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TITLE 38, UNITED STATES CODE

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PART II—GENERAL BENEFITS

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SUBCHAPTER I—GENERAL

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[§ 1703. Contracts for hospital care and medical services in non-Department facilities

[(a) When Department facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or

services required, the Secretary, as authorized in section 1710 of this title, may contract with non-Department facilities in order to furnish any of the following:

[(1) Hospital care or medical services to a veteran for the treatment of—

[(A) a service-connected disability;

[(B) a disability for which a veteran was discharged or released from the active military, naval, or air service; or

[(C) a disability of a veteran who has a total disability permanent in nature from a service-connected disability.

[(2) Medical services for the treatment of any disability of—

[(A) a veteran described in section 1710(a)(1)(B) of this title;

[(B) a veteran who (i) has been furnished hospital care, nursing home care, domiciliary care, or medical services, and (ii) requires medical services to complete treatment incident to such care or services; or

[(C) a veteran described in section 1710(a)(2)(E) of this title, or a veteran who is in receipt of increased pension, or additional compensation or allowances based on the need of regular aid and attendance or by reason of being permanently housebound (or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance), if the Secretary has determined, based on an examination by a physician employed by the Department (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in Department facilities.

[(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a Department facility or nursing home care under section 1720 of this title until such time following the furnishing of care in the non-Department facility as the veteran can be safely transferred to a Department facility.

[(4) Hospital care for women veterans.

[(5) Hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State (other than the Commonwealth of Puerto Rico) not contiguous to the contiguous States, except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense of the Department in Government and non-Department facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the furnishing of medical services for veterans hospitalized or treated by the Department within the 48 contiguous States and the Commonwealth of Puerto Rico.

[(6) Diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent Department out-patient clinics to obviate the need for hospital admission.

[(7) Outpatient dental services and treatment, and related dental appliances, for a veteran described in section 1712(a)(1)(F) of this title.

[(8) Diagnostic services (on an inpatient or outpatient basis) for observation or examination of a person to determine eligibility for a benefit or service under laws administered by the Secretary.

[(b) In the case of any veteran for whom the Secretary contracts to furnish care or services in a non-Department facility pursuant to a provision of subsection (a) of this section, the Secretary shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.

[(c) The Secretary shall include in the budget documents which the Secretary submits to Congress for any fiscal year a detailed report on the furnishing of contract care and services during the most recently completed fiscal year under this section, sections 1712A, 1720, 1720A, 1724, and 1732 of this title, and section 115 of the Veterans' Benefits and Services Act of 1988 (Public Law 100-322; 102 Stat. 501).

[(d)(1) The Secretary shall conduct a program of recovery audits for fee basis contracts and other medical services contracts for the care of veterans under this section, and for beneficiaries under sections 1781, 1782, and 1783 of this title, with respect to overpayments resulting from processing or billing errors or fraudulent charges in payments for non-Department care and services. The program shall be conducted by contract.

[(2) Amounts collected, by setoff or otherwise, as the result of an audit under the program conducted under this subsection shall be available, without fiscal year limitation, for the purposes

for which funds are currently available to the Secretary for medical care and for payment to a contractor of a percentage of the amount collected as a result of an audit carried out by the contractor.

[(3) The Secretary shall allocate all amounts collected under this subsection with respect to a designated geographic service area of the Veterans Health Administration, net of payments to the contractor, to that region.

[(4) The authority of the Secretary under this subsection terminates on September 30, 2020.]

§ 1703. Veterans Community Care Program

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

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

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

(B) Ensuring continuity of care and services.

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

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

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

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

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

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

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

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

(2) The Department of Defense.

(3) The Indian Health Service.

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

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

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

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

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

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

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

(iii) either—

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

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

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

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

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

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

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

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

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

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

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

(E) Whether the covered veteran faces an unusual or excessive burden to access hospital care, medical services, or extended care services from the Department medical facility where a covered veteran seeks hospital care, medical services, or extended care services, which shall include consideration of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the entity—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) TREATMENT OF OTHER HEALTH PLAN CONTRACTS.—In any case in which a covered veteran is furnished hospital care, medical services, or extended care services under this section for a non-service-connected disability described in subsection (a)(2) of section 1729 of this title, the Secretary

shall recover or collect reasonable charges for such care or services from a health plan contract described in section 1729 in accordance with such section.

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

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

(2) A covered veteran described in this paragraph—

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

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

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

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

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

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

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

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

(v) The cost of such care and services.

