VA MISSION ACT OF 2018
(VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act)

Title I - Caring For Our Veterans Act of 2018

Subtitle A - Developing an Integrated High-Performing Network

Chapter 1 - Establishing Community Care Programs

Sec. 101. Establishment of Veterans Community Care Program.

Section 101 would establish the Veterans Community Care Program to provide care in the community to veterans who are enrolled in the VA healthcare system or otherwise entitled to VA care.

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 *requires* access to community care if VA does not offer the care or services the veteran requires, VA does not operate a full-service medical facility in the state a veteran resides, the veteran was eligible for care in the community under the 40-mile rule in the Veterans Choice Program and meets certain other criteria, VA is not able to furnish care within the designated access standards established by VA, or a veteran and the veteran's referring clinician agree that furnishing care or 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 care or services the veteran needs.
- The nature of the care or services required.
- The frequency that care or services needs to be furnished.
- The timeliness of available appointments for the care or services the veteran needs.
- Whether the covered veteran faces an unusual or excessive burden to accessing care or services from the VA medical facility where the covered veteran seeks care or services, which would include consideration of the following:
    - Whether the covered veteran faces an excessive driving distance, geographical challenge, or environmental factor that impedes access.
    - Whether the care or services sought by the veteran is provided by a VA medical facility that is reasonably accessible.
    - Whether a medical condition of the covered veteran affects his/her ability to travel.
    - Whether there is a compelling reason that the covered veteran needs to receive care or services from a medical facility other than a VA medical facility.
    - Any other considerations VA considers appropriate.

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

- Deficient timeliness would be determined when compared with the same medical service line at different VA 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.

This section requires that any decision review shall be subject to the Department's clinical appeal process and may not be appealed via the Board of Veterans Appeals.

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 VA 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.

This section would establish payment rates for community care as, to the extent practicable, the Medicare rate. It would authorize VA 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 extent practicable, value-based reimbursement models to promote high-quality care. 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 require that in a case in which a veteran is eligible for and requires an organ or bone marrow transplant, and the veteran has, in the opinion of the primary care provider of the veteran, a medically compelling reason to travel outside the region of the Organ Procurement and Transplantation Network, established under section 372 of the National Organ Transplantation Act (Public Law 98–507; 42 U.S.C. 274), the Secretary shall consider authorization of such transplant at a non-Department facility.

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

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, arrangements under section 405 of the Indian Health Care Improvement Act,

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.

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

Section 102 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 Veterans Community Care Program established in section 101 of this bill. VA 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.

Section 103 would authorize VA to enter into VCAs with State Veterans Homes and eliminate competitive contracting actions and other requirements associated with federal contracts. State Veterans Homes, while not considered federal contractors 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 standards and standards for quality.

Section 104 would require VA to establish access standards, 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 allow a covered veteran to request a determination regarding whether the veteran is eligible to receive care or services from a community provider due to VA being unable to meet certain designated access standards as established by VA. This section would direct VA to publish the designated access standards in both the Federal Register and VA's website and to review the access standards every three years at a minimum.

This section would also require VA to establish quality standards, after consulting with pertinent federal entities, the private sector, and nongovernmental entities, and would direct VA to collect measures on the following:

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

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

This section would also require VA to consider any potential changes to the quality 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.

Section 105 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 have entered into a contract or agreement to provide services under this section and Federally-qualified health centers (FQHC) 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 VA would be authorized to charge an adjustable copayment determined in regulations by VA. Veterans who are required to make a copayment at VA could pay that copayment for the first two visits and then VA would be authorized to charge an adjusted copayment after those 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 to 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.

Section 106 would require VA to perform market area assessments at least once every four years and would prescribe the elements that need to be included in the assessments, to include:

- Demand, disaggregated by geographic market areas determined by VA, including requests for VA services.
- An inventory of VA's health care capacity across all medical facilities.
- An assessment of the capacity provided by contracted private providers, including the number of providers, the geographic location of the providers, and the 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 VA collaborations as it relates to providing health care to veterans.
- An assessment of the effects on VA health care capacity by the access and quality standards established under this bill.

