To amend title 38, United States Code, to improve veterans’ health care benefits, and for other purposes.

IN THE SENATE OF THE UNITED STATES

DECEMBER 1, 2017

Mr. McCAIN (for himself and Mr. Moran) introduced the following bill; which was read twice and referred to the Committee on Veterans’ Affairs

A BILL

To amend title 38, United States Code, to improve veterans’ health care benefits, and for other purposes.

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 “Veterans Community Care and Access Act of 2017”.

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

1 Sec. 1. Short title; table of contents.
2 Sec. 2. References to title 38, United States Code.

TITLE I—DEVELOPING AN INTEGRATED HIGH-PERFORMING NETWORK

Subtitle A—Establishing the Veterans Community Care Program
Sec. 101. Establishment of Veterans Community Care Program.
Sec. 102. Strategy regarding the High Performing Integrated Healthcare Net-
work of the Department.
Sec. 103. Access standards and standards for quality.

Subtitle B—Forming Partnerships and Agreements
Sec. 111. Continuity of care and existing agreements.
Sec. 112. Authorization of agreements between Department of Veterans Affairs
and non-Department providers.
Sec. 113. Prevention of certain health care providers from providing non-De-
partment health care services to veterans.
Sec. 114. Conforming amendments for State veterans homes.

Subtitle C—Paying Providers
Sec. 121. Prompt payment to providers.
Sec. 122. Payment rates for community care.
Sec. 123. Authority to pay for authorized care not subject to an agreement.

TITLE II—STREAMLINING COMMUNITY CARE PROGRAMS

Subtitle A—Streamlining Community Care Programs
Sec. 201. Access to walk-in care.
Sec. 203. Conforming amendments.

Subtitle B—Improving Information Sharing With Providers
Sec. 211. Improving information sharing with community providers.
Sec. 212. Establishment of processes to ensure safe opioid prescribing practices
by non-Department of Veterans Affairs health care providers.

Subtitle C—Improving Collections
Sec. 221. Aligning with best practices on collection of health insurance informa-
tion.
Sec. 222. Improving authority to collect.

TITLE III—IMPROVING DEPARTMENT OF VETERANS AFFAIRS
CARE DELIVERY

Subtitle A—Improving Personnel Practices
Sec. 301. Licensure of health care professionals of the Department of Veterans
Affairs providing treatment via telemedicine.
Sec. 302. Graduate medical education and residency.
Sec. 303. Annual report on awards or bonuses awarded to certain high-level
employees of the department of veterans affairs.

Subtitle B—Facilities, Construction, and Leases
Sec. 311. Facilitating sharing of medical facilities with other Federal agencies.
Sec. 312. Review of enhanced use leases.

TITLE IV—INNOVATIVE PILOT PROGRAMS
Sec. 401. Pilot program to establish or affiliate with graduate medical residency programs at facilities operated by Indian tribes, tribal organizations, and the Indian Health Service in rural areas.

Sec. 402. Authority for Department of Veterans Affairs Center for Innovation for Care and Payment.

TITLE V—OTHER HEALTH CARE MATTERS

Sec. 501. Authorization of appropriations for health care from Department of Veterans Affairs.

Sec. 502. Appropriation of amounts for Veterans Choice Program.


Sec. 504. Amending statutory requirements for the position of the Chief Officer of the Readjustment Counseling Service.

Sec. 505. Authorization of certain major medical facility projects of the Department of Veterans Affairs.

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act 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.

TITLE I—DEVELOPING AN INTEGRATED HIGH-PERFORMING NETWORK

Subtitle A—Establishing the Veterans Community Care Program

SEC. 101. ESTABLISHMENT OF VETERANS COMMUNITY CARE PROGRAM.

(a) Establishment.—

(1) In general.—Section 1703 is amended to read as follows:
“§ 1703. Veterans Community Care Program

“(a) IN GENERAL.—(1) Subject to the availability of appropriations for such purpose and subject to paragraph (4), hospital care, medical services, and extended care services under this chapter shall be furnished to a covered veteran described in subsection (b) by health care providers specified in subsection (c) in accordance with this section.

“(2) The furnishing of care and services under this section may be referred to as the ‘Veterans Community Care Program’.

“(3)(A) In carrying out this section, the Secretary may develop categories of certain health care providers specified in subsection (c) for the purpose of providing a covered veteran hospital care, medical services, and extended care services when the covered veteran does not state a preference for a health care provider.

“(B) In developing categories of health care providers under subparagraph (A), the Secretary shall not—

“(i) prioritize or rank such categories in a manner that limits the options a covered veteran may have in selecting a health care provider specified in subsection (c); or

“(ii) direct a covered veteran to receive care or services from certain health care providers instead of other health care providers.
“(4) In carrying out this section, the Secretary shall not limit any hospital care, medical service, extended care service, or class of hospital care, medical service, or extended care service that are set forth in the Medical Benefits Package of the Department, as modified as determined by the Secretary.

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

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

“(B) is not enrolled in such system but is otherwise entitled to hospital care, a medical service, or an extended care service under subsection (c)(2) of such section; and

“(2)(A) has been furnished hospital care or medical services under this chapter on at least one occasion during the preceding two-year period; or

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

“(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) CONTRACTS TO ESTABLISH NETWORKS OF HEALTH CARE PROVIDERS.—(1) The Secretary shall enter into consolidated, competitively bid contracts, which may be regional contracts, to establish networks of non-Department health care providers specified in paragraphs (1) and (5) of subsection (c) for contract purposes of—

“(A) providing sufficient access to hospital care, medical services, and extended care services under this section;

“(B) managing the operations of such health care providers; and
“(C) managing the delivery of hospital care, medical services, and extended care services under this section.

“(2) 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.

“(3)(A) Whenever the Secretary provides notice to an entity under paragraph (2) 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 and the decision of the Secretary to terminate the contract under paragraph (2).

“(B) Each report submitted under subparagraph (A) shall include the following:

“(i) An explanation of the reasons for terminating the contract.

“(ii) A description of the effect of the failure of the entity to meet contractual obligations and the termination of the contract, including with respect to cost, schedule, and requirements.

“(iii) A description of the actions taken by the Secretary to mitigate such failure and termination.
“(e) Coordination of Care and Services.—(1) The Secretary shall ensure that for each covered veteran seeking care or services under this section, a care coordination team is provided by a medical facility of the Department.

“(2) The Secretary shall ensure that each care coordination team provided under this section, with respect to a covered veteran, is responsible for the following:

“(A) Coordination and management of hospital care, medical services (including telemedicine), and extended care services furnished under this title, including the following:

“(i) Collaboration with the patient aligned care teams (PACT) within the medical facility of the Department; and

“(ii) Coordination within and across Veterans Integrated Service Networks with non-Department health care providers acting under a contract or agreement to furnish hospital care, a medical service, or an extended care service on behalf of the Department and who meets such terms and conditions as the Secretary may require.

“(B) Ensure continuity of care for the covered veteran to avoid any delay or lapse in care or serv-
ices from an action or error of the Department or any individual of the care coordination team of the covered veteran.

“(C) Submitting information to the Secretary in furtherance of analysis conducted under section 1730B(a) of this title.

“(3) The Secretary shall develop an organizational construct for care coordination teams at medical facilities of the Department that may include the following individuals:

“(A) An employee of the Department who furnishes hospital care, a medical service, or an extended care service at the facility.

“(B) A non-Department health care provider acting under a contract or agreement to furnish hospital care, a medical service, or an extended care service on behalf of the Department and who meets such terms and conditions as the Secretary may require.

“(C) An employee of the Department or a health care provider described in subparagraph (B) who serves to seamlessly coordinate the delivery of hospital care, medical services, and extended care services to covered veterans.
“(f) ELIGIBILITY REFORM AND CONDITIONS THAT REQUIRE ACCESS TO COMMUNITY CARE.—(1) Subject to the availability of appropriations, the Secretary shall furnish hospital care, medical services, and extended care services to a covered veteran, at the election of a covered veteran, through health care providers specified in subsection (c) as follows:

“(A) When a medical facility of the Department does not offer the hospital care, medical services, or extended care services the covered veteran requires.

“(B) When a medical facility of the Department cannot furnish or schedule an appointment for hospital care, medical services, or extended care services in accordance with access standards established under section 1703B of this title.

“(C) When the covered veteran and a referring clinician of the covered veteran agree that furnishing hospital care, medical services, or extended care services through a non-Department entity or provider would be in the best medical interest of the covered veteran, after consideration of the standards established under sections 1703B and 1703C of this title or due to a non-clinical reason, compelling circumstance, or other considerations that are in the best medical interest of the covered veteran.
“(2) Not later than 120 days after the date of the enactment of the Veterans Community Care and Access Act of 2017, the Secretary shall submit to the appropriate committees of Congress a report describing the guidelines and standards the Secretary intends to use to carry out paragraph (1) in accordance with sections 1703B and 1703C of this title.

“(g) SCHEDULING SERVICES.—(1) The Secretary shall ensure that services are established in order to schedule appointments for hospital care, medical services, and extended care services under this chapter.