(2) In monitoring the hospital care, medical services, and extended care services furnished under this section, the Secretary shall do the following:

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

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

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

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

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

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

(vi) assess the timeliness of such networks in—

(I) accepting referrals; and

(II) scheduling and completing appointments.

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

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

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

(3) Not later than 540 days after the date of the enactment of the Caring for Our Veterans Act of 2018 and not less frequently than once each year thereafter, the Secretary shall submit to the

Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the information gathered under paragraph (2).

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

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

(o) DEFINITIONS.—In this section:

(1) The term "appropriate committees of Congress" means—

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

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

(2) The term "medical service line" means a clinic within a Department medical center.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) The Secretary may discontinue a Veterans Care Agreement with an eligible entity or provider at such time and upon such reasonable notice to the eligible entity or provider as may be specified in regulations prescribed under this section, if an official designated by the Secretary—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) PARITY OF TREATMENT.—Eligibility for hospital care, medical services, and extended care services furnished to any veteran pursuant to a Veterans Care Agreement shall be subject to the same terms as though provided in a facility of the Department, and provisions of this chapter appli-

cable 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.

§ 1703B. Access standards

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

(2) The Secretary shall ensure that the access standards established under paragraph (1) define such categories of care to cover all care and services within the medical benefits package of the Department of Veterans Affairs.

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

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

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

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

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

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

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

(1) conduct a review of such standards; and

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

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

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

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

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

(A) the requested care is clinically necessary; and

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

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

(i)(1) The term "appropriate committees of Congress" means—

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

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

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

§ 1703C. Standards for quality

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

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

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

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

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

(i) Timely care.

(ii) Effective care.

(iii) Safety, including, at a minimum, complications, readmissions, and deaths.

(iv) Efficiency.

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

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

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

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

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

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

(c)(1) The term "appropriate committees of Congress" means—

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

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

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

§ 1703D. Prompt payment standard

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) DEFINITIONS.—In this section:

(1) The term "appropriate committees of Congress" means—

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

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

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

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

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

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

§ 1703E. Center for Innovation for Care and Payment

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

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

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

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

(B) create cost savings for the Department.

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

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

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

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

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

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

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

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

(6)(A) Models tested under this section may not be designed in such a way that would allow the United States to recover or collect reasonable charges from a Federal health care program for care or services furnished by the Secretary to a veteran under pilot programs carried out under this section.

(B) In this paragraph, the term "Federal health care program" means—

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

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

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

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

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

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

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

(2) provided for information technology systems.

(e) NOTICE.—The Secretary shall—

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

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

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

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

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

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

(C) The reasons for such waiver or waivers.

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

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

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

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

(H) The estimated budget of the pilot program.

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

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

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

(i) which does not have a preamble; and

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

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

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

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

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

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

(iii)(I) Notwithstanding Rule XXII of the Standing Rules of the Senate, it is in order at any time after the third session day on which the Committee on Veterans' Affairs has reported or has been discharged from consideration of a joint resolution described in paragraph (C) (even though a previous motion to the same effect has been disagreed to) to move to proceed to the consideration of the joint resolution, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived. The motion to proceed is not debatable. The motion is not subject to a motion to postpone. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the resolution is agreed to, the joint resolution shall remain the unfinished business until disposed of.

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

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

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

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

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

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

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

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

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

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

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

(H) This subparagraph is enacted by Congress—

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

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

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

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

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

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

(ii) the Secretary submits to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report setting forth the amount of the additional expenditure and a justification for the additional expenditure; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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§ 1706A. Remediation of medical service lines

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

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

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

(3) Utilizing direct hiring authority.

(4) Providing improved training opportunities for staff.

(5) Acquiring improved equipment.

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

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

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

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

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

(1) submit to Congress an analysis of the remediation actions and costs of such actions taken with respect to each medical service line with respect to which the Secretary submitted an assessment and plan under paragraph (1) in the preceding year, including an update on the progress of each such medical service line in complying with the standards for quality and

timeliness established by the Secretary and any other actions the Secretary is undertaking to assist the medical service line in complying with standards for quality as established by the Secretary; and

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

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SUBCHAPTER II—HOSPITAL, NURSING HOME, OR DOMICILIARY CARE AND MEDICAL TREATMENT

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§ 1712. Dental care; drugs and medicines for certain disabled veterans; vaccines