- The number of appointments for health care services, disaggregated by VA medical facilities and non-Department health care providers.

This section would require VA to submit the market area assessments to Congress and use the market area assessments to determine the capacity of the health care provider networks established in section 101 of this bill, to inform VA's budget, to assess the appropriateness of the access and quality standards established under this bill, and to develop recommendations for changes to those standards as needed.

This section would also require VA to submit a strategic plan to Congress, no later than one year after the date of enactment and at least every four years thereafter and to specify:

- Demand, disaggregated by geographic market areas determined by VA.
- The health care capacity to be provided at each VA medical center.
- The health care capacity to be provided through community care providers.

This section would direct VA to take a number of elements into consideration in the strategic plan, including veterans' satisfaction, the access and quality standards established under this bill, and conditions and needs of veterans with service-connected disabilities. In preparing the strategic plan, it would also direct VA to identify emerging issues, challenges, and opportunities; develop long-term and short-term recommendations to address them; conduct a comprehensive examination of VA programs and policies; and assess the remediation of medical services lines described in section 1706A.

This section would require VA to be responsible for overseeing the transformation and organizational change to achieve a high performing integrated health care network, developing the capital infrastructure planning and procurement processes required, and developing a multi-year budget process that is capable of forecasting future budget year requirements.

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

Section 107 would apply the same affirmative action moratorium on VCA contractors and subcontractors as is applied to TRICARE contractors and subcontractors in Directive 2014–01 of the Office of Federal Contract Compliance Programs of the Department of Labor.

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

Section 108 would allow VA to deny, suspend, or revoke the eligibility of a non-Department health care provider to participate in the community care program if that the provider was previously removed from VA employment or had their medical license revoked. GAO would be required to report on the implementation of this section two years after enactment.

Sec. 109. Remediation of medical services lines.

Section 109 would require VA to submit to Congress a plan to remediate medical service lines 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 (EDRP) 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 VA considers appropriate.

Individuals at the facility, Veterans Integrated Service Network (VISN), and central office levels would be identified as being responsible for overseeing the progress of that medical service line in complying with the quality standards established by VA.

This section would require interim and annual reports with an analysis of the remediation actions and the costs of such actions.

Chapter 2 - Paying Providers and Improving Collections

Sec. 111. Prompt payment to providers.

Section 111 would establish a prompt payment process that requires VA to pay for, or deny payment for, services within 30 calendar days of receipt of a clean electronic claim or within 45 calendar days of receipt of a clean paper claim. In the case of a denial, VA would have to notify the provider of the reason for denying the claim and what, if any, additional information would be required to process the claim. Upon the receipt of the additional information, VA would have to pay, deny, or otherwise adjudicate the claim within 30 calendar days. These requirements would only apply to payments made on an invoice basis and would not apply to capitation or other forms of periodic payments to entities or providers. Non-Department entities or providers would be required to submit a claim to VA within 180 days of providing care or services.

Any claim that has not been denied, made pending, or paid within the specified time periods would be considered overdue and subject to interest payment penalties. VA would also be directed to report annually on the number of and the amount paid in overdue claims. VA would be authorized to deduct the amount of any overpayment from payments due to an entity or provider under certain conditions. The Secretary would also be required to publish regulations for the administration of this section.

Claims processing may be performed by either a contracted third party administrator or other entity to conduct these administrative functions. This section would require an independent review of claims that includes the capacity of VA to process such claims in a timely manner and a cost benefit analysis comparing the capacity of VA to a third party entity capable of processing

such claims. This section would also require that VA conduct a study on whether to establish a funding mechanism for a Department contractor to act as a fiscal intermediary for the Federal Government to pay claims.

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

Section 112 would authorize VA to pay for services not subject to a contract or agreement. It would also give VA the flexibility to pay for services deemed necessary and would direct VA to take reasonable efforts to enter into a formal agreement, 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.

Section 113 would authorize VA to collect from a third party for care provided to non-veterans by amending statute 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.

