Caring For Our Veterans Act of 2017
Discussion Draft – HEY17847

TITLE I—DEVELOPING AN INTEGRATED HIGH-PERFORMING NETWORK

Subtitle A—Establishing Community Care Programs

Sec. 101. Establishment of Veterans Community Care Program.

This section would amend section 1703 to establish the Veterans Community Care Program to provide care to veterans in the community.

Under this section, VA would be required to coordinate veterans' care and would be required to:

- Ensure the scheduling of medical appointments in a timely manner.
- Ensure continuity of care and services.
- Coordinate coverage for veterans who utilize care outside of a region from where they reside.
- Ensure veterans do not experience a lapse in health care services.

This section would authorize access to community care if the Department does not offer the care or service the veteran requires or a veteran and the veteran's primary care provider agree that furnishing care and services in the community would be in the best medical interest of the veteran after considering criteria, including:

- The distance between the veteran and the facility that provides the hospital care, medical service or extended care service the veteran needs.
- The nature of the hospital care, medical service, or extended care service required.
- The frequency that the hospital care, medical service, or extended care service needs to be furnished.
- Whether an appointment for the hospital care, medical service, or extended care service the covered veteran requires is available from a health care provider of the Department within the lesser of—
    - The access guidelines of the Department and
    - A period determined by a VA health care provider to be clinically necessary for the receipt of such hospital care, medical service, or extended care service.
- Whether the covered veteran faces an unusual or excessive burden to access hospital care, medical services, or extended care services from the Department medical facility where a covered veteran seeks hospital care, medical services, or extended care services, which would include consideration of the following:
    - Whether the covered veteran faces an excessive driving distance, geographical challenge, or environmental factor that impedes the access of the covered veteran.
    - Whether the hospital care, medical service, or extended care service sought by the veteran is provided by a medical facility of the Department that is reasonably accessible to a covered veteran.
    - Whether a medical condition of the covered veteran affects the ability of the covered veteran to travel.
    - Whether there is compelling reason that the veteran needs to receive hospital care, medical services, or extended care services from a medical facility other than a medical facility of the Department.
    - Any other considerations as the Secretary considers appropriate.

This section would also authorize VA to furnish care to veterans in the community when access and quality measures are deficient.

- Deficient access would be determined when compared with the same medical service line at different Department facilities.
- Deficient quality would be measured when compared with two or more distinct and appropriate quality measures at non-VA medical service lines.

VA would be limited in exercising this authority at no more than 36 service lines nationally and 3 service lines per facility.

VA would be required to submit to Congress a plan to remediate the services with specific actions, including but not limited to:

- Increasing personnel or temporary personnel assistance, including mobile deployment teams.
- Utilizing special hiring incentives, including the Education Debt Reduction Program and recruitment, relocation, and retention incentives.
- Utilizing direct hiring authority.
- Providing improved training opportunities for staff.
- Acquiring improved equipment.
- Making structural modifications to the facility used by the medical service line.
- Such other actions as the Secretary considers appropriate.

Individuals at the facility, VISN and central office levels would be identified as being responsible for overseeing the progress of that medical service line in complying with the access guidelines and standards of quality established by the Secretary.

This section would also require VA to establish access guidelines and standards for quality, after consulting with pertinent federal entities, the private sector, and nongovernmental entities, so that veterans can make informed decisions about their health care.

This section would authorize tiered networks so long as VA does not prioritize providers in one tier over another in a manner that limits a veteran's choice of providers.

This section would require the Secretary to enter into contracts establishing health care provider networks and would assign VA specific requirements and authorizations related to this process. For example, to the extent practicable, VA would be responsible for scheduling appointments for hospital care, medical services, or extended care services. If the Secretary terminates a contract, VA would be required to report on the circumstances, consequences, and mitigation plans related to the entity failing to meet contractual obligations.

This section would establish payment rates for community care as, to the extent practicable, the Medicare rate. It would authorize the Secretary to pay higher rates in highly rural areas. For Alaska, the Alaskan Fee Schedule would be followed. For states with All-Payer Model Agreements, the Medicare rate would be calculated based on the payment rates of those Agreements. VA would be allowed to incorporate, to the greatest extent practicable, value-based reimbursement models to promote high-quality care.