(a)(1) Outpatient dental services and treatment, and related dental appliances, shall be furnished under this section only for a dental condition or disability—

(A) which is service-connected and compensable in degree;

(B) which is service-connected, but not compensable in degree, but only if—

(i) the dental condition or disability is shown to have been in existence at the time of the veteran's discharge or release from active military, naval, or air service;

(ii) the veteran had served on active duty for a period of not less than 180 days or, in the case of a veteran who served on active duty during the Persian Gulf War, 90 days immediately before such discharge or release;

(iii) application for treatment is made within 180 days after such discharge or release, except that (I) in the case of a veteran who reentered active military, naval, or air service within 90 days after the date of such veteran's prior discharge or release from such service, application may be made within 180 days from the date of such veteran's subsequent discharge or release from such service, and (II) if a disqualifying discharge or release has been corrected by competent authority, application may be made within 180 days after the date of correction; and

(iv) the veteran's certificate of discharge or release from active duty does not bear a certification that the veteran was provided, within the 90-day period immediately before the date of such discharge or release, a complete dental examination (including dental X-rays) and all appropriate dental services and treatment indicated by the examination to be needed;

(C) which is a service-connected dental condition or disability due to combat wounds or other service trauma, or of a former prisoner of war;

(D) which is associated with and is aggravating a disability resulting from some other disease or injury which was incurred in or aggravated by active military, naval, or air service;

(E) which is a non-service-connected condition or disability of a veteran for which treatment was begun while such veteran was receiving hospital care under this chapter and such services and treatment are reasonably necessary to complete such treatment;

(F) from which a veteran who is a former prisoner of war is suffering;

(G) from which a veteran who has a service-connected disability rated as total is suffering; or

(H) the treatment of which is medically necessary (i) in preparation for hospital admission, or (ii) for a veteran otherwise receiving care or services under this chapter.

(2) The Secretary concerned shall at the time a member of the Armed Forces is discharged or released from a period of active military, naval, or air service of not less than 180 days or, in the case of a veteran who served on active duty during the Persian Gulf War, 90 days provide to such member a written explanation of the provisions of clause (B) of paragraph (1) of this subsection and enter in the service records of the member a statement signed by the member acknowledging receipt of such explanation (or, if the member refuses to sign such statement, a certification from an officer designated for such purpose by the Secretary concerned that the member was provided such explanation).

(3) The total amount which the Secretary may expend for furnishing, during any twelve-month period, outpatient dental services, treatment, or related dental appliances to a veteran under this section through private facilities for which the Secretary has contracted **[**under clause (1), (2), or (5) of section 1703(a) of this title**]** *or entered an agreement* may not exceed $1,000 unless the Secretary determines, prior to the furnishing of such services, treatment, or appliances and based on an examination of the veteran by a dentist employed by the Department (or, in an area where no

such dentist is available, by a dentist conducting such examination under a contract or fee arrangement), that the furnishing of such services, treatment, or appliances at such cost is reasonably necessary.

(4)(A) Except as provided in subparagraph (B) of this paragraph, in any year in which the President's Budget for the fiscal year beginning October 1 of such year includes an amount for expenditures for contract dental care [under the provisions of this subsection and section 1703 of this title] during such fiscal year in excess of the level of expenditures made for such purpose during fiscal year 1978, the Secretary shall, not later than February 15 of such year, submit a report to the appropriate committees of the Congress justifying the requested level of expenditures for contract dental care and explaining why the application of the criteria prescribed in section 1703 of this title for contracting with private facilities and in the second sentence of section 1710(c) of this title for furnishing incidental dental care to hospitalized veterans will not preclude the need for expenditures for contract dental care in excess of the fiscal year 1978 level of expenditures for such purpose. In any case in which the amount included in the President's Budget for any fiscal year for expenditures for contract dental care under such provisions is not in excess of the level of expenditures made for such purpose during fiscal year 1978 and the Secretary determines after the date of submission of such budget and before the end of such fiscal year that the level of expenditures for such contract dental care during such fiscal year will exceed the fiscal year 1978 level of expenditures, the Secretary shall submit a report to the appropriate committees of the Congress containing both a justification (with respect to the projected level of expenditures for such fiscal year) and an explanation as required in the preceding sentence in the case of a report submitted pursuant to such sentence. Any report submitted pursuant to this paragraph shall include a comment by the Secretary on the effect of the application of the criteria prescribed in the second sentence of section 1710(c) of this title for furnishing incidental dental care to hospitalized veterans.