“(2)(A) In carrying out paragraph (1), the Secretary shall determine whether services established under such paragraph should reside within the respective medical facility of the Department or reside with an entity with whom the Secretary enters into a contract for such services.

“(B) In carrying out subparagraph (A), the Secretary shall assess the following:

“(i) Whether a medical facility of the Department is currently managing scheduling services and the Secretary determines such medical facility has the capability to continue to manage scheduling.
“(ii) Whether a medical facility of the Department has the capacity to manage scheduling services based on the following:

“(I) An initial review of the medical facility to acquire scheduling service responsibilities and the preference of the medical facility to acquire such responsibilities.

“(II) The market area assessment currently underway pursuant to section 1730B(e) of this title.

“(III) The capacity of the medical facility to perform scheduling services that meet standards established under sections 1703B and 1703C of this title.

“(iii) Whether one or more contracts were in effect on the day before the date of the enactment of the Veterans Community Care and Access Act of 2017 that include scheduling services, as determined by the Secretary, and may be modified by the Secretary for services under this subsection.

“(h) 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 ‘clinician’ has the meaning given
that term by the Centers for Medicare & Medicaid
Services and includes Doctors of Medicine (MD),
Doctors of Osteopathy (DO), Doctors of Dental Sur-
gery or Dental Medicine (DMD/DDS), Doctors of
Podiatry, Doctors of Optometry, Chiropractors, Phy-
sician Assistants (PA), Nurse Practitioners (NP),
Clinical Nurse Specialists, Certified Registered
Nurse Anesthetists, and such other health profes-
sionals as the Secretary may specify for purposes of
this section.

“(3) The term ‘medical facility of the Depart-
ment’ includes a medical center, a community-based
outpatient clinic, an outpatient clinic, or any other
facility of the Department at which hospital care,
medical services, or extended care services are fur-
nished.”.

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

“1703. Veterans Community Care Program.”.

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

(c) EFFECTIVE DATE.—The amendments made by
subsection (a) shall take effect on the date that the Sec-
etary promulgates regulations under subsection (b).

SEC. 102. STRATEGY REGARDING THE HIGH PERFORMING
INTEGRATED HEALTHCARE NETWORK OF
THE DEPARTMENT.

(a) IN GENERAL.—Subchapter III of chapter 17 is
amended by inserting after section 1730A the following
new section:

“§1730B. Quadrennial Veterans Health Administra-
tion review, management of high-per-
forming integrated healthcare network,
and market area assessments

“(a) QUADRENNIAL VETERANS HEALTH ADMINIS-
TRATION REVIEW.—(1) Not later than one year after the
date of the enactment of the Veterans Community Care
and Access Act of 2017 and not less frequently than once
every four years thereafter, the Secretary shall conduct a
1 comprehensive examination (to be known as a ‘quadren-
2 nial Veterans Health Administration review’) of programs
3 and policies of the Department regarding the delivery of
4 health care services and the need for health care services
5 for veterans in future years.

"(2) The Secretary shall designate an individual in
a Senior Executive Service position (as defined in section
3132(a) of title 5) or equivalent as the Director of the
High-Performing Integrated Healthcare Network of the
Department (in this section referred to as the ‘Director’) who shall be responsible for carrying out this section and
advising the Secretary and the Under Secretary for Health
on matters pertaining to this section.

"(3) Each quadrennial Veterans Health Administra-
tion review conducted under paragraph (1) shall include
a strategic plan to meet future requirements and demand
for hospital care, medical services, and extended care serv-
ices under the laws administered by the Secretary that in-
cludes a five-year budget forecast for meeting such re-
quirements and demand based on the information con-
tained in the market area assessments conducted under
subsection (c) and such other information as the Secretary
considers appropriate.
“(4) In preparing the quadrennial Veterans Health Administration review under paragraph (1), including the strategic plan under paragraph (3), the Secretary shall—

“(A) consider the access and quality standards established under sections 1703B and 1703C of this title, respectively;

“(B) consider the needs of the Department to furnish health care services to veterans based on—

“(i) identified health care services that provide management of health conditions or disorders related to military service for which there is limited experience or access to such health care services from non-Department health care providers in the commercial market;

“(ii) the overall health of veterans throughout their lifespan; or

“(iii) such other services as the Secretary determines appropriate;

“(C) consult with key stakeholders within the Department, the heads of other Federal agencies, and other relevant governmental and nongovernmental entities, including State, local, and tribal government officials, members of Congress, veterans service organizations, private sector representatives, academics, and other policy experts;
“(D) identify emerging issues, trends, problems, and opportunities that could affect health care services furnished under the laws administered by the Secretary;

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

“(F) compare the Veterans Equitable Resource Allocation (VERA) system to other resource allocation systems or models for the purpose of analyzing the effectiveness of such systems in allocating resources to furnish hospital care, medical services, and extended care services to veterans; and

“(G) consider the work of the Center for Innovation for Care and Payment under section 1703F of this title with respect to research, development, and testing payment and service delivery models.

“(b) MANAGEMENT OF HIGH-PERFORMING INTEGRATED HEALTHCARE NETWORK.—(1) The Director shall be responsible for the management, design, implementation, and assessment of the high-performing integrated healthcare network of the Department.

“(2) In managing, designing, implementing, and assessing the high-performing integrated healthcare network
of the Department under this subsection, the Director shall be responsible for the following:

“(A) Overseeing the transformation and organizational change across the Department to achieve such high-performing integrated healthcare network.

“(B) Developing and implementing the quadrennial Veterans Health Administration review and strategic plan under subsection (a).

“(C) Overseeing the market area assessments performed under subsection (c).

“(D) Developing the capital infrastructure planning and procurement processes, whether minor or major construction projects or leases, in coordination with other offices of the Department.

“(E) 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 healthcare network.

“(3) To ensure that the Director is able to carry out the responsibilities under paragraph (2), the Secretary shall ensure that coordination and information sharing occurs with other relevant offices of the Department, including the following offices:

“(A) The Office of Management.
“(B) The Office of Acquisition, Logistics and Construction.

“(C) The Office of Information and Technology.

“(4) In carrying out this subsection, the Director shall confer with the Director of the Defense Health Agency and consider best practices and recommendations from non-Department entities, including entities carrying out market area assessments under subsection (c), that have developed plans, implemented systems, or advised other healthcare systems.

“(5)(A) Not less frequently than once every three months, the Secretary or the Director shall brief the appropriate committees of Congress on the activities conducted under this subsection.

“(B) Each briefing conducted under subparagraph (A) shall include the following:

“(i) An assessment of any remediation or improvement conducted by the Department with respect to a medical service line of the Department that the Secretary has determined does not meet an access standard or standard for quality established under section 1703B or 1703C of this title, respectively, in providing hospital care, a medical service, or an extended care service, including the following:
“(I) An assessment of the factors that led the Secretary to make such determination.

“(II) An assessment of the medical service line in relation to the market area assessment most recently performed under subsection (c), particularly with respect to how it relates to the demand for the medical service line in the area and by veterans using a medical facility of the Department for such medical service line.

“(III) A plan with specific actions, and the time to complete them, to meet the access standards and standards for quality established under sections 1703B and 1703C of this title, respectively, which shall include consideration of—

“(aa) increasing personnel or temporary personnel assistance, including mobile deployment teams;

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

“(cc) using direct hiring authority;
“(dd) providing improved training opportunities for staff;
“(ee) acquiring improved equipment;
“(ff) making structural modifications to the facility used by the medical service line;
“(gg) partnering with health care providers that have the capacity to meet the demand in the market area and meet access and quality standards established under sections 1703B and 1703C of this title; and
“(hh) such other actions as the Secretary considers appropriate.
“(ii) An assessment of the progress made by the Department with respect to the responsibilities of the Director under paragraph (2).
“(c) MARKET AREA ASSESSMENTS.—(1) Not less frequently than once every four years, the Secretary shall perform market area assessments regarding the health care services furnished under the laws administered by the Secretary.
“(2) Each market area assessment performed under paragraph (1) shall include the following:
“(A) An assessment of the demand for hospital care, medical services, and extended care services from the Department, disaggregated by geographic market areas that are consistent with industry market areas or boundaries, including the number of requests for such care and services under the laws administered by the Secretary.

“(B) An inventory of the health care capacity of the Department across the facilities of the Department.

“(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 this title, 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 by the access and quality standards established under sections 1703B and 1703C of this title, respectively.

“(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; and

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

“(I) Analysis of information submitted from care coordination teams under section 1703(e)(2)(D) of this title from each Department medical facility that includes the following:

“(i) An analysis of coordination and management best practices.

“(ii) Satisfaction survey data from the covered veterans from each care coordination team under section 1703(e) of this title.
“(iii) Findings and determinations related to the coordination of care under section 1703(e) of this title to assist the Director in the design, implementation, and assessment of the high-performing integrated healthcare network of the Department.

“(iv) A standardized climate survey developed jointly with the Centers for Medicare & Medicaid Services Alliance to Modernize Healthcare (CAMHI) for the employees of each medical facility of the Department that compiles data on culture, communication, teamwork, quality of worklife, rewards or recognition, leadership, and productivity.