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

Section 114 would allow VA to enter into an agreement with a third party entity to electronically process health care claims from community providers.

Chapter 3 - Education and Training Programs

Sec. 121. Education program on health care options.

Section 121 would require VA to develop and administer an education program to inform veterans about their VA health care options, the interaction between health insurance and VA health care, and how to utilize the access and quality standards established in section 104. It would also require VA to evaluate and report on the program annually.

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

Section 122 would require VA 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 131. It also would require VA to evaluate and report on the program annually.

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

Section 123 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 would also require VA to evaluate and report on the program annually.

Chapter 4 - Other Matters Relating to Non-Department of Veterans Affairs Providers

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

Section 131 would ensure that contracted providers have reviewed the evidence-based guidelines for prescribing opioids set forth in the Opioid Safety Initiative. This section would also require VA to implement a process to make certain that community care providers have access to available and relevant medical history of the patient, including a list of all medication prescribed to the veteran as known by VA.

This section would require that contracted providers submit medical records of any care or services furnished, including records of any prescriptions for opioids, to VA in a timeframe and format specified by VA. VA would be responsible for recording those prescriptions in the electronic health record and for enabling other monitoring of the prescriptions as outlined in the Opioid Safety Initiative.

This section would require a report each year evaluating the compliance of contracted providers with the requirements of this subsection. If VA determines that a community provider is not complying with the Opioid Safety Initiative, VA is authorized to refuse authorization of care by such provider and direct their removal from the community care network.

Sec. 132. Improving information sharing with community providers.

Section 132 would clarify that VA could share medical record information with non-Department entities for the purpose of providing health care to patients or performing other health care related activities and remove certain restrictions on VA's ability to recover funds from third parties for the cost of non-service-connected care.

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

Section 133 would require VA to establish competency standards for non-Department providers in treating veterans for injuries and illnesses that VA has a special expertise in, such as post-traumatic stress disorder, traumatic brain injury, and military sexual trauma. This section would also direct that all non-Department providers, to the extent practicable as determined by VA, meet these standards before furnishing care.

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

Section 134 would allow any licensed health care provider or delegate to be considered an authorized recipient and user for the purposes of querying and receiving data from the national network of State-based prescription drug monitoring programs. Under this authority, licensed health care providers or delegates would be required to query the network in accordance with applicable VA regulations and policies and no State would be authorized to restrict the access of licensed health care providers or delegates from accessing that State's prescription drug monitoring programs.

Chapter 5 - Other Non-Department Health Care Matters

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

Section 141 would require VA 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 VA 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.

Section 142 would amend section 802 of the Choice Act to authorize VA, beginning March 1, 2019, to use the remaining Veterans Choice Fund to pay for any health care services under Chapter 17 of Title 38 at non-Department facilities or through non-Department providers furnishing care in VA facilities.

Sec. 143. Sunset of Veterans Choice Program.

Section 143 would provide a sunset date for the Veterans Choice Program one year after the date of enactment of this Act.

Sec. 144. Conforming amendments.

Section 144 would repeal and replace existing authorities to account for changes made by section 101 of the bill to consolidate and create the Veterans Community Care program.

Subtitle B - Improving Department of Veterans Affairs Health Care Delivery

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

Section 151 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 would also make 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 would define 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, providing data on provider and patient satisfaction, the effect of telemedicine on patient wait-times, health care utilization, and other measures.

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

Section 152 would establish a VA Center for Innovation for Care and Payment. VA, acting through the Center, would be authorized to 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 and access to care furnished by VA. VA, acting through the Center, would be required to test payment and service delivery models to determine whether such models improve the quality of, access to, or patient satisfaction of such care and services, as well as the cost savings associated with such models. VA would be required to test models where VA determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. VA would be required to focus on models expected to reduce program costs while preserving or enhancing the quality of or access to care VA provides. VA would be authorized to consider a number of different factors in selecting models to test. The models tested under this program could not be designed in such a way as to allow the United States to recover or collect reasonable charges from a Federal health care program (including Medicare, Medicaid, and TRICARE) for care or services furnished by VA to veterans.