(B) A report under subparagraph (A) of this paragraph with respect to a fiscal year is not required if, in the documents submitted by the Secretary to the Congress in justification for the amounts included for Department programs in the President's Budget, the Secretary specifies with respect to contract dental care described in such subparagraph—

(i) the actual level of expenditures for such care in the fiscal year preceding the fiscal year in which such Budget is submitted;

(ii) a current estimate of the level of expenditures for such care in the fiscal year in which such Budget is submitted; and

(iii) the amount included in such Budget for such care.

(b) Dental services and related appliances for a dental condition or disability described in paragraph (1)(B) of subsection (a) shall be furnished on a one-time completion basis, unless the services rendered on a one-time completion basis are found unacceptable within the limitations of good professional standards, in which event such additional services may be afforded as are required to complete professionally acceptable treatment.

(c) Dental appliances, wheelchairs, artificial limbs, trusses, special clothing, and similar appliances to be furnished by the Secretary under this section may be procured by the Secretary either by purchase or by manufacture, whichever the Secretary determines may be advantageous and reasonably necessary.

(d) The Secretary shall furnish to each veteran who is receiving additional compensation or allowance under chapter 11 of this title, or increased pension as a veteran of a period of war, by reason of being permanently housebound or in need of regular aid and attendance, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran. The Secretary shall continue to furnish such drugs and medicines so ordered to any such veteran in need of regular aid and attendance whose pension payments have been discontinued solely because such veteran's annual income is greater than the applicable maximum annual income limitation, but only so long as such veteran's annual income does not exceed such maximum annual income limitation by more than $1,000.

(e) In order to assist the Secretary of Health and Human Services in carrying out national immunization programs under other provisions of law, the Secretary may authorize the administration of immunizations to eligible veterans who voluntarily request such immunizations in connection with the provision of care for a disability under this chapter in any Department health care facility. Any such immunization shall be made using vaccine furnished by the Secretary of Health and Human Services at no cost to the Department. For such purpose, notwithstanding any other

provision of law, the Secretary of Health and Human Services may provide such vaccine to the Department at no cost. Section 7316 of this title shall apply to claims alleging negligence or malpractice on the part of Department personnel granted immunity under such section.

§ 1712A. Eligibility for readjustment counseling and related mental health services

(a)(1)(A) Upon the request of any individual referred to in subparagraph (C), the Secretary shall furnish counseling, including by furnishing counseling through a Vet Center, to the individual—

(i) in the case of an individual referred to in clauses (i) through (iv) of subparagraph (C), to assist the individual in readjusting to civilian life; and

(ii) in the case of an individual referred to in clause (v) of such subparagraph who is a family member of a veteran or member described in such clause—

(I) in the case of a member who is deployed in a theater of combat operations or an area at a time during which hostilities are occurring in that area, during such deployment to assist such individual in coping with such deployment; and

(II) in the case of a veteran or member who is readjusting to civilian life, to the degree that counseling furnished to such individual is found to aid in the readjustment of such veteran or member to civilian life.

(B) Counseling furnished to an individual under subparagraph (A) may include a comprehensive individual assessment of the individual's psychological, social, and other characteristics to ascertain whether—

(i) in the case of an individual referred to in clauses (i) through (iv) of subparagraph (C), such individual has difficulties associated with readjusting to civilian life; and

(ii) in the case of an individual referred to in clause (v) of such subparagraph, such individual has difficulties associated with—

(I) coping with the deployment of a member described in subclause (I) of such clause; or

(II) readjustment to civilian life of a veteran or member described in subclause (II) of such clause.

(C) Subparagraph (A) applies to the following individuals:

(i) Any individual who is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who served on active duty in a theater of combat operations or an area at a time during which hostilities occurred in that area.

(ii) Any individual who is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who provided direct emergency medical or mental health care, or mortuary services to the causalities of combat operations or hostilities, but who at the time was located outside the theater of combat operations or area of hostilities.

(iii) Any individual who is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who engaged in combat with an enemy of the United States or against an opposing military force in a theater of combat operations or an area at a time during which hostilities occurred in that area by remotely controlling an unmanned aerial vehicle, notwithstanding whether the physical location of such veteran or member during such combat was within such theater of combat operations or area.

(iv) Any individual who received counseling under this section before the date of the enactment of the National Defense Authorization Act for Fiscal Year 2013.