“(3) The Secretary shall submit to the appropriate committees of Congress each market area assessment performed under paragraph (1) and the complete market area assessment being performed on the day before the date of the enactment of the Veterans Community Care and Access Act of 2017 in the same form as such assessments are delivered to the Secretary.

“(4) The Secretary shall use the market area assessments performed under paragraph (1) to inform the quadrennial Veterans Health Administration review and strategic plan under subsection (a) and to determine the ca-
capacity of the Department and the capacity of the health care provider networks established under section 1703(d) of this title.

“(5) The Secretary shall publish the capacity findings and results from the market area assessments performed under paragraph (1) with respect to the Department and health care provider networks established under section 1703(d) of this title on a publicly accessible Internet website of the Department.

“(d) DEPARTMENT BUDGET.—The Secretary shall ensure that the budget request of the Department 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 information described in subsection (b)(5) and is consistent with the quadrennial Veterans Health Administration review and strategic plan under subsection (a).

“(e) 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 chapter 17 is amended by inserting after the item relating to section 1730A the following new item:

“1730B. Quadrennial Veterans Health Administration review, management of high-performing integrated healthcare network, and market area assessments.”.

(c) WAIVER OF CERTAIN REQUIREMENTS FOR MARKET ASSESSMENT IN PROGRESS.—Paragraph (2) of section 1730B(c) of title 38, United States Code, as added by subsection (a), shall not apply to a market area assessment that was being performed by the Secretary of Veterans Affairs on the day before the date of the enactment of this Act.

SEC. 103. ACCESS STANDARDS AND STANDARDS FOR QUALITY.

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

§ 1703B. Access standards

“(a) IN GENERAL.—(1) The Secretary shall establish access standards for hospital care, medical services, and extended care services furnished by the Department, including through health care providers under section 1703 of this title.

“(2) The Secretary shall ensure that the hospital care, medical services, and extended care services fur-
nished to a veteran by the Department, including through health care providers under section 1703 of this title, is furnished within the access standards established under paragraph (1).

“(3) The access standards established under paragraph (1) shall align with the categories of hospital care, medical services, and extended care services set forth under subsection (b) and shall be informed by the market area assessments performed under section 1730B(e) of this title.

“(b) Categories of Hospital Care, Medical Services, and Extended Care Services Furnished.—The categories of hospital care, medical services, and extended care services subject to access standards established under subsection (a) are as follows:

“(1) Primary care services.

“(2) Specialty care services, including services that may require a referral and services that may be considered wellness or preventative care.

“(3) Behavioral health services, including mental health and substance abuse disorder treatment.

“(4) Urgent care.

“(5) Home health services, including services that may be virtual.

“(6) Dental services.
“(7) As determined by the Secretary, any additional types of services for which the Department or the networks established under section 1703(d) of this title have experienced increased demand according to the market area assessments performed under section 1730B(c) of this title or an increase in access complaints to network health care providers or the Department.

“(e) APPLICATION.—(1) The Secretary may establish and apply access standards under subsection (a) according to the market area assessments under section 1730B(c) of this title.

“(2) In carrying out section 1703 of this title, the Secretary shall apply access standards established under subsection (a) to a covered veteran under such section with respect to the residence, as defined in section 17.1505 of title 38, Code of Federal Regulations (or any successor regulation), of the covered veteran.

“(d) COMPARATIVE INFORMATION.—The Secretary shall ensure that the access standards required by subsection (a) provide veterans, employees of the Department, and health providers in the Veterans Community Care Program established under section 1703 of this title with relevant comparative information that is clear, useful, and timely, so that veterans can make informed and respon-
sible decisions regarding their hospital care, medical services, and extended care services.

“(e) COORDINATION.—The Secretary shall coordinate with the Secretary of Defense, and may consult with the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, entities in the private sector, and other nongovernmental entities in establishing access standards under subsection (a).

“(f) PERIODIC REVIEW.—Not later than two years after the date on which the Secretary establishes access standards under this section 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 that includes the following:

“(A) A report on the findings of the Secretary with respect to the review conducted under paragraph (1) and any modification to such standards as the Secretary considers appropriate.

“(B) For each medical service line that the Secretary determined, during the period covered by the report, did not meet a standard established under this section, identification of the
leadership team in the facility and the Veterans Integrated Service Network that are responsible for overseeing the progress of the medical service line in meeting such standard.

“(g) PUBLICATION.—The Secretary shall publish the health care access standards established under subsection (a) and any modifications to such standards in the Federal Register and on a publicly accessible Internet website of the Department.

“(h) 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.

§ 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, including through health care providers under section 1703 of this title.

“(2) The Secretary shall ensure that the hospital care, medical services, and extended care services fur-
lished to a veteran by the Department, including through health care providers under section 1703 of this title, is furnished within the standards for quality established under paragraph (1).

“(3) The standards for quality established under paragraph (1) shall align with the Department of Defense according to categories of hospital care, medical services, and extended care services set forth under section 1703B(b) of this title and shall be informed by the market area assessments performed under section 1730B(c) of this title.

“(4) In establishing standards for quality under paragraph (1), the Secretary shall—

“(A) conduct a survey of covered veterans described in section 1703(b) of this title through a third party entity to assess the satisfaction of such veterans with service and quality of care; and

“(B) collect data sets that include, at a minimum—

“(i) general information;

“(ii) surveys of patients’ experiences;

“(iii) timely and effective care;

“(iv) complications;

“(v) readmissions and deaths;

“(vi) use of medical imaging;
“(vii) payment and value of care; and
“(viii) use of telemedicine.
“(5) The Secretary shall develop such standards for quality and collect data according to health care settings consistent with the Department of Defense and the Centers for Medicare & Medicaid Services, including, at a minimum, the following:
“(A) Inpatient hospitals.
“(B) Nursing homes.
“(C) Individual health care providers.
“(D) Dialysis facilities.
“(E) Hospice.
“(F) Inpatient rehabilitation facilities.
“(G) Long-term care hospitals.
“(H) Outpatient facilities.
“(6) The standards for quality established under paragraph (1) shall be informed by existing health quality measures, such as those defined by the HealthCare Effectiveness Data and Information Set, that are applied to public and privately sponsored health care systems with the purpose of providing veterans relevant comparative information to make informed decisions regarding their health care.
“(b) IMPROVING AND STRENGTHENING QUALITY STANDARDS.—Not later than one year after the date on
which the Secretary establishes standards under sub-
section (a), the Secretary shall—

“(1) publish the quality rating of medical facili-
ties of the Department on a publicly available Inter-
net website, such as a website of 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 community health care providers
who provide hospital care, medical services, or ex-
tended care services under section 1703 of this title;
and

“(2) consider and solicit public comment on po-
tential changes to the established quality measures
to ensure that they include the most up-to-date and
applicable industry measures for veterans.

“(c) COORDINATION.—The Secretary shall coordinate
with the Secretary of Defense, and may consult with the
Secretary of Health and Human Services, the Adminis-
trator of the Centers for Medicare & Medicaid Services,
entities in the private sector, and other nongovernmental
entities in establishing standards for quality under this
section.

“(d) PERIODIC REVIEW.—Not later than two years
after the date on which the Secretary establishes stand-
ards for quality under this section and not less frequently than once every three years thereafter, the Secretary shall—

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

“(2) submit to the appropriate committees of Congress a report that includes the following:

“(A) A report on the findings of the Secretary with respect to the review conducted under paragraph (1) and any modification to such standards as the Secretary considers appropriate.

“(B) For each medical service line that the Secretary determined, during the period covered by the report, did not meet a standard established under this section, identification of the leadership team in the facility and the Veterans Integrated Service Network that are responsible for overseeing the progress of the medical service line in meeting such standard.

“(e) PUBLICATION.—The Secretary shall publish the health care quality standards established under subsection (a) and any modifications to such standards in the Federal Register and on a publicly accessible Internet website of the Department.
“(f) 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 chapter 17, as amended by section 102, is further amended by inserting after the item relating to section 1703 the following new items:

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

(e) SUBMITTAL OF ACCESS STANDARDS AND STANDARDS FOR QUALITY.—

(1) IN GENERAL.—Not later than July 1, 2018, the Secretary of Veterans Affairs shall submit to the appropriate committees of Congress a report detailing the access standards and standards for quality established under sections 1703B and 1703C of title 38, United States Code, respectively, as added by subsection (a).

(2) APPROPRIATE COMMITTEES OF CONGRESS DEFINED.—In this subsection, 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.

Subtitle B—Forming Partnerships and Agreements

SEC. 111. CONTINUITY OF CARE AND EXISTING AGREEMENTS.

(a) In General.—Notwithstanding section 1703 of title 38, United States Code, as amended by section 101 of this Act, the Secretary of Veterans Affairs shall ensure veterans do not experience a delay or lapse in care or services by continuing the following:

(1) All contracts, memorandums of understanding, and memorandums of agreements 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 auspices of the Department of Veterans Affairs and Indian Health Service Memorandum of Understanding, signed October 1, 2010.
(2) The National Reimbursement Agreement, signed December 5, 2012.

(3) Agreements that were in effect on the day before the date of the enactment of this Act and entered into under section 101, 102, or 103 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146).

(4) Agreements that were in effect on the day before the date of the enactment of this Act for the purpose of dialysis treatment, only if the contracts or agreements established under section 1703 of title 38, United States Code, as amended by section 101 of this Act, do not stipulate that such treatments be furnished by providers under such contracts or agreements.

(b) MODIFICATIONS.—Subsection (a) shall not be construed to prohibit the Secretary and the parties to the contracts, agreements, memorandums of understanding, and memorandums of agreements described in such subsection from making such changes to such contracts, agreements, memorandums of understanding, and memorandums of agreements as may be otherwise authorized pursuant to other provisions of law or the terms of the contracts, agreements, memorandums of understanding, and memorandums of agreements.
(c) Treatment of Existing Contractors.—To the extent practicable, the Secretary shall give health care providers who are providing hospital care, medical services, or extended care services pursuant to a contract with the Secretary under section 1703 of title 38, United States Code, as in effect on the day before the date of the enactment of this Act, the opportunity to furnish hospital care, medical services, or extended care services under such section as amended by section 101 of this Act.

SEC. 112. AUTHORIZATION OF AGREEMENTS BETWEEN DEPARTMENT OF VETERANS AFFAIRS AND NON-DEPARTMENT PROVIDERS.

(a) In General.—Subchapter I of chapter 17, as amended by sections 101 and 103, is further 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 is not available to a veteran described in section 1703(b) of this title from a medical facility of the Department or through a contract or sharing agreement entered into under this title under an authority other than this section, the Secretary may furnish such care or service to such veteran to avoid a delay or lapse in such care or service
by entering into an agreement under this section with a
health care provider specified in section 1703(e) of this
title to provide such care or 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 Agree-
ment’.

“(C) For purposes of subparagraph (A), hospital
care, a medical service, or an extended care service may
be considered not available to a veteran from a medical
facility of the Department or through a contract or shar-
ing 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 de-
scribed in such subparagraph impracticable or inadvisable.

“(D) A Veterans Care Agreement may be entered
into by the Secretary or any Department official author-
ized 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 para-
graph (3), for hospital care, a medical service, or an ex-
tended 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 no 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 will be re-
viewed during the next cycle required by subparagraph
(A), and such review will serve as its review within the
first two years of its taking effect for purposes of clause
(i).

“(3) In addition to such other Veterans Care Agree-
ments as the Secretary may determine are of material size,
each Veterans Care Agreement that takes effect after the
date of the enactment of the Veterans Community Care
and Access Act of 2017 shall be considered of material
size.

“(4)(A) The Secretary, and any other Department of-
ficial authorized by the Secretary, may enter into an
agreement under this section for extended care services
only if the Secretary does not expect such agreement
would result in an obligation of the Department that ex-
ceeds a rate of $5,000,000 annually.

“(B) If the Secretary enters into an agreement with
a provider under this section and pursuant to the agree-
ment the Department incurs an obligation that exceeds
an annual rate of, with respect to extended care services,
the rate set forth in subparagraph (A), and with respect
to services that are not extended care services,
$2,000,000, the Secretary shall submit to the appropriate
committees of Congress notice that such obligation has ex-
ceeded such rate and an accounting of the cost and need
for such agreement if such provider is unable or unwilling
to enter into a contract or other agreement under section
1703 of this title.

“(C) In this paragraph, the term ‘appropriate com-
mittees 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.

“(b) ELIGIBLE ENTITIES AND PROVIDERS.—For
purposes of this section, an eligible entity or provider is—
“(1) any provider of services that has enrolled and entered into a provider agreement under section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)) and any physician or other supplier who has enrolled and entered into a participation agreement under section 1842(h) of such Act (42 U.S.C. 1395u(h));

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

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

“(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 and subpart 9.4 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 the Medicare program.

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

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

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

“(B) that payment by the Secretary under this section on behalf of a veteran to a provider of services or care shall, unless rejected and refunded by the provider within 30 days of receipt, constitute payment in full and extinguish any liability on the part of the veteran for the treatment or care provided, and no provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate this requirement;
“(C) to provide only the care and services authorized by the Department under this section and to obtain the prior written consent of the Department to furnish care or services outside the scope of such authorization;

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

“(E) to not seek to recover or collect from a health plan contract or third party, as those terms are defined in section 1729 of this title, for any service for which payment is made 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 AGREEMENTS.—(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 par-
ticipation 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 standards for quality established under section 1703C of this title shall be applied in 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 is not an award for the purposes of such laws that would otherwise require the use of competitive procedures for furnishing of care and services.

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

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

“(i) all laws regarding integrity, ethics, or fraud, or that subject a person to civil or criminal penalties; and
“(ii) all laws that protect against employment discrimination or that otherwise ensure equal employment opportunities.

“(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 related to section 1703 the following new item:

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

SEC. 113. 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 De-
partment 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 li-

cense 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 ac-
tion 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 prac-
tices.

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

(c) **Non-Department Health Care Services Defined.**—In this section, the term “non-Department health care services” means hospital care, medical services, and extended care services furnished at non-Department facilities under chapter 17 of title 38, United States Code.

**SEC. 114. 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:

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

“(B)(i) Except as provided in clause (ii), and unless otherwise provided in this section or regulations prescribed...
pursuant to this 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; and

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

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

(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.
Subtitle C—Paying Providers

SEC. 121. PROMPT PAYMENT TO PROVIDERS.

(a) IN GENERAL.—Subchapter I of chapter 17 is amended by inserting after section 1703C, as added by section 103 of this Act, 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, medical services, or extended care services under this chapter shall submit to the Secretary a claim for payment for furnishing the care or services not later than 180 days after the date on which the entity or provider furnished the care or services.

“(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 or provider within the time periods specified in sub-
section (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 chap-
ter 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 Sec-
retary of the Treasury under section 3902 of title 31 and published in the Federal Register.

“(c) 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 sub-
section 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 jeop-
ardize the Secretary’s ability to recover the full amount of such indebtedness.

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

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

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

“(g) PROCESSING OF CLAIMS.—In processing a claim for compensation for hospital care, medical services, or extended care services furnished by a health care entity or provider under this chapter, the Secretary shall act through—
“(1) a non-Department entity that is under contract or agreement for the program established under section 1703(a) of this title; or

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

“(h) REPORT ON ENCOUNTER DATA SYSTEM.—(1) Not later than 90 days after the date of the enactment of the Veterans Community Care and Access Act of 2017, the Secretary shall submit to the appropriate committees of Congress a report on the feasibility and advisability of adopting a funding mechanism similar to what is utilized by other Federal agencies to allow a contracted entity to act as a fiscal intermediary for the Federal Government to distribute, or pass through, Federal Government funds for certain non-underwritten hospital care, medical services, or extended care services.

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

“(i) DEFINITIONS.—In this section:

“(1) The term ‘appropriate committees of Congress’ means—
“(A) the Committee on Veterans’ Affairs and the Committee on Appropriations of the Senate; and

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

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

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

“(4) The term ‘fraudulent claims’ means the intentional and deliberate misrepresentation of a material fact or facts by a health care entity or provider made to induce the Secretary to pay a claim that was not legally payable to that provider. This term, as used in this section, shall not include a good faith interpretation by a health care entity or provider of utilization, medical necessity, coding, and billing requirements of the Secretary.

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

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item related to section 1703C, as added by section 103 of this Act, the following new item:

“1703D. Prompt payment standard.”.

SEC. 122. PAYMENT RATES FOR COMMUNITY CARE.

(a) IN GENERAL.—Subchapter I of chapter 17, as amended by section 121 of this Act, is further amended by inserting after section 1703D the following new section:
§ 1703E. Payment rates for community care

(a) In general.—Except as provided in subsection (b), and to the extent practicable, the rate paid for hospital care or medical 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 (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. and 1395 et seq.) for the same care or services, including rates adjusted for critical access hospitals under section 1834(g) of such Act (42 U.S.C. 1395m(g)).

(b) Exception.—(1)(A) A higher rate than the rate paid by the United States as described in subsection (a) may be negotiated with respect to the furnishing of care or services to a veteran described in section 1703(b) of this title who resides in a highly rural area or in a market area where the availability of care or services is limited and a higher rate of pay may be required.

(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.

(2) 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, provider agreement or Veterans Care Agreement, is in place.

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

“(c) Value-Based Reimbursement.—Notwithstanding subsection (a), the Secretary shall incorporate, to the greatest extent practicable, the use of value-based reimbursement models to promote the provision of high quality care.”.

(b) Clerical Amendment.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1703D, as added by section 121 of this Act, the following new item:

“1703E. Payment Rates for Community Care.”.

SEC. 123. 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 that 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) Reports on Use of Authority.—Whenever the Secretary compensates a provider under subsection (a) for the furnishing of hospital care, a medical service, or an extended care service, the care coordination team that coordinated the furnishing of such care or service under section 1703(e)(1) of this title shall—

"(1) submit to the appropriate committees of Congress a report on the furnishing of such care; and

"(2) analyze the future demand for such care or service from such provider.

"(c) 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.

“(d) 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 terms ‘hospital care’ and ‘medical service’ have the meanings given such terms in section 1701 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 8158 the following new item:

“8159. Authority to pay for services authorized but not subject to an agreement.”.
TITLE II—STREAMLINING
COMMUNITY CARE PROGRAMS
Subtitle A—Streamlining
Community Care Programs

SEC. 201. 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 covered veterans are able to access walk-in care from qualifying non-Department entities or providers.

“(b) Covered Veterans.—For purposes of this section, a covered veteran is any veteran described in section 1703(b) of this title.

“(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—

“(1) has entered into a contract or other agreement with the Secretary to furnish services under this section; or

“(2) entered into an agreement with the Secretary that was in effect on the day before the date
of the enactment of the Veterans Community Care and Access Act of 2017 to furnish walk-in care.

“(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.— (1) The Secretary shall ensure continuity of care for each covered veteran who receives a walk-in care service under this section through the care coordination team provided such covered veteran under section 1703(e)(1) of this title.

“(2) The Secretary shall inform and educate covered veterans on procedures to utilize and access walk-in care under this section.

“(3) The Secretary shall develop a mechanism to coordinate with qualifying non-Department entities or providers through the care coordination teams provided under section 1703(e)(1) of this title that includes the use of medical records from walk-in care providers to accurately represent access to care, health needs of the covered veterans, and to monitor conditions of covered veterans.

“(f) Copayments.—(1) The Secretary shall require each covered veteran to pay the United States a copayment for each episode of walk-in care provided under this
section, except if the episode of walk-in care for the covered veteran is related to a service-connected disability of the covered veteran.

“(2) The Secretary may adjust the copayment required of a covered veteran under this subsection based upon the priority group of enrollment of the veteran, the number of episodes of care furnished to a covered 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) Copayments required by this subsection shall apply notwithstanding any other provision of law that would allow the Secretary to offset a covered veteran’s copayment obligation with amounts recovered from a third party under section 1729 of this title.

“(g) REGULATIONS.—Not later than one year after the date of the enactment of the Veterans Community Care and Access Act of 2017, the Secretary shall promulgate regulations to carry out this section.

“(h) WALK-IN CARE DEFINED.—In this section, the term ‘walk-in care’ means non-urgent, non-emergent, convenience care provided by a qualifying non-Department entity or provider that furnishes episodic care and not lon-
horizontal management of conditions and certain services as defined through contracts or agreements described in subsection (c) or regulations the Secretary shall prescribe for purposes of this section.”.

(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 related to section 1725 the following new item:

“§1725A. Access to walk-in care.”.

SEC. 202. 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 in fiscal year 2019, amounts remaining in the Veterans Choice Fund may be used
to furnish hospital care, medical services, and extended care services to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities or through non-Department providers at 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 (e)”.

SEC. 203. 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”; and

(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”; and

(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 1703” and inserting “under chapter 17”.


(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date described in section 101(b)(2).
Subtitle B—Improving Information Sharing With Providers

SEC. 211. 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.

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

“(I) To a third party in order to recover or collect reasonable charges for care furnished to, or paid on behalf of, a patient in connection with a non-service connected disability as permitted by section 1729 of this title or for a condition for which recovery is authorized or with respect to which the United States is deemed to be a third party beneficiary under the Act entitled ‘An Act to provide for the recovery from tortiously liable third persons of the cost of hospital and medical care and treatment fur-
nished 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. 212. 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 under sections 911(a)(2) and 912(c) of the Jason Simcakoski Memorial and Promise Act (Public Law 114–198; 38 U.S.C. 1701 note) before first providing care under the laws administered by the Secretary and at any time when those guidelines are modified thereafter.

(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 relevant medical history of the veteran and a list of all medications prescribed to the veteran.
(c) **Submittal of Prescriptions.**—

(1) **In General.**—Except as provided in paragraph (3), the Secretary shall require, to the maximum extent practicable, each covered health care provider to submit prescriptions for opioids—

(A) to the Department for prior authorization for the prescribing of a limited amount of opioids under contracts the Department has with retail pharmacies; or

(B) directly to a pharmacy of the Department for the dispensing of such prescription.

(2) **Department Responsibility.**—In carrying out paragraph (1), upon receipt by the Department of a prescription for opioids for a veteran under the laws administered by the Secretary, the Secretary shall—

(A) record such prescription in the electronic health record of the veteran; and

(B) monitor such prescription as outlined in the Opioid Safety Initiative of the Department.

(3) **Exception.**—

(A) **In General.**—A covered health care provider is not required under paragraph (1)(B)
to submit an opioid prescription directly to a pharmacy of the Department if—

(i) the health care provider determines that there is an immediate medical need for the prescription, including an urgent or emergent prescription or a prescription dispensed as part of an opioid treatment program that provides office-based medications; and

(ii)(I) following an inquiry into the matter, a pharmacy of the Department notifies the health care provider that it cannot fill the prescription in a timely manner; or

(II) the health care provider determines that the requirement under paragraph (1)(B) would impose an undue hardship on the veteran, including with respect to travel distances, as determined by the Secretary.

(B) NOTIFICATION TO DEPARTMENT.—If a covered health care provider uses an exception under subparagraph (A) with respect to an opioid prescription for a veteran, the health care provider shall, on the same day the pre-
scription is written, submit to the Secretary for inclusion in the electronic health record of the veteran a notice, in such form as the Secretary may establish, providing information about the prescription and describing the reason for the exception.

(C) REPORT.—

(i) IN GENERAL.—Not less frequently than quarterly, the Secretary shall submit to the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representa-
tives a report evaluating the compliance of covered health care providers with the requirements under this paragraph and set-
ting forth data on the use by health care providers of exceptions under subparagraph (A) and notices under subparagraph (B).

(ii) ELEMENTS.—Each report re-
quired by clause (i) shall include the fol-
lowing with respect to the quarter covered by the report:

(I) The number of exceptions used under subparagraph (A) and no-
ties received under subparagraph (B).

(II) The rate of compliance by the Department with the requirement under subparagraph (B) to include such notices in the health records of veterans.

(III) The identification of any covered health care providers that, based on criteria prescribed the Secretary, are determined by the Secretary to be statistical outliers regarding the use of exceptions under subparagraph (A).

(d) USE OF OPIOID SAFETY INITIATIVE GUIDELINES.—

(1) IN GENERAL.—If a director of a medical center of the Department or a Veterans Integrated Service Network determines that the opioid prescribing practices of a covered health care provider conflicts with or is otherwise inconsistent with the standards of appropriate and safe care, as that term is used in section 913(d) of the Jason Simeakoski Memorial and Promise Act (Public Law 114–198; 38 U.S.C. 1701 note), the director shall take such
action as the director considers appropriate to en-
sure the safety of all veterans receiving care from
that health care provider, including removing or di-
recting the removal of any such health care provider
from provider networks or otherwise refusing to au-
thorize care of veterans by such health care provider
in any program authorized under the laws adminis-
tered by the Secretary.

(2) INCLUSION IN CONTRACTS.—The Secretary
shall ensure that any contracts entered into by the
Secretary with third parties involved in admin-
istering programs that provide care in the commu-
nity 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 direc-
tors described in that paragraph, as the case may
be.

(e) DENIAL OR REVOCATION OF ELIGIBILITY OF
NON-DEPARTMENT PROVIDERS.—The Secretary shall
deny or revoke the eligibility of a non-Department health
care provider to provide health care to veterans under the
laws administered by the Secretary if the Secretary deter-
mines that the opioid prescribing practices of the pro-
vider—
(1) violate the requirements of a medical license of the health care provider; or

(2) detract from the ability of the health care provider to deliver safe and appropriate health care.

(f) 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.

**Subtitle C—Improving Collections**

**SEC. 221. ALIGNING WITH BEST PRACTICES ON COLLECTION OF HEALTH INSURANCE INFORMATION.**

Section 1705A is amended—

(1) in subsection (a)(1), by striking “Any individual” and all that follows through “covered.” and inserting the following: “Any individual who applies for or seeks hospital care or medical services under this chapter shall, at the time of such application, or otherwise when requested by the Secretary, furnish the Secretary with such current information as the Secretary may require to identify any health-plan contract, as defined in subsection (i)(l) of section 1729, under which such individual is covered, to include, as applicable, the name, address, and telephone number of such health-plan contract; the
name of the policy holder, if coverage under a health-plan contract is in the name of a person other than such individual; the plan identification number; and the group code of the plans.”; and

(2) in subsection (c)—

(A) by striking “The Secretary” and inserting “(1) Except as provided in paragraph (2), the Secretary”; and

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

“(2) The Secretary may charge an individual who does not provide the information required by subsection (a) reasonable charges for the provision of such care and services.”.

SEC. 222. IMPROVING AUTHORITY TO COLLECT.

(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) ADDITIONAL AMENDMENTS.—Such section is further amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking “(1) Sub-
ject” 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.”;

(B) in paragraph (2)—

(i) in subparagraph (C), by striking
the semicolon and inserting “; or”;
(ii) by amending subparagraph (D) 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.”; and

(iii) by striking subparagraph (E); and

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

“(4) In the case of a health-plan contract where the United States has a right to recover or collect reasonable charges, the Secretary shall collect from a veteran or responsible individual any copayment or cost-share required under this chapter.”;

(2) in subsection (b), by adding at the end the following new paragraph:

“(3)(A) The obligation of the third party to pay is not dependent upon an individual executing an assignment of benefits to the United States, nor is the obligation to pay dependent upon any other submission by the beneficiary to the third party, including any claim or appeal.

“(B) In any case in which the Secretary makes a claim, appeal, representation, or other filing under the authority of this chapter, any procedural requirement in any third-party plan for the beneficiary of such plan to make
the claim, appeal, representation, or other filing is deemed to be satisfied.”; and

(3) in subsection (f)—

(A) by inserting “(1)” before “No law”; and

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

“(2) The absence of a participating provider agreement, Veterans Care Agreement, or other contractual arrangement with a third party described in subsection (i)(3)(D) shall not operate to prevent, or reduce the amount of, any such recovery or collection by the United States. For purposes of this section, the Department shall recover or collect as if it were a participating provider.”; and

(e) DEFINITIONS.—Subsection (i) of such section is amended to read as follows:

“(i) In this section:

“(1) The term ‘health-plan contract’ includes any of the following:

“(A) An insurance policy or contract including any health maintenance organization, preferred provider organization, point of service organization, accountable care organization, or any other type of health insurance policy or
contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement under which hospital care or medical services for individuals are provided or the expenses of such services are paid.

“(B) A workers’ compensation law or plan.

“(2) The term ‘payment’ includes reimbursement and indemnification.

“(3) The term ‘third party’ means any of the following:

“(A) A State or political subdivision of a State.

“(B) An employer or an employer’s insurance carrier.

“(C) An automobile accident reparations or liability insurance carrier.

“(D) A person or entity obligated to provide, or to pay the expenses of, health services under a health-plan contract.

“(4) The term ‘reasonable charges’ shall include the following:

“(A) For hospital care or medical services furnished by the Department, charges established in accordance with this section.
“(B) For hospital care or medical services paid for under subparagraphs (A) and (B) of subsection (a)(2), the amount paid to a non-Department entity or provider.”.

TITLE III—IMPROVING DEPARTMENT OF VETERANS AFFAIRS CARE DELIVERY

Subtitle A—Improving Personnel Practices

SEC. 301. LICENSURE OF HEALTH CARE PROFESSIONALS OF THE DEPARTMENT OF VETERANS AFFAIRS PROVIDING TREATMENT VIA TELEMEDICINE.

(a) In General.—Chapter 17, as amended by section 102, is further amended by adding at the end 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 in a State 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 profes-
sional is any health care professional who—

“(1) is an employee of the Department ap-
pointed under 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 ac-
cordance with applicable policies of the Department;
and

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

“(c) PROPERTY OF FEDERAL GOVERNMENT.—Sub-
section (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.).”.

(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 102, the following new item:

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

(e) REPORT ON TELEMEDICINE.—

(1) IN GENERAL.—Not later than one year after the earlier of the date on which services provided under section 1730C 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. 302. GRADUATE MEDICAL EDUCATION AND RESIDENCY.

(a) INCREASE IN NUMBER OF GRADUATE MEDICAL EDUCATION RESIDENCY POSITIONS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall increase the number of graduate medical education residency positions at covered facilities
by not fewer than 1,500 positions in the 10-year period beginning on the date of the enactment of this Act.

(2) COVERED FACILITIES.—For purposes of this section, a covered facility is any of the following:

(A) A facility of the Department of Veterans Affairs.

(B) A 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 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 community health center.

(F) A facility operated by the Department of Defense.

(G) Such other health care facility as the Secretary considers appropriate for purposes of this section.

(3) 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.

(4) Parameters for location, affiliate
sponsor, and duration.—When determining char-
acteristics of residency positions under paragraph
(1), the Secretary shall consider the extent to which
there is a clinical need for providers, as determined
by the market area assessment most recently per-
formed under section 1730B(c) of title 38, United
States Code, as added by section 102.

(5) Parameters for types of special-
ties.—When determining the types of specialties to
be included in residency positions under paragraph
(1), the Secretary shall consider the following:

(A) The types of specialties that improve
the quality and coverage of medical services
provided to veterans.

(B) The range of clinical specialties cov-
ered by providers in standardized geographic
areas surrounding facilities.

(C) Whether the specialty is included in
the most recent staffing shortage determination
of the Department under section 7412 of title
38, United States Code.
(D) The most recent market area assessment performed under section 1730B(e) of title 38, United States Code, as added by section 102.

(b) APPLICATION TO PARTICIPATE.—To participate as a resident in one of the positions increased under subsection (a)(1), an individual shall submit to the Secretary an application therefor together with an agreement described in subsection (d) under which the participant agrees to serve a period of obligated service in the Veterans Health Administration as provided in the agreement in return for payment of stipend and benefit support as provided in the agreement.

(c) SELECTION.—

(1) IN GENERAL.—An individual becomes a participant in a residency program under this section upon the Secretary’s approval of the individual’s application under subsection (b) and the Secretary’s acceptance of the agreement under subsection (d) (if required).

(2) NOTICE.—Upon the Secretary’s approval of an individual’s participation in the program under paragraph (1), the Secretary shall promptly notify the individual of that approval. Such notice shall be in writing.
(d) AGREEMENT.—

(1) IN GENERAL.—An agreement between the Secretary and a resident in a position under subsection (a)(1) shall be in writing and shall be signed by the resident containing such terms as the Secretary may specify.

(2) REQUIREMENTS.—The agreement must specify the terms of the service obligation resulting from participating as a resident under this section, including by requiring a service obligation equal to the number of years of stipend and benefit support.

(e) CONDITIONS OF EMPLOYMENT.—The Secretary may prescribe the conditions of employment of persons appointed to positions under subsection (a)(1), including necessary training, and the customary amount and terms of pay for such positions during the period of such employment and training.

(f) OBLIGATED SERVICE.—

(1) IN GENERAL.—Each person appointed to a position under subsection (a)(1) shall provide service as a full-time employee of the Department for the period of obligated service provided in the agreement of the participant entered into under subsection (d). Such service shall be provided in the full-time clinical practice of such participant’s profession or in
another health-care position in an assignment or location determined by the Secretary.

(2) COMMENCEMENT DATE.—Not later than 60 days before the date on which a person commences serving in a position under subsection (a)(1), the Secretary shall notify the person of such date. Such date shall be the first day of the person’s period of obligated service.

(g) BREACH OF AGREEMENT: LIABILITY.—

(1) PENALTY.—A person appointed under this section to a position under subsection (a)(1) (other than a person who is liable under paragraph (2)) who fails to accept payment, or instructs the educational institution in which the person is enrolled not to accept payment, in whole or in part, for a residency under the agreement entered into under subsection (d) of this title shall be liable to the United States for liquidated damages in the amount of $1,500. Such liability is in addition to any period of obligated service or other obligation or liability under the agreement.

(2) LIABILITY.—

(A) IN GENERAL.—A person appointed to a position under subsection (a)(1) shall be liable to the United States for the amount which has
been paid to or on behalf of the person under
the agreement if any of the following occurs:

(i) The person is dismissed from the
position for disciplinary reasons.

(ii) The person voluntarily terminates
the residency before the completion of such
course of training.

(iii) The person loses the person’s li-
cense, registration, or certification to prac-
tice the person’s health care profession in
a State.

(B) LIABILITY SUPPLANTS SERVICE OBLI-
GATION.—Liability under this paragraph is in
lieu of any service obligation arising under the
person’s agreement under subsection (d).

(h) RECOVERY.—

(1) IN GENERAL.—If a person breaches the per-
son’s agreement under subsection (d) by failing (for
any reason) to complete such person’s period of obli-
gated service, the United States shall be entitled to
recover from the person an amount equal to the
product of—

(A) three;

(B) the sum of—
(i) the amounts paid under this section to or on behalf of the person; and

(ii) the interest on such amounts that would be payable if at the time the amounts were paid they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States; and

(C) the quotient of—

(i) the difference between—

(I) the total number of months in the person’s period of obligated service; and

(II) the number of months of such period served by the person; and

(ii) the total number of months in the person’s period of obligated service.

(2) Period of Recovery.—Any amount which the United States is entitled to recover under this subsection shall be paid to the United States not later than the date that is one year after the date of the breach of the agreement.

(i) Annual Report.—

(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, the Secretary shall submit to the appropriate committees of Congress a report on the implementation of this section during the previous year.

(2) CONTENTS.—Each report submitted under paragraph (1) shall include, for the period covered by the report, the following:

(A) The number of positions described in subsection (a) that were filled.

(B) The location of each such position.

(C) The academic affiliate associated with each such position.

(D) A description of the challenges faced in filling the positions described in subsection (a) and the actions the Secretary has taken to address such challenges.

(3) APPROPRIATE COMMITTEES OF CONGRESS DEFINED.—In this subsection, 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.
 SEC. 303. ANNUAL REPORT ON AWARDS OR BONUSES
AWARDED TO CERTAIN HIGH-LEVEL EMPLOYEES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) In General.—Chapter 7 is amended by adding at the end the following new section:

“§ 726. Annual report on awards to certain high-level employees

“(a) In General.—Not later than 30 days after the end of each fiscal year, the Secretary shall submit to the appropriate committees of Congress a report that contains, for the most recent fiscal year ending before the submittal of the report, a description of the performance awards and bonuses awarded to Regional Office Directors of the Department, Directors of Medical Centers of the Department, and Directors of Veterans Integrated Service Networks.

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

“(1) The type of award or bonus, specifically those awarded for performance or on the basis of recruitment, relocation and retention as the case may be.

“(2) The amount of each award or bonus.
“(3) The job title of the individual awarded the award or bonus.

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

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

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

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

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 7 of such title is amended by inserting after the item relating to section 725 the following new item:

“726. Annual report on awards to certain high-level employees.”.

Subtitle B—Facilities, Construction, and Leases

SEC. 311. FACILITATING SHARING OF MEDICAL FACILITIES WITH OTHER FEDERAL AGENCIES.

(a) CONSTRUCTION OR LEASE OF SHARED FACILITY.—

(1) IN GENERAL.—Subchapter I of chapter 81 is amended by inserting after section 8111A the following new section:
§ 8111B. Authority to plan, design, construct, or lease a shared medical facility

(a) In General.—(1) The Secretary may enter into agreements with other Federal agencies for the planning, designing, constructing, or leasing shared medical facilities with the goal of improving access to, and quality and cost effectiveness of, health care provided by the Department and other Federal agencies.

(2) Facilities planned, designed, constructed, or leased under paragraph (1) shall be managed by the Director of the High-Performing Integrated Healthcare Network of the Department designated under section 1730B(a) of this title.

(b) Transfer of Amounts to Other Federal Agencies.—(1) The Secretary may transfer to another Federal agency amounts appropriated to the Department for ‘Construction, Minor Projects’ for use for the planning, design, or construction of a shared medical facility if the estimated share of the project costs to be borne by the Department does not exceed the threshold for a major medical facility construction project under section 8104(a)(3)(A) of this title.

(2) The Secretary may transfer to another Federal agency amounts appropriated to the Department for ‘Construction, Major Projects’ for use for the planning, design, or construction of a shared medical facility if—
“(A) the estimated share of the project costs to
be borne by the Department is more than the
threshold for a major medical facility construction
project under subsection (a)(3)(A) of section 8104 of
this title; and

“(B) the requirements for such a project under
such section have been met.

“(3) The Secretary may transfer to another Federal
agency amounts appropriated to the applicable appropria-
tions account of the Department for the purpose of leasing
space for a shared medical facility if the estimated share
of the lease costs to be borne by the Department does not
exceed the threshold for a major medical facility lease
under section 8104(a)(3)(B) of this title.

“(c) Transfer of Amounts to Department.—(1)
Amounts transferred to the Department by another Fed-
eral agency for the necessary expenses of planning, design-
ing, or constructing a shared medical facility for which
the estimated share of the project costs to be borne by
the Department does not exceed the threshold for a major
medical facility project under section 8104(a)(3)(A) of this
title may be deposited in the ‘Construction, Minor
Projects’ account of the Department and used for such
necessary expenses.
“(2) Amounts transferred to the Department by another Federal agency for the necessary expenses of planning, designing, or constructing a shared medical facility for which the estimated share of the project costs to be borne by the Department is more than the threshold for a major medical facility project under section 8104(a)(3)(A) of this title may be deposited in the ‘Construction, Major Projects’ account of the Department and used for such necessary expenses if the requirements for such project under section 8104 of this title have been met.

“(3) Amounts transferred to the Department by another Federal agency for the purpose of leasing space for a shared medical facility may be credited to the applicable appropriations account of the Department and shall be available without fiscal year limitation.

“(4) Amounts transferred under paragraphs (1) and (2) shall be available for the same time period as amounts in the account to which those amounts are transferred.”.

(2) Clerical amendment.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 8111A the following new item:

“8111B. Authority to plan, design, construct, or lease a shared medical facility.”
(b) Modification of Definition of Medical Facility.—Paragraph (3) of section 8101 is amended to read as follows:

“(3) The term ‘medical facility’ means any facility or part thereof that is, or will be, under the jurisdiction of the Secretary, or as otherwise designated by law, for the provision of healthcare services (including hospital care, outpatient care, nursing home care, domiciliary care, or medical services), including any necessary building and auxiliary structure, garage, parking facility, mechanical equipment, trackage facilities leading thereto, abutting sidewalks, accommodations for attending personnel, and recreation facilities associated therewith.”.

SEC. 312. REVIEW OF ENHANCED USE LEASES.

Section 8162 is amended—

(1) in subsection (a), by amending paragraph (2) to read as follows:

“(2) With respect to enhanced-use leases entered into on or after the date of enactment of the Veterans Community Care and Access Act of 2017, the Secretary may enter into an enhanced-use lease only if the Secretary determines that—
“(A) the lease will not be inconsistent with and will not adversely affect the mission of the Department; and

“(B)(i) the lease will enhance the use of the property; or

“(ii) the leased property will provide supportive housing as defined in section 8161 of this title.”;

and

(2) in subsection (b), by amending paragraph (6) to read as follows:

“(6) The Director of the Office of Management and Budget shall review each such enhanced-use lease prior to execution for compliance with paragraph (5) of this subsection.”.

**TITLE IV—INNOVATIVE PILOT PROGRAMS**

**SEC. 401. PILOT PROGRAM TO ESTABLISH OR AFFILIATE WITH GRADUATE MEDICAL RESIDENCY PROGRAMS AT FACILITIES OPERATED BY INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND THE INDIAN HEALTH SERVICE IN RURAL AREAS.**

(a) Pilot Program Required.—The Secretary of Veterans Affairs, in consultation with the Director of the Indian Health Service, shall carry out a pilot program—
(1) to establish graduate medical education residency training programs at covered facilities; or

(2) to affiliate with established programs described in paragraph (1).

(b) COVERED FACILITIES.—For purposes of the pilot program, a covered facility is any facility—

(1) described in subparagraph (B) or (C) of section 302(a)(2); and

(2) located in a rural or remote area, as determined by the Secretary and the Director of the Indian Health Service.

(c) LOCATIONS.—

(1) IN GENERAL.—The Secretary shall carry out the pilot program at not more than five covered facilities that have been selected by the Secretary for purposes of the pilot program.

(2) CRITERIA.—The Secretary shall establish criteria for selecting covered facilities under paragraph (1).

(d) DURATION.—The Secretary shall carry out the pilot program during the eight-year period beginning on the date that is 180 days after the date of the enactment of this Act.

(e) REIMBURSEMENT OF COSTS.—The Secretary shall reimburse each covered facility participating in the
pilot program for the following costs associated with the
pilot program:

(1) Curriculum development.

(2) Recruitment, training, supervision, and re-
tention of residents and faculty.

(3) Accreditation of programs of education
under the pilot program by the Accreditation Coun-
cil for Graduate Medical Education (ACGME) or the
American Osteopathic Association (AOA).

(4) The portion of faculty salaries attributable
to activities relating to carrying out the pilot pro-
gram.

(5) Payment for expenses relating to providing
medical education under the pilot program.

(6) Stipends and benefits.

(f) PERIOD OF OBLIGATED SERVICE.—

(1) IN GENERAL.—The Secretary shall enter
into an agreement with each individual who partici-
pates in the pilot program under which such indi-
vidual agrees to serve under the same terms as es-
stablished under section 302.

(2) LOAN REPAYMENT.—During the period of
obligated service of an individual under paragraph
(1), the individual—
(A) shall be deemed to be an eligible individual under subsection (b) of section 108 of the Indian Health Care Improvement Act (25 U.S.C. 1616a) for purposes of participation in the Indian Health Service Loan Repayment Program under such section during the portion of such period that the individual serves at a covered facility; and

(B) shall be deemed to be an eligible individual under section 7682(a) of title 38, United States Code, for purposes of participation in the Department of Veterans Affairs Education Debt Reduction Program under subchapter VII of chapter 76 of such title during the portion of such period that the individual serves at a facility of the Department.

(3) Concurrent service.—Any period of obligated service required of an individual under paragraph (1) shall be served—

(A) with respect to service at a covered facility, concurrently with any period of obligated service required of the individual by the Indian Health Service; and

(B) with respect to service at a facility of the Department of Veterans Affairs, concur-
ently with any period of obligated service re-
quired of the individual by the Department.

(g) TREATMENT OF PARTICIPANTS.—A residency po-
osition into which a participant in the pilot program is
placed as part of the pilot program shall be considered
a position referred to in section 302(a)(1) for purposes
of the limitation on number of new positions authorized
under such section.

(h) REPORT.—Not later than three years before the
date on which the pilot program terminates, the Secretary
of Veterans Affairs shall submit to the Committee on Vet-
erans’ Affairs of the Senate and the Committee on Vet-
erans’ Affairs of the House of Representatives a report
on the feasibility and advisability of—

(1) expanding the pilot program to additional
locations; and

(2) making the pilot program or any aspect of
the pilot program permanent.

SEC. 402. AUTHORITY FOR DEPARTMENT OF VETERANS AF-
FAIRS CENTER FOR INNOVATION FOR CARE
AND PAYMENT.

(a) IN GENERAL.—Subchapter I of chapter 17, as
amended by section 122, is further amended by inserting
after section 1703E, as added by section 122, the fol-
lowing new section:
“§ 1703F. 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 as appropriate to develop new, innovative approaches to testing payment and service delivery models 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 improve the access to and quality, timeliness, and patient satisfaction of such care and services, as well as the cost savings associated with such models.

(4)(A) The Secretary shall test models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits care leading to poor clinical outcomes or potentially avoidable expenditures.

(B) The Secretary shall focus on models expected 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 models for testing, the Secretary may consider the following additional 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 applicable individuals.

“(B) Whether the model places the applicable individual, including family members and other caregivers of the applicable individual, at the center of the care team of the applicable 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 veterans under pilot programs carried out under this section.
“(B) In this paragraph, the term ‘Federal health care program’ means—

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

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

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

“(b) DURATION.—Pilot programs carried out by the Secretary under this section shall terminate no later than five years after their commencement.

“(c) LOCATION.—The Secretary shall ensure that pilot programs carried out under this section occur in different areas that are appropriate for the intended purposes of the pilot program.

“(d) BUDGET.—Funding for pilot programs carried out by the Secretary under this section will be derived from appropriations provided in advance in appropriations Acts for the Veterans Health Administration and from appropriations provided for information technology systems.
“(e) NOTICE.—The Secretary shall publish information about such pilot programs in the Federal Register, and shall take reasonable actions to provide direct notice to veterans eligible to participate in a pilot program operated under this section.

“(f) WAIVER OF AUTHORITIES.—(1) Subject to reporting under paragraph (2) and approval under paragraph (3), in implementing the pilot programs under this section, the Secretary may waive such requirements in subchapters I, II, and III of this chapter as may be 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 a report 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 of the House of Representatives to report a bill to amend the provision or provisions of law that would be waived by the Department describing in detail the following:

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

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

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

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

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

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

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

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

“(B)(i) The waiver requested by the Secretary under paragraph (2) shall be considered approved under this paragraph if there is enacted into law a bill or joint resolution approving such request in its entirety. Such bill or joint resolution shall be passed by recorded vote to reflect the vote of each member of Congress thereon.

“(ii) The provisions of this paragraph are enacted by the Congress—

“(I) as an exercise of the rulemaking power of the Senate and the House of Representatives and as such shall be considered as part of the rules of each House, and shall supersede other rules only to the extent that they are inconsistent therewith; and

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

“(C) During the 60-calendar-day period beginning on the date on which the Secretary submits the report described in paragraph (2) to Congress, it shall be in order as a matter of highest privilege in each House of Congress
to consider a bill or joint resolution, if offered by the ma-
ajority leader of such House (or a designee), approving
such request in its entirety.

“(g) LIMITATIONS.—(1) The waiver provisions in
subsection (f) shall not be available unless the Secretary
submits the first proposal, in accordance with the require-
ments in subsection (f), for a pilot program within 18
months of the date of the enactment of the Veterans Com-


“(2) Notwithstanding section 502 of this title, deci-
sions 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 other-
wise.

“(3)(A) If the Secretary determines that the 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)(A) and shall be sub-
ject to the terms and conditions of subsection (f)(2);
or

“(ii) terminate such pilot program within 30
days of submitting the interim report to Congress.
“(B) If the Secretary terminates the pilot program under subparagraph (A)(ii), for purposes of clauses (vi) and (vii) of subsection (f)(2)(A), 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 CONSULTATION.—(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 develop-
ment 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 applicable individuals.”.
(b) CONFORMING AMENDMENT.—The table of sections at the beginning of such chapter, as amended by section 122, is further amended by inserting after the item relating to section 1703E the following new item:

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

TITLE V—OTHER HEALTH CARE MATTERS

SEC. 501. AUTHORIZATION OF APPROPRIATIONS FOR HEALTH CARE FROM DEPARTMENT OF VETERANS AFFAIRS.

(a) In General.—There is authorized to be appropriated to the Secretary of Veterans Affairs such amounts as may be necessary to carry out the purposes set forth in subsection (b).

(b) Use of Amounts.—The purposes set forth in this subsection are as follows:

(1) To increase the access of veterans to care as follows:

(A) To hire primary care and specialty care physicians for employment in the Department of Veterans Affairs.

(B) To hire other medical staff, including the following:

(i) Physicians.

(ii) Nurses.

(iii) Social workers.
(iv) Mental health professionals.
(v) Physician assistants.
(vi) Other health care professionals as
the Secretary considers appropriate.
(C) To carry out the following:
(i) Section 7412 of title 38, United
States Code.
(ii) Section 7302(e) of such title.
(iii) Subchapters II and VII of chap-
ter 76 of such title.
(iv) Section 301(b)(2) of the Veterans
Access, Choice, and Accountability Act of
2014 (Public Law 113–146; 38 U.S.C.
7302 note).
(D) To pay for expenses, equipment, and
other costs associated with the hiring of pri-
mary care, specialty care physicians, and other
medical staff under subparagraphs (A), (B),
and (C).
(2) To improve the physical infrastructure of
the Department as follows:
(A) To maintain and operate hospitals,
nursing homes, domiciliary facilities, and other
facilities of the Veterans Health Administra-

(B) To enter into contracts or hire temporary employees to repair, alter, or improve facilities under the jurisdiction of the Department that are not otherwise provided for under this paragraph.

(C) To carry out leases for facilities of the Department.

(D) To carry out minor construction projects of the Department.

(3) To carry out sections 303 and 401.

(e) **FUNDING PLAN AND REPORT.**—

(1) **IN GENERAL.**—Not later than 180 days after the date on which amounts are appropriated to the Department pursuant to the authorization in subsection (a), the Secretary of Veterans Affairs shall submit to the appropriate committees of Congress a funding plan and report on how the Secretary intends to obligate the amounts so appropriated and how it relates to the quadrennial Veterans Health Administration review and strategic plan under section 1730B(a) of title 38, United States Code, as added by section 102.

(2) **APPROPRIATE COMMITTEES OF CONGRESS DEFINED.**—In this subsection, 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.

SEC. 502. APPROPRIATION OF AMOUNTS FOR VETERANS
CHOICE PROGRAM.

(a) In general.—There is authorized to be appro-
priated, and is appropriated, to the Secretary of Veterans
Affairs, out of any funds in the Treasury not otherwise
appropriated, $4,000,000,000 to be deposited in the Vet-
erans Choice Fund under section 802 of the Veterans Ac-
cess, Choice, and Accountability Act of 2014 (Public Law

(b) Availability.—The amount appropriated under
subsection (a) shall remain available until expended pursu-
ant to section 802(c)(4) of the Veterans Access, Choice,
and Accountability Act of 2014 (Public Law 113–146; 38

SEC. 503. APPLICABILITY OF DIRECTIVE OF OFFICE OF
FEDERAL CONTRACT COMPLIANCE PRO-
GRAMS.

(a) In general.—Directive 2014–01 of the Office
of Federal Contract Compliance Programs of the Depart-
ment of Labor (effective as of May 7, 2014) shall apply to any entity entering into an agreement under section 1703A or section 1745 of title 38, United States Code, as amended by sections 112 and 114, respectively, 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. 504. AMENDING STATUTORY REQUIREMENTS FOR THE POSITION OF THE CHIEF OFFICER OF THE READJUSTMENT COUNSELING SERVICE.

Section 7309(b)(2) is amended—

(1) in subparagraph (B), by striking “in the Readjustment Counseling Service”; and

(2) in subparagraph (C), by striking “in the Readjustment Counseling Service”.

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SEC. 505. AUTHORIZATION OF CERTAIN MAJOR MEDICAL
FACILITY PROJECTS OF THE DEPARTMENT
OF VETERANS AFFAIRS.

(a) Authorization.—The Secretary of Veterans Af-
fairs 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: Realignment of medical
facilities in Livermore, California, in an amount not to ex-
ceed $117,300,000.

(b) Authorization of Appropriations for Con-
struction.—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 Construc-
tion, 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 section (a), the Secretary of Vet-
erans Affairs shall submit to the Committee on Veterans’
Affairs of the Senate and the Committee on Veterans’ Af-
fairs of the House of Representatives the following infor-
mation:

(1) A line item accounting of expenditures re-
lating 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 the Army Corps of Engineers providing services relating to such project, including reimbursement agreements and the costs to the Department of Veterans Affairs for such services.