This section would also allow for the continuity of existing memorandums of understanding and memorandums of agreement that were in effect on the day before enactment of this bill between VA and the American Indian and Alaska Native health care systems as established under the terms of the Department of Veterans Affairs and Indian Health Service Memorandum of Understanding, signed October 1, 2010, the National Reimbursement Agreement, signed December 5, 2012, and agreements entered into under sections 102 and 103 of the 2014 Choice law to enhance the collaboration between VA and the Native Hawaiian health care system.

This section would require that a veteran not pay more for utilizing non-VA care than the veteran would pay for comparable care or services at VA.

This section would also require VA to monitor network care and report to Congress on the care provided to veterans.

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

This section would authorize VA to enter into Veterans Care Agreements (VCAs) that are not subject to competition or other requirements associated with federal contracts, so that they can more easily meet veterans' demands for care in the community.

Eligibility for care would be subject to the same terms as VA care itself and the rates paid under VCAs, to the extent practicable, would be in accordance with rates paid under the Medicare program. The Secretary would be responsible for development of a certification process for VCAs and a system for monitoring the quality of care.

This section would also establish the terms VCAs must agree to in order to become a provider in the Community Care program.

Sec. 103. Conforming amendments for State Veterans Homes.

This section would allow VA authority to enter into VCAs with State Veterans Homes, eliminating competitive contracting actions and other requirements associated with federal contracts. State Veterans Homes, while not considered federal contactors for the purposes of this section, would still be required to follow federal laws related to fraud, waste, and abuse as well as employment law.

Sec. 104. Access guidelines and standards for quality.

This section would require the Secretary to take into consideration common health care access measurements and data when establishing localized benchmarking guidelines for access.

This section would also require VA to establish standards for quality and directs the Secretary to collect measures on the following:

- Veterans' satisfaction with service and the quality of care at Department facilities within the past two years.
- Timely care.
- Effective care.
- Safety – including at a minimum: complications, readmissions, and death.

- Efficiency.

This section would require the Secretary to publish data on these quality and access measures on the Hospital Compare website through the Centers for Medicare and Medicaid to give veterans the information to compare performance measures between Department and community health care providers.

This section would also require VA to consider any potential changes to the measures within two years of enactment and open this process to public comment to ensure the measures are up-to-date and rely on applicable industry measures.

Sec. 105. Access to Walk-In Care.

This section would authorize access to walk-in care for enrolled veterans who have used VA health care services in the 24-month period before seeking walk-in services. Community providers that are a part of VA's community care network and FQHCs would provide these services.

Veterans who are not required to make a copayment at VA would be entitled to two visits without a copayment and then would pay an adjustable copayment determined in regulations by the Secretary. Veterans who are required to make a copayment at VA would make their normal copayment then an adjusted copayment after two visits.

VA would be required to ensure continuity of care under this section, including through the establishment of a mechanism to receive medical records from walk-in care providers and share pertinent patient medical records with walk-in care providers.

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

This section would require the Secretary to perform market area assessments at least every four years and prescribes the elements that need to be included in the assessments:

- Demand, disaggregated by geographic market areas determined by the Secretary, including requests for services from the Department;
- An inventory of VA's health care capacity across all facilities;
- An assessment of the capacity provided by contracted private providers, including the number of providers, the geographic location of the providers, and categories or types of health care services provided by the providers.
- An assessment obtained from other Federal direct delivery systems of their capacity to provide health care to veterans.
- An assessment of the health care capacity of non-contracted providers where there is insufficient network supply.
- 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.
- An assessment of the effects on health care capacity by the access guidelines and standards of quality established under the bill.
- The number of appointments for health care services, disaggregated by Department facilities and

non-Department health care providers.

This section would require the Secretary to submit the market area assessments to Congress and use the market area assessments in determining the capacity of the health care provider networks established in section 101.

This section would also require the Secretary to submit a strategic plan to Congress, no later than one year after the date of enactment of the bill and at least every four years after. This four-year forecast should specify:

- Demand, disaggregated by geographic market areas determined by the Secretary;
- The health care capacity to be provided at each medical center of the Department; and
- The health care capacity to be provided through community care providers.

This section would direct the Secretary to take a number of elements into consideration in the strategic plan, including veterans' satisfaction, the access guidelines and standards of quality established under this bill, conditions and needs of veterans with service-connected disabilities, and to identify emerging issues, challenges, and opportunities at the Department and develop long-term and short-term recommendations to address them.

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

This section would apply the TRICARE contractor and subcontractor compliance directive, Directive 2014–01 of the Office of Federal Contract Compliance Programs of the Department of Labor, to VCAs established in the amended section 1703.

Subtitle B—Paying Providers and Improving Collections

Sec. 111. Prompt payment to providers.

This section would create standards for timely payment to providers. An eligible provider must submit a claim to the Secretary within 180 days of furnishing care or services. VA must reimburse clean electronic claims in 30 days, clean paper claims in 45 days, and adjudicate appealed denied claims within 30 days.

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

This section would add a new section to chapter 81 to authorize the Secretary to pay for services not subject to a VCA. It gives the Secretary flexibility to pay for services deemed necessary and directs them to take reasonable efforts to enter into a formal agreement and contract, or other legal arrangement, to ensure that future care and services are covered.

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

This section would authorize VA to collect from a third party for care furnished to non-veterans by amending section 1729 of title 38, U.S.C. to refer to "individuals" instead of "veterans". It would also authorize VA to seek collections when VA pays for care, rather than furnishes it, and remove duplicative

language regarding VA's authority to collect from other health insurance for treatment of a non-service-connected disability.

Subtitle C—Education and Training Programs

Sec. 121. Education program on health care options.

This section would require the Secretary to develop and administer an education program to inform veterans about their health care options through VA, the interaction between health insurance and VA health care; and how to utilize the access guidelines and quality standards established in section 104. It also would require the Secretary to evaluate and report on the program annually.

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

This section would require the Secretary to develop and administer a training program for VA employees and contractors on how to administer non-Department health care programs and the management of prescriptions for opioids as established under section 141. It also would require VA to evaluate and report on the program annually.

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

This section would establish a program to provide continuing medical education material to non-Department medical professionals at no cost to them. The program would focus on educating these non-Department medical professionals on identifying and treating common mental and physical conditions of veterans and their family members. It also would require the Secretary to evaluate and report on the program annually.

Subtitle D—Other Matters Relating to Non-Department of Veterans Affairs Providers

Sec. 131. Improved management of opioid prescriptions by non-Department of Veterans Affairs health care providers.

This section would require the Secretary to provide all non-Department community providers participating in the Community Care program with the agency's materials and guidelines from its Opioid Safety Initiative. Each provider would be required to certify they have reviewed the guidelines and information.

It would require, to the extent practicable, that non-VA providers submit prescriptions for opioids directly to a VA pharmacy for dispensing and recording. It would allow for prescriptions to be submitted to a retail pharmacy for the prescribing of a limited amount of opioids.

This section would also require the Secretary to develop a process for recording prescriptions (for opioids and other classes of drugs deemed appropriate by VA) filled at non-VA pharmacies in a patient's VA health record.

Sec. 132. Benefits for persons disabled by treatment under Veterans Community Care Program.

This section would allow veterans who are disabled or died because of negligence, or an event not

reasonably foreseeable, from the hospital care, medical services, or extended care services furnished by a community provider to seek damages and benefits. It also would require that any funds received by the veteran in a judgement against a non-VA provider be offset.

Subtitle E—Other Health Care Matters

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

This section would require the Secretary to submit to Congress a justification for any new supplemental appropriations request submitted outside of the standard budget process no later than 45 days before the date on which a budgetary issue would start affecting a program or service. It would also require a detailed strategic plan on how the Secretary intends to use the requested appropriation and for how long the requested funds are expected to meet the need.

Sec. 142. Veterans Choice Fund flexibility.

This section would amend section 802 of the 2014 Choice Act to authorize VA, beginning in fiscal year 2019, to use remaining Veterans Choice Fund to pay for any health care services under Chapter 17 of Title 38 at non-VA facilities or through non-Department providers furnishing care in VA facilities.

Sec. 143. Sunset of Veterans Choice Program.

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

Sec. 144. Conforming amendments.

This section would repeal and replace existing authorities to account for changes made by section 101 of the bill to consolidate and create the Community Care program.

TITLE II—IMPROVING DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE DELIVERY

Subtitle A—Improving Personnel Practices

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

This section would create a new authority to allow VA health care professionals to practice telemedicine regardless of the location of the provider or patient during the treatment. The section makes clear that telemedicine does not need to be delivered in a Federal facility.

The section would also invoke Federal supremacy regarding state telemedicine delivery laws and regulations to ensure uniform care delivery nationally. It defines a "covered health care professional" as a VA employee who is authorized to furnish health care and is required to adhere to all quality standards relating to the provision of medicine in accordance with VA policies. It would require VA to submit a report to Congress within 1 year of enactment of this telemedicine program, providing data on provider and patient satisfaction, the effect of telemedicine on patient wait-times, health care utilization, and other measures.

Sec. 202. Graduate medical education and residency.

This section would allow the Secretary to increase the number of graduate medical education residency positions by up to 1,500 positions, and directs the Secretary to follow a number of parameters in deciding on location, affiliate sponsor, duration, and types of specialties for the positions. Parameters include clinical need generally in the local community and specifically among veterans and whether there is a staffing shortage of clinical specialties. It also would establish rules for program participation, including application and selection procedures; conditions of employment and obligated service; and establishment of agreements and breach thereof. Finally, it would require VA to report annually on program characteristics.

Sec. 203. 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.

This section would direct the Secretary, in consultation with the Director of the Indian Health Service, to affiliate with an already established graduate medical education residency training program or establish a new program at a facility operated by the Indian Health Service, or a facility operated by an Indian tribe, tribal organization, or Native Hawaiian Health Centers, that is located in a rural or remote area.

Sec. 204. Exception on limitation on awards and bonuses for recruitment, relocation, and retention.

This section would amend section 705(a) of the 2014 Choice Act that limits the aggregate annual amount of awards that can be paid to VA employees by no longer including recruitment, relocation, or retention incentives in that limit.

Sec. 205. Annual Report on performance awards and bonuses awarded to certain high-level employees of the Department.

This section would require the Secretary to submit an annual report on the performance awards and bonuses presented to regional office directors, directors of medical centers, and directors of VISNs.

Sec. 206. Modification of treatment of certified clinical perfusionists of the Department.

This section would amend sections 7455 and 7401 of title 38 to include certified clinical perfusionists in the list of excepted positions and convert such positions to full Title 38 status to assist in the recruitment and retention of highly skilled perfusionists.

Sec. 207. Authority to Regulate Pay Authorized for Title 38 Hybrid Employees and Title 5 Health Care Workers.

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

Sec. 208. Modification of pay cap for nurses.

This section would establish a higher maximum amount of basic pay for registered nurses. Currently, the maximum rate of basic pay for nurses for any grade may not exceed the rate of basic pay established

for positions at level IV of the Executive Service. This section would allow for basic pay for registered nurses serving as a nurse executive or a grade for the position of certified registered nurse anesthetist up to level I of the Executive Schedule. This section would allow for basic pay for all other registered nurses to be increased up to level III of the Executive Schedule.

Sec. 209. Reimbursement of continuing professional education requirements for board certified advanced practice registered nurses.

This section would allow the Secretary to reimburse any board-certified advanced practice registered nurse, physician, or dentist up to $1,000 per year for continuing professional education, in order to help them better meet their continuing education requirements.

Sec. 210. Program on establishment of peer specialists in patient aligned care team settings within medical centers of the Department of Veterans Affairs.

This section would direct VA to integrate two peer specialists into VA's patient aligned care teams at not fewer than 50 VA medical centers by December 31, 2018. In considering which VA medical centers to select for this program, VA shall place peer specialists in at least five facilities that have a polytrauma center and at least 10 that do not have a polytrauma center. VA must consider rural areas, areas not in close proximity to an active duty military installation, and areas that represent different geographic locations. This section would also require a report to Congress.

Sec. 211. Amending statutory requirements for the position of the Chief Officer of the Readjustment Counseling Service.

This section would amend section 7309 removing the words "in the Readjustment Counseling Service" so that a candidate for the position of Chief Officer of the Readjustment Counseling Service has three years of experience providing direct counseling services or outreach services as well as three years administrating these services, regardless of whether that service and administration was done in a Vet Center.

Sec. 212. Technical amendment to appointment and compensation system for directors of medical centers and directors of Veterans Integrated Service Networks.

This section would amend section 7404 to make an exception for increasing the compensation scale and raises for VA Medical Center directors and directors of Veterans Integrated Service Networks.

Subtitle B—Improvement of Underserved Facilities of the Department

Sec. 221. Development of criteria for designation of certain medical facilities of the Department of Veterans Affairs as underserved facilities and plan to address problem of underserved facilities.

This section would require the VA Secretary to develop criteria within 180 days to designate VA medical facilities as underserved facilities. It would also require VISN directors to assess the medical facilities in their VISNs at least annually to determine which shall be designated as underserved. In addition, it would require the VA Secretary to develop an annual plan for addressing the problem of underserved facilities within one year of enactment of this Act.

Sec. 222. Pilot program on tuition reimbursement and loan repayment for health care providers of the Department of Veterans Affairs at underserved facilities.

This section would require the Secretary to begin a pilot program to assess the feasibility and advisability to providing incentives to individuals to work in underserved VHA facilities. The program would provide medical students with tuition reimbursement and health care providers with loan repayment in exchange for commitments to serving in underserved facilities.

Sec. 223. Program to furnish mobile deployment teams to underserved facilities.

This section would require the Secretary to establish a program to furnish mobile deployment teams to underserved facilities, considering various factors in determining the make-up of the teams. Specifically, the Secretary must use the results of the annual analysis required under Section 221 in determining which personnel are most needed by underserved VHA facilities.

Sec. 224. Inclusion of Vet Center employees in education debt reduction program of Department of Veterans Affairs.

This section would require that the Secretary ensure that clinical staff working at Vet Centers are eligible to participate in VA's education debt reduction program.

Subtitle C—Construction and Leases

Sec. 231. Definition of major medical facility project and major medical facility lease.

This section would amend section 8101 to include an outpatient clinic in the definition of a medical facility.

This section would amend section 8104 to increase the limit above which a project is considered a major medical facility project requiring Congressional authorization from $10 million to $20 million.

It also would amend the definition of a major medical facility lease to align with the rental value as used by the General Services Administration under 40 U.S.C. 3307(a)(2).

Sec. 232. Review of enhanced use leases.

This section would amend Section 8162 to allow more flexibility in the Secretary's issuance of enhanced-use leases. The Director of the Office of Management and Budget will now provide a review that the lease is in compliance with enhanced-use lease regulations, not grant approval.

Sec. 233. Authorization of certain major medical facility projects of the Department of Veterans Affairs.

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

This section directs the Secretary to submit to the House and Senate Committees on Veterans' Affairs within 90 days a detailed project proposal, line item accounting of expenditures, any future obligations for the project, a justification for the expenditures, and any agreements with a non-Department federal entity to provide construction services for the project.

TITLE III – FAMILY CAREGIVERS

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

This section would amend section 1720G of title 38, U.S.C., to expand eligibility for VA's Program of Comprehensive Assistance for Family Caregivers to veterans with a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service on or before May 7, 1975, during the 2-year period following the date on which the VA Secretary submits to Congress a certification that the Department has fully implemented the information technology system required by section 302(a) of the bill. After the date that is 2 years after the date on which the certification is submitted, eligibility would be expanded to also include veterans with a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service after May 7, 1975, and before September 11, 2001.

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

This section would require VA to implement an information technology system that fully supports the Family Caregiver Program and allows for data assessment and comprehensive monitoring by not later than June 1, 2018.

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

Section 303 would amend requirements in Public Law 111-163 for VA's annual evaluation report on the Program of Comprehensive Assistance for Family Caregivers and the Program of General Caregiver Support to include a description of any barriers to accessing and receiving care and services. The report on the Program of Comprehensive Assistance for Family Caregivers would also include an evaluation of the sufficiency and consistency of the training provided to family caregivers.

TITLE IV – APPROPRIATION OF AMOUNTS

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

This section would authorize and appropriate $1 billion to the Secretary. The funds may be used for educational assistance for providers, the increase of graduate medical education residency positions, and recruitment, relocation, and retention incentives. The section also requires a report on the expenditures of these funds.

Sec. 402. Appropriation of amounts for Veterans Choice Program.

This section would authorize and appropriate $3 billion to be used for the Veterans Choice Fund of section 802 of the Choice Act.