Pilot programs would be authorized to last no longer than 5 years and VA would be prohibited from carrying out more than 10 programs concurrently.

VA would be required to ensure that pilot programs are carried out in different areas that are appropriate for the purposes of the pilot program and must include both urban and rural areas and both large and small VA medical centers.

Funding for the pilot programs would be derived from appropriations provided in advance in appropriations acts for VHA and from appropriations provided for information technology systems. VA would be prohibited from expending more than $50 million per fiscal year. This could be increased with written consent from HVAC/SVAC Chairmen.

VA would be required to publish information about such pilot programs in the Federal Register and take reasonable actions to provide direct notice to veterans eligible to participate in a pilot program and advocates for veterans, to ensure veterans have information about such pilot programs.

In implementing the pilot programs under this section, VA would be authorized to waive such requirements in subchapters I, II, and III of chapter 17 of title 38, U.S.C., as may be necessary solely for the purpose of carrying out this section with respect to testing models under this program. Before VA could waive any of these authorities, VA would have to submit a report to Congress explaining the authorities to be waived and the reasons for such waivers, along with other information. Upon receipt of a report from VA, Congress would be required to submit the report to each standing committee with jurisdiction to report a bill to amend the provision or provisions of law that would be waived. If Congress enacted a bill or joint resolution approving the requested waiver in its entirety, VA would be allowed to act upon that waiver.

The waiver provisions would not be available unless VA submits the first proposal for a waiver for a pilot program within 18 months of the date of the enactment.

If VA determines that a pilot program is not improving the quality of or access to care or producing cost savings, VA would have authority to propose a modification to the pilot program or terminate the program within 30 days of submitting an interim report to Congress.

VA would be required to conduct an evaluation of each model tested, to include, at a minimum, an analysis of the quality of and access to care furnished and the changes in spending by reason of that model. VA would be required to make each evaluation available to the public in a timely fashion.

VA would be required to obtain advice from the Special Medical Advisory Group in the development and implementation of any pilot program operated under this section.

VA would be authorized to expand, through rulemaking, the duration and scope of successful pilot programs to the extent VA determines that such expansion is expected to reduce spending without reducing the quality of or access to care or improve the quality of or access to care without increasing spending; VA would also have to determine that such expansion would not deny or limit the coverage or provision of benefits for applicable individuals.

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

Section 153 would authorize VA to support the cost of a donor transplant operation (including perioperative care) for a live donor who is not a veteran but who is donating an organ for a veteran in a VA facility or community facility.

Subtitle C - Family Caregivers

Sec. 161. Expansion of Family Caregiver Program of Department of Veterans Affairs.

Section 161 would 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 VA has fully implemented the information technology system required by section 162(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. 162. Implementation of information technology system of Department of Veterans Affairs to assess and improve the family caregiver program.

Section 162 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 October 1, 2018.

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

Section 163 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 II - VA Asset and Infrastructure (AIR) Review Act

Subtitle A - Asset and Infrastructure Review

Sec. 202. The Commission

Section 202 would establish a nine member Asset and Infrastructure Review (AIR) Commission. The President would be required to appoint AIR commissioners with the advice and consent of the Senate and transmit nominations to the Senate by May 31, 2021. The President would be required to consult with Congressional leaders and congressionally chartered, membership-based veterans service organizations (VSOs) in selecting individuals for Commission nomination.

The Commission would meet during calendar years 2022 and 2023 and be terminated on December 31, 2023. Each meeting of the Commission would be required to be open and all proceedings, information, and deliberations of the Commission would be available for review by the public.

Sec. 203. Procedure for Making Recommendations.

Section 203 would require VA, not later than February 1, 2021, and after consulting with VSOs, to publish in the Federal Register and transmit to the Committees on Veterans' Affairs of the House of Representatives and the Senate (HVAC/SVAC) the criteria proposed by VA to be used

in assessing and making recommendations regarding the modernization or realignment of VHA facilities. There would be a 90-day public comment period for VA's proposed criteria.

Not later than May 31, 2021, VA would be required to publish in the Federal Register and transmit to HVAC/SVAC, the final criteria to be used in making recommendations regarding the modernization or realignment of VHA facilities.

Not later than January 31, 2022, and after consulting with VSOs, VA would be required to publish in the Federal Register and transmit to HVAC/SVAC a report detailing recommendations regarding the modernization or realignment of VHA facilities. VA would be required to consider the following factors in making recommendations regarding the modernization or realignment of VHA facilities:

- The degree to which any health care delivery or other site for providing services to veterans reflect VA's metrics regarding market area health system planning;
- The provision of effective and efficient access to high-quality health care and services to veterans;
- The extent to which real property that no longer meets the needs of the Federal Government could be reconfigured, repurposed, consolidated, realigned, exchanged, outleased, replaced, sold, or disposed;
- VHA's need to acquire infrastructure or facilities that will be used for the provision of health care and services to veterans;
- The extent to which operation and maintenance costs are reduced through consolidating, collocating, and reconfiguring space and through realizing other operational efficiencies;
- The extent and timing of potential costs and savings, including the number of years such costs and savings will be incurred, beginning with the date of completion of the proposed recommendation;
- The extent to which the real property aligns with VA's mission;
- The extent to which any action would impact other VA missions including education, research, or emergency preparedness;
- Local stakeholder inputs and any factors identified through public field hearings;
- Capacity and commercial market assessments;
- The extent to which VHA has appropriately staffed the medical facility, including determinations whether there has been insufficient resource allocation or deliberate understaffing; and
- Any other factors VA determines appropriate.

VA would be further required to assess the capacity of each VISN and VA medical facility to furnish hospital care or medical services to veterans and each assessment would be required to:

- Identify existing deficiencies in the furnishing of care and services to veterans and how such deficiencies may be filled by entering into contracts or agreements with community health care providers or other entities under other provisions of law and changing the way care and services are furnished at such VISNs or VA medical facilities (including through extending hours of operation, adding personnel, and expanding treatment space through construction, leasing, or sharing of health care facilities);

- Forecast both the short-term and long-term demand in furnishing care and services at such VISN or VA medical facility;
- Consider how demand affects the need to enter into contracts or agreements;
- Consider the commercial health care market of designated catchment areas conducted by a non-governmental entity; and
- Consider the unique ability of the Federal government to retain a presence in a rural area otherwise devoid of commercial health care providers or from which such providers are at risk of leaving.

In carrying out the assessments, VA would be required to consult with VSOs and veterans served by each VISN and medical facility affected by the assessment. VA would also be required to:

- Submit the local capacity and commercial market assessments to HVAC/SVAC with the recommendations regarding the modernization or realignment of VHA facilities and to make the assessments publicly available;
- Include with the recommendations regarding the modernization or realignment of VHA facilities a summary of the selection process that resulted in the recommendation for each VHA facility and a justification for each recommendation and to transmit the summaries and justifications not later than 7 days after the date of transmittal to HVAC/SVAC;
- Consider all facilities equally without regard to whether the facility has been previously considered or proposed for reuse, modernization, or realignment; and
- Make all information used by VA to prepare a recommendation available to the Commission and the Comptroller General.

The Commission would be required to conduct public hearings on the Secretary's recommendations regarding the modernization or realignment of VHA facilities, to include required public hearings in regions affected by a VA recommendation for the closure of a facility and, to the greatest extent practicable, public hearings in regions affected by a recommendation for another (non-closure) action by VA. Each public hearing would be required to include, at a minimum, a local veteran who is enrolled in the VA health care system and identified by a local VSO and a local elected official.

The Commission, not later than January 31, 2023, would be required to transmit to the President a report and analysis of the recommendations made by VA together with the Commission's recommendations for the modernization or realignment of VHA facilities.

The Commission would be authorized to change a recommendation made by VA for the modernization or realignment of a VHA facility only if the Commission:

- Determines that VA deviated substantially from VA's final criteria in making such recommendation;
- Determines that the change is consistent with the final criteria;
- Publishes a notice of the proposed change in the Federal Register not less than 45 days before transmitting the Commission's recommendations to the President; and
- Conducts public hearings on the proposed change.

The Commission would be required to explain and justify any recommendation made by the Commission that is different from the recommendations made by VA in the Commission's report that is transmitted to the President and to transmit the copy of such report to HVAC/SVAC on the same day that it is transmitted to the President. The Commission would be required to promptly provide information used by the Commission in making its recommendations to any Member of Congress upon request.

Not later than February 15, 2023, the President would be required to transmit to the Commission and to Congress a report containing the President's approval or disapproval of the Commission's recommendations. If the President approves of the Commission's recommendations, the President would be required to transmit a copy of the Commission's recommendations together with a certification of approval. If the President disapproves of the Commission's recommendations in whole or in part, the President would be required to transmit to the Commission and Congress the reasons for that disapproval. Not later than March 15, 2023, the Commission must transmit to the President a report containing a review and analysis of the reasons for disapproval provided by the President and recommendations for modernizations and realignments. If the President approves all of the Commission's recommendations, the President would be required to transmit a copy of the recommendations to Congress together with a certification of such approval. The process for modernization or realignment of VHA facilities would terminate if the President does not transmit a certification of approval to Congress by March 30, 2023.

Section 204. Actions regarding Infrastructure and Facilities of the Veterans Health Administration.

Section 204 would require VA to initiate or begin the planning of all actions recommended by the Commission in the report transmitted to Congress by the President no later than three years after the date on which the President transmits such report. VA would be prohibited from carrying out any action recommended by the Commission in the report transmitted to Congress by the President if a joint resolution is enacted in accordance with section 207.

Section 205. Implementation.

Section 205 would authorize VA to take such action as may be necessary to modernize or realign any VHA facility (including the acquisition of such land, construction of replacement facilities, and the conduct of such advance planning and design as may be required to transfer functions from a VHA facility to another facility) and carry out such activities for the purposes of environmental restoration and mitigation at any VHA facilities.

VA would be required to carry out environmental abatement, mitigation, and restoration and compliance with historical preservation requirements with regard to any property made excess to VA's needs as a result of modernization or realignment; consult with the Governor of a State and the heads of local governments concerned for purposes of considering any plan for the use of such property by the local community concerned before any action is taken with respect to disposal or any surplus real property or infrastructure; and consult with the Governor of a State and the heads of local government for the purpose of considering the continued availability of a

road for public access through, into, or around a VHA facility that is to be modernized or realigned.

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

Section 206 would establish a VA AIR Account to be administered by VA. VA would be authorized to use the Account to carry out the AIR Act; to cover property management and disposal costs incurred at VHA facilities; to cover costs associated with construction projects undertaken under the AIR Act; and other purposes the VA determines support the mission and operations of VA.

VA would be required to establish and include in the budget submission a consolidated budget justification display in support of the Account for each fiscal year that details the amount and nature of credits to and expenditures from the Account during the preceding fiscal year. VA would also be required to transmit to Congress a report containing an accounting of all the funds credited to and expended from the Account and any funds remaining in the Account. The Account would be required to be closed at the time and in the manner provided under section 1555 of title 31 U.S.C. and unobligated funds to be held by the Treasury until transferred to VA.

Section 207. Congressional consideration of Commission Report.

Section 207 would define certain expedited procedures for the Congressional consideration of the AIR Commission report.

Section 208. Other Matters.

Section 208 would require VA to publish any information transmitted or received by VA, the Commission, or the President regarding the AIR Act online within 24 hours. VA would be prohibited from pausing major or minor construction activities as a result of the AIR Act. VA would be authorized, after consulting with VSOs, to include a recommendation for a future AIR Commission or other capital asset realignment and management process in a budget submission.

Subtitle B - Other Infrastructure Matters

Sec. 211. Improvement to training of construction personnel.

Section 211 would require VA to implement a training and certification program for construction and facilities management personnel. VA would be required to create the training and certification program within one year of enactment, to ensure a majority of covered employees are certified within two years of enactment, and to ensure that all covered employees are certified as quickly as possible thereafter. VA would be required to model the training and certification program on existing curricula and certification programs in title 10 U.S.C. (namely, the existing Defense Acquisition Workforce Improvement Act program). VA would be authorized to provide the training in-person, online, provided by another Federal department or agency, or a combination of the above. VA would be authorized to offer one or more than one level of certification and to enter into a contract with an appropriate entity to provide the training

curriculum and certification. All VA employees who are members of occupational series relating to construction or facilities management or VA employees who award or administer contracts for major construction, minor construction, or non-recurring maintenance (including contract specialists or contracting officers' representatives) would be included.

Sec. 212. Review of enhanced use leases.

Section 212 would require the Office of Management and Budget to review each enhanced-use lease (EUL) before it goes into effect to determine whether it is in compliance with relevant statutes.

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

Section 213 would require VA to submit a report to Congress on the care provided to veterans in Pacific territories, to include whether it would be feasible for VA to establish a medical facility in any Pacific territory that does not contain such a facility.

Title III - Improvements to Recruitment of Health Care Professionals

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

Section 301 would provide scholarships to medical students in exchange for service to VA. A minimum of 50 two to four year scholarships for medical and dental students would be required so long as the shortage of those positions exceed 500. Once the number falls below 500, the minimum number of scholarships provided annually would be at least ten percent of the number of positions deemed in shortage. The obligation requirement for the scholarship is successful completion of residency training leading to board eligibility in a specialty and 18 months of clinical service at a VA facility for each year of scholarship support. This section would also authorize VA to provide preference to veterans and require VA to conduct annual advertising to educational institutions.

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

Section 302 would increase the amount of education debt reduction available through the Education Debt Reduction Program from $120,000 to $200,000 over five years and $24,000 to $40,000 annually.

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

Section 303 would establish a new loan repayment program for medical or osteopathic student educational loans for newly graduated medical students, or residents with at least 2 years of training remaining, who are training in specialties deemed by VA to be experiencing a shortage.

The loan repayment would be $40,000 per year for a maximum of $160,000. In exchange for the loan repayment, the recipient would agree to obtain a license to practice medicine, complete training leading to board eligibility in a specialty, and to serve in clinical practice at a VA facility for a period of 12 months for each $40,000 of loan repayment with a minimum of 24 months of obligated service.

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

Section 304 would establish a pilot program for supporting four years of medical school education costs for two veterans at each of the five Teague-Cranston Schools and the four traditional black medical schools. The covered medical schools would include Texas A&M College of Medicine, Quillen College of Medicine at East Tennessee State University, Boonshoft School of Medicine at Wright State University, Edwards School Medicine at Marshall University, the University of South Carolina School of Medicine, Drew University of Medicine and Science, Howard University of Medicine, Meharry Medical College, and Morehouse School of Medicine.

The medical schools that opt to participate in the program would be required to reserve two seats each in the class of 2019. Eligible veteran scholarship recipients would be those within ten years of military discharge who are not eligible for GI Bill benefits but who meet the minimum admission requirement for medical school and apply for the entering class of 2019. The scholarship recipients would agree to successfully complete medical school, obtain a license to practice medicine, complete post-graduate training leading to board eligibility in a specialty applicable to VA, and after training, serve in clinical practice at a VA facility for four years.

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

Section 305 would repeal the recruitment, retention, and relocation bonus offset from the Comprehensive Addiction and Recovery Act (P.L. 114-198).

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

Section 306 would require VA to ensure that clinical staff working at Vet Centers are eligible to participate in the Education Debt Reduction Program.

Title IV - Health Care in Underserved Areas

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

Section 401 would require VA to: (1) develop criteria to designate VA medical facilities as underserved facilities; (2) consider a number of factors with respect to such facilities, including the ratio of veterans to providers; the range of specialties covered; whether the local community

is medically underserved; the type, number, and age of open consults; and whether the facility is meeting VA's wait time goals; (3) perform an analysis not less than annually to determine which facilities qualify as underserved; and (4) submit a plan to Congress, within one year of enactment and not less frequently than annually, to address underserved facilities.

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

Section 402 would require VA to carry out a three year pilot program to furnish mobile deployment teams of medical personnel to underserved facilities and to consider the medical positons of greatest need at such facilities and the size and composition of teams to be deployed. VA would be required to use the analysis required under section 401 to form the mobile deployment teams and required to report to Congress on VA's progress with implementing the pilot program and recommendations with respect to extending or expanding the pilot and making it permanent.

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

Section 403 would require VA to establish a pilot program to establish medical residency programs at covered facilities, including VA facilities, a facility operated by an Indian tribe or tribal organization, an Indian Health Service facility, a FQHC, or a DOD facility. It would also require VA to consider a number of factors with respect to clinical need for providers when determining facilities to place residents and to report regularly to Congress on the implementation of the pilot.

Title V - Other Matters

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

Section 501 would require VA to submit an annual report to Congress on performance awards and bonuses presented to Regional Office Directors, VAMC Directors, VISN Directors, and SES positions, including the amount of each award or bonus, the job title of the individual receiving the award or bonus, and the location where each individual works.

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

Section 502 of the bill would stipulate that a VA podiatrist is eligible to be appointed to a supervisory position to the same degree that a VA physician is eligible to be appointed to such a position. To ensure appropriate supervision of specialty providers within the VA healthcare system, section 502 of the bill would also require VA to work with appropriate stakeholders to establish standards to ensure that specialists appointed to supervisory positions do not provide direct clinical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties. Further, section 502 of the bill would make Doctors of Podiatric Medicine (DPMs) equal to Doctors of Osteopathy (DOs) and VA Medical Doctors (MDs) in terms of pay within the VA healthcare system.

Sec. 503. Definition of major medical facility project.

Section 503 would modify the definition of a VA major medical facility project as a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of $20 million (was previously $10 million).

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

Section 504 would authorize a VA major medical facility projects in Livermore, California, in an amount not to exceed $117.3 million.

Sec. 505. Department of Veterans Affairs personnel transparency.

Section 505 would require VA to make information regarding vacancies, accessions and separation actions, new hires, and personnel encumbering positions publically available on a VA website; require an Inspector General review of the website on a semi-annual basis; and require VA to report to Congress annually on the steps VA is taking to achieve full staffing capacity, including the amount of additional funds necessary to enable VA to reach full staffing capacity.

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

Section 506 would require VA to carry out a program to place at least 2 peer specialists within patient aligned care teams in certain VAMCs to promote the use and integration of services for mental health, substance use disorder, and behavioral health in a primary care setting.

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

Section 507 of the bill would create a two-year pilot program under which VA will increase the use of medical scribes in emergency department and specialty care settings at 10 VA medical centers. To provide transparency on staffing methodology for medical scribes at the Department, this pilot would have half of the participating scribes be employed by the Department, with half employed under contract with a private-sector provider of medical scribes. Under this legislation, VA would be required to report to Congress every 180 days regarding the effects the pilot program has had on provider efficiency, patient satisfaction, average wait time, the number of patients seen per day and the amount of time required to train an employee to perform medical scribe functions under the pilot program. A report from the Comptroller General is also required not more than 90 days after the conclusion of the pilot.

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

Section 508 would extend VA's authority to collect certain funding fees for housing loans guaranteed by the VA through September 30, 2028.

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

Section 509 would extend current eligibility restrictions for recipients of a VA pension who receive Medicaid-covered nursing home care through September 30, 2028.

Sec. 510. Appropriation of amounts.

Section 510 would authorize and appropriate $5.2 billion to the Veterans Choice Fund.

Sec. 511. Technical correction.

Section 511 would redesignate section 1712I of title 38 U.S.C. as section 1720I of title 38 U.S.C.