(v) Any individual who is a family member of any—

(I) member of the Armed Forces, including a member of a reserve component of the Armed Forces, who is serving on active duty in a theater of combat operations or in an area at a time during which hostilities are occurring in that area; or

(II) veteran or member of the Armed Forces described in this subparagraph.

(2) Upon request of an individual described in paragraph (1)(C), the Secretary shall provide the individual a comprehensive individual assessment as described in paragraph (1)(B) as soon as practicable after receiving the request, but not later than 30 days after receiving the request.

(b)(1) If, on the basis of the assessment furnished under subsection (a) of this section, a licensed or certified mental health care provider employed by the Department (or, in areas where no such licensed or certified mental health care provider is available, a licensed or certified mental health care provider carrying out such function under a contract or fee arrangement with the Secretary) determines that the provision of mental health services to such veteran is necessary to facilitate the successful readjustment of the veteran to civilian life, such veteran shall, within the

limits of Department facilities, be furnished such services on an outpatient basis. For the purposes of furnishing such mental health services, the counseling furnished under subsection (a) of this section shall be considered to have been furnished by the Department as a part of hospital care. Any hospital care and other medical services considered necessary on the basis of the assessment furnished under subsection (a) of this section shall be furnished only in accordance with the eligibility criteria otherwise set forth in this chapter (including the eligibility criteria set forth in section 1784 of this title).

(2) Mental health services furnished under paragraph (1) of this subsection may, if determined to be essential to the effective treatment and readjustment of the veteran, include such consultation, counseling, training, services, and expenses as are described in sections 1782 and 1783 of this title.

(c) Upon receipt of a request for counseling under this section from any individual who has been discharged or released from active military, naval, or air service but who is not otherwise eligible for such counseling, the Secretary shall—

(1) provide referral services to assist such individual, to the maximum extent practicable, in obtaining mental health care and services from sources outside the Department; and

(2) if pertinent, advise such individual of such individual's rights to apply to the appropriate military, naval, or air service, and to the Department, for review of such individual's discharge or release from such service.

(d) The Under Secretary for Health may provide for such training of professional, paraprofessional, and lay personnel as is necessary to carry out this section effectively, and, in carrying out this section, may utilize the services of paraprofessionals, individuals who are volunteers working without compensation, and individuals who are veteran-students (as described in section 3485 of this title) in initial intake and screening activities.

(e)(1) In furnishing counseling and related mental health services under subsections (a) and (b) of this section, the Secretary shall have available the same authority to enter into contracts *or agreements* with private facilities that is available to the Secretary ❙(under sections 1703(a)(2) and 1710(a)(1)(B) of this title)❙ in furnishing medical services to veterans suffering from total service-connected disabilities.

(2) Before furnishing counseling or related mental health services described in subsections (a) and (b) of this section through a contract facility, as authorized by this subsection, the Secretary shall approve (in accordance with criteria which the Secretary shall prescribe by regulation) the quality and effectiveness of the program operated by such facility for the purpose for which the counseling or services are to be furnished.

(3) The authority of the Secretary to enter into contracts under this subsection shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

(f) The Secretary, in cooperation with the Secretary of Defense, shall take such action as the Secretary considers appropriate to notify veterans who may be eligible for assistance under this section of such potential eligibility.

(g) In carrying out this section and in furtherance of the Secretary's responsibility to carry out outreach activities under chapter 63 of this title, the Secretary may provide for and facilitate the participation of personnel employed by the Secretary to provide services under this section in recreational programs that are—

(1) designed to encourage the readjustment of veterans described in subsection (a)(1)(C); and

(2) operated by any organization named in or approved under section 5902 of this title.

(h) For the purposes of this section:

(1) The term "Vet Center" means a facility which is operated by the Department for the provision of services under this section and which is situated apart from Department general health care facilities.

(2) The term "Department general health-care facility" means a health-care facility which is operated by the Department for the furnishing of health-care services under this chapter, not limited to services provided through the program established under this section.

(3) The term "family member", with respect to a veteran or member of the Armed Forces, means an individual who—

(A) is a member of the family of the veteran or member, including—

(i) a parent;

(ii) a spouse;

(iii) a child;
(iv) a step-family member; and
(v) an extended family member; or

(B) lives with the veteran or member but is not a member of the family of the veteran or member.

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§ 1720G. Assistance and support services for caregivers

(a) PROGRAM OF COMPREHENSIVE ASSISTANCE FOR FAMILY CAREGIVERS.—(1)(A) The Secretary shall establish a program of comprehensive assistance for family caregivers of eligible veterans.

(B) The Secretary shall only provide support under the program required by subparagraph (A) to a family caregiver of an eligible veteran if the Secretary determines it is in the best interest of the eligible veteran to do so.

(2) For purposes of this subsection, an eligible veteran is any individual who—

(A) is a veteran or member of the Armed Forces undergoing medical discharge from the Armed Forces;

[(B) has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001; and**]**

(B) for assistance provided under this subsection—

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

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

(I) on or before May 7, 1975; or

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

(iii) after the date that is two years after the date on which the Secretary submits to Congress the certification described in clause (i), has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service; and

(C) is in need of personal care services because of—

(i) an inability to perform one or more activities of daily living;

(ii) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury**[**; or**]***;*

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

[(iii)**]** *(iv)* such other matters as the Secretary considers appropriate.

(3)(A) As part of the program required by paragraph (1), the Secretary shall provide to family caregivers of eligible veterans the following assistance:

(i) To each family caregiver who is approved as a provider of personal care services for an eligible veteran under paragraph (6)—

(I) such instruction, preparation, and training as the Secretary considers appropriate for the family caregiver to provide personal care services to the eligible veteran;

(II) ongoing technical support consisting of information and assistance to address, in a timely manner, the routine, emergency, and specialized caregiving needs of the family caregiver in providing personal care services to the eligible veteran;

(III) counseling; and

(IV) lodging and subsistence under section 111(e) of this title.

(ii) To each family caregiver who is designated as the primary provider of personal care services for an eligible veteran under paragraph (7)—

(I) the assistance described in clause (i);

(II) such mental health services as the Secretary determines appropriate;

(III) respite care of not less than 30 days annually, including 24-hour per day care of the veteran commensurate with the care provided by the family caregiver to permit extended respite;

(IV) medical care under section 1781 of this title[; and];

(V) a monthly personal caregiver stipend[.]*; and*

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

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

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

(B) Respite care provided under subparagraph (A)(ii)(III) shall be medically and age-appropriate and include in-home care.

(C)(i) The amount of the monthly personal caregiver stipend provided under subparagraph (A)(ii)(V) shall be determined in accordance with a schedule established by the Secretary that specifies stipends based upon the amount and degree of personal care services provided.

(ii) The Secretary shall ensure, to the extent practicable, that the schedule required by clause (i) specifies that the amount of the monthly personal caregiver stipend provided to a primary provider of personal care services for the provision of personal care services to an eligible veteran is not less than the monthly amount a commercial home health care entity would pay an individual in the geographic area of the eligible veteran to provide equivalent personal care services to the eligible veteran.

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

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

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

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

[(iii)] *(iv)* If personal care services are not available from a commercial home health entity in the geographic area of an eligible veteran, the amount of the monthly personal caregiver stipend payable under the schedule required by clause (i) with respect to the eligible veteran shall be determined by taking into consideration the costs of commercial providers of personal care services in providing personal care services in geographic areas other than the geographic area of the eligible veteran with similar costs of living.

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

(4) An eligible veteran and a family member of the eligible veteran seeking to participate in the program required by paragraph (1) shall jointly submit to the Secretary an application therefor in such form and in such manner as the Secretary considers appropriate.

(5) For each application submitted jointly by an eligible veteran and family member, the Secretary shall evaluate *(in collaboration with the primary care team for the eligible veteran to the maximum extent practicable)*—

(A) the eligible veteran—

(i) to identify the personal care services required by the eligible veteran; and

(ii) to determine whether such requirements could be significantly or substantially satisfied through the provision of personal care services from a family member; and

(B) the family member to determine the amount of instruction, preparation, and training, if any, the family member requires to provide the personal care services required by the eligible veteran—

(i) as a provider of personal care services for the eligible veteran; and

(ii) as the primary provider of personal care services for the eligible veteran.

(6)(A) The Secretary shall provide each family member of an eligible veteran who makes a joint application under paragraph (4) the instruction, preparation, and training determined to be required by such family member under paragraph (5)(B).

(B) Upon the successful completion by a family member of an eligible veteran of instruction, preparation, and training under subparagraph (A), the Secretary shall approve the family member as a provider of personal care services for the eligible veteran.

(C) The Secretary shall, subject to regulations the Secretary shall prescribe, provide for necessary travel, lodging, and per diem expenses incurred by a family member of an eligible veteran in undergoing instruction, preparation, and training under subparagraph (A).

(D) If the participation of a family member of an eligible veteran in instruction, preparation, and training under subparagraph (A) would interfere with the provision of personal care services to the eligible veteran, the Secretary shall, subject to regulations as the Secretary shall prescribe and in consultation with the veteran, provide respite care to the eligible veteran during the provision of such instruction, preparation, and training to the family member so that the family member can participate in such instruction, preparation, and training without interfering with the provision of such services to the eligible veteran.

(7)(A) For each eligible veteran with at least one family member who is described by subparagraph (B), the Secretary shall designate one family member of such eligible veteran as the primary provider of personal care services for such eligible veteran.

(B) A primary provider of personal care services designated for an eligible veteran under subparagraph (A) shall be selected from among family members of the eligible veteran who—

(i) are approved under paragraph (6) as a provider of personal care services for the eligible veteran;

(ii) elect to provide the personal care services to the eligible veteran that the Secretary determines the eligible veteran requires under paragraph (5)(A)(i);

(iii) have the consent of the eligible veteran to be the primary provider of personal care services for the eligible veteran; and

(iv) are considered by the Secretary as competent to be the primary provider of personal care services for the eligible veteran.

(C) An eligible veteran receiving personal care services from a family member designated as the primary provider of personal care services for the eligible veteran under subparagraph (A) may, in accordance with procedures the Secretary shall establish for such purposes, revoke consent with respect to such family member under subparagraph (B)(iii).

(D) If a family member designated as the primary provider of personal care services for an eligible veteran under subparagraph (A) subsequently fails to meet any requirement set forth in subparagraph (B), the Secretary—

(i) shall immediately revoke the family member's designation under subparagraph (A); and

(ii) may designate, in consultation with the eligible veteran, a new primary provider of personal care services for the eligible veteran under such subparagraph.

(E) The Secretary shall take such actions as may be necessary to ensure that the revocation of a designation under subparagraph (A) with respect to an eligible veteran does not interfere with the provision of personal care services required by the eligible veteran.

(8) If an eligible veteran lacks the capacity to make a decision under this subsection, the Secretary may, in accordance with regulations and policies of the Department regarding appointment of guardians or the use of powers of attorney, appoint a surrogate for the eligible veteran who may make decisions and take action under this subsection on behalf of the eligible veteran.

(9)(A) The Secretary shall monitor the well-being of each eligible veteran receiving personal care services under the program required by paragraph (1).

(B) The Secretary shall document each finding the Secretary considers pertinent to the appropriate delivery of personal care services to an eligible veteran under the program.

(C) The Secretary shall establish procedures to ensure appropriate follow-up regarding findings described in subparagraph (B). Such procedures may include the following:

(i) Visiting an eligible veteran in the eligible veteran's home to review directly the quality of personal care services provided to the eligible veteran.

(ii) Taking such corrective action with respect to the findings of any review of the quality of personal care services provided an eligible veteran as the Secretary considers appropriate, which may include—

(I) providing additional training to a family caregiver; and

(II) suspending or revoking the approval of a family caregiver under paragraph (6) or the designation of a family caregiver under paragraph (7).

(10) The Secretary shall carry out outreach to inform eligible veterans and family members of eligible veterans of the program required by paragraph (1) and the benefits of participating in the program.

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

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

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

(b) PROGRAM OF GENERAL CAREGIVER SUPPORT SERVICES.—(1) The Secretary shall establish a program of support services for caregivers of covered veterans who are enrolled in the health care system established under section 1705(a) of this title (including caregivers who do not reside with such veterans).

(2) For purposes of this subsection, a covered veteran is any individual who needs personal care services because of—

(A) an inability to perform one or more activities of daily living;

(B) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury; or

(C) such other matters as the Secretary shall specify.

(3)(A) The support services furnished to caregivers of covered veterans under the program required by paragraph (1) shall include the following:

(i) Services regarding the administering of personal care services, which, subject to subparagraph (B), shall include—

(I) educational sessions made available both in person and on an Internet website;

(II) use of telehealth and other available technologies; and

(III) teaching techniques, strategies, and skills for caring for a disabled veteran;

(ii) Counseling and other services under section 1782 of this title.

(iii) Respite care under section 1720B of this title that is medically and age appropriate for the veteran (including 24-hour per day in-home care).

(iv) Information concerning the supportive services available to caregivers under this subsection and other public, private, and nