “under the VA Care in the Community Program”.

(D) Medicare Provider Agreements.—Section 1866(a)(1)(L) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(L)) is amended—

(i) by striking “under section 1703 of title 38” and inserting “under the VA Care in the Community Program (as defined in section 1701(12) of title 38, United States Code)”;

(ii) by striking “such section” and inserting “such program”.

(b) Repeal of Authority To Contract for Scarce Medical Specialists.—

(1) In general.—Section 7409 of title 38, United States Code, is repealed.
(2) Clerical amendment.—The table of sections at the beginning of chapter 74 of such title is amended by striking the item relating to section 7409.

(c) Effective date.—The amendments made by subsections (a) and (b) shall take effect on the date on which the Secretary certifies to the Committees on Veterans’ Affairs of the House of Representatives and the Senate that the Secretary is fully implementing section 1703A of title 38, United States Code, as added by section 102.

SEC. 108. IMPLEMENTATION AND TRANSITION.

(a) Implementation.—The Secretary of Veterans Affairs shall commence the implementation of section 1703A of title 38, United States Code, as added by section 102, and section 1703B of such title, as added by section 103, and shall make the transfer under section 106(b), by not later than one year after the date of the enactment of this Act. The Secretary shall prescribe interim final regulations to implement such sections and publish such regulations in the Federal Register.

(b) Training.—Before commencing the implementation of sections 1703A and 1703B of title 38, United States Code, as added by sections 102 and 103, respectively, the Secretary of Veterans Affairs shall—
(1) certify to the Committees on Veterans’ Affairs of the House of Representatives and the Senate that—

(A) each network provider (as defined by section 1701(11) of title 38, United States Code) and eligible non-network provider that furnishes care or services under such section 1703A or section 1703B is trained to furnish such care or services under such sections; and

(B) each employee of the Department that refers, authorizes, or coordinates such care or services is trained to carry out such sections; and

(2) establish standard, written guidance for network providers, non-Department health care providers, and any non-Department administrative entities acting on behalf of such providers, with respect to the policies and procedures for furnishing care or services under such sections.
TITLE II—OTHER
ADMINISTRATIVE MATTERS

SEC. 201. REIMBURSEMENT FOR EMERGENCY AMBULANCE SERVICES.

(a) In General.—Section 1725(c) of title 38, United States Code, is amended by adding at the end the following new paragraph:

“(5) In delineating the circumstances under which reimbursement may be made under this section for ambulance services for an individual, the Secretary shall treat such services as emergency services for which reimbursement may be made under this section if the Secretary determines that—

“(A) the request for ambulance services was made as a result of the sudden onset of a medical condition of such a nature that a prudent layperson who possesses an average knowledge of health and medicine—

“(i) would have reasonably expected that a delay in seeking immediate medical attention would have been hazardous to the life or health of the individual; or

“(ii) could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious
jeopardy, the serious impairment of bodily functions, or the serious dysfunction of any bodily organ or part; and

“(B) the individual is transported to the most appropriate medical facility capable of treating such medical condition.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply with respect to ambulance services provided on or after January 1, 2019.

SEC. 202. IMPROVEMENT OF CARE COORDINATION FOR VETERANS THROUGH EXCHANGE OF CERTAIN MEDICAL RECORDS.

Section 7332(b) of title 38, United States Code, is amended—

(1) in paragraph (2), by adding at the end the following new subparagraphs:

“(H) To a public or private health care provider in order to provide treatment or health care to a shared patient.

“(I) To a third party in order to recover or collect reasonable charges for care furnished to a veteran for a non-service-connected disability pursuant to section 1729 of this title or
section 1 of Public Law 87–693 (42 U.S.C. 2651).”; and

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

“(4) Nothing in this section shall be construed to authorize any provision of records in violation of relevant health record privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).”.

SEC. 203. ELIMINATION OF COPAYMENT OFFSET.

(a) In General.—Section 1729(a) of title 38, United States Code, is amended by adding at the end the following new paragraph:

“(4) Notwithstanding any other provision of law, any amount that the United States may collect or recover under this section shall not affect any copayment amount a veteran is otherwise obligated to pay under this chapter.”.

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and apply with respect to a copayment obligation that arises on or after the date of the enactment of this Act.
SEC. 204. USE OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE COLLECTIONS FUND FOR CERTAIN IMPROVEMENTS IN COLLECTIONS.

Section 1729A(c)(1)(B) of title 38, United States Code, is amended by inserting “(including with respect to automatic data processing or information technology improvements)” after “collection”.

SEC. 205. DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE PRODUCTIVITY IMPROVEMENT.

(a) IN GENERAL.—Subchapter I of chapter 17 of title 38, United States Code, is further amended by inserting after section 1705A the following new section:

§ 1705B. Management of health care: productivity

“(a) RELATIVE VALUE UNIT TRACKING.—The Secretary shall track relative value units for all Department providers.

“(b) CLINICAL PROCEDURE CODING TRAINING.—The Secretary shall require all Department providers to attend training on clinical procedure coding.

“(c) PERFORMANCE STANDARDS.—The Secretary shall establish for each Department facility—

“(1) standardized performance standards based on nationally recognized relative value unit production standards applicable to each specific profession in order to evaluate clinical productivity at the provider and facility level;
“(2) remediation plans to address low clinical productivity and clinical inefficiency; and

“(3) an ongoing process to systematically review the content, implementation, and outcome of the plans developed under paragraph (2).

“(d) DEFINITIONS.—In this section:

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

“(2) The term ‘relative value unit’ means a unit for measuring workload by determining the time, mental effort and judgment, technical skill, physical effort, and stress involved in delivering a procedure.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is further amended by inserting after the item relating to section 1705A the following new item:

“1705B. Management of health care: productivity.”.

(e) REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the implementation of section
1705B of title 38, United States Code, as added by subsection (a). Such report shall include, for each professional category of Department providers, the relative value unit of such category of providers at the national, Veterans Integrated Service Network, and facility levels.

SEC. 206. LICENSURE OF HEALTH CARE PROFESSIONALS OF THE DEPARTMENT OF VETERANS AFFAIRS PROVIDING TREATMENT VIA TELEMEDICINE.

(a) IN GENERAL.—Chapter 17 of title 38, United States Code, is further amended by inserting after section 1730A the following new section:

§ 1730B. Licensure of health care professionals providing treatment via telemedicine

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

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

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

“(d) COVERED HEALTH CARE PROFESSIONAL DEFINED.—In this section, the term ‘covered health care professional’ means a health care professional who—

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

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

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

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

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 of such title is further
amended by inserting after the item relating to section

1730A the following new item:

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

(c) REPORT ON TELEMEDICINE.—

(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report on the effectiveness of the use of telemedicine by the Department of Veterans Affairs.

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

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

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

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

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

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

(iii) The productivity of health care providers.

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

(v) The reduction, if any, in the use by veterans of in-person services at Department facilities and non-Department facilities.

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

(E) The number of appointments for the receipt of telemedicine furnished by the Department that were requested during such period, disaggregated by Veterans Integrated Service Network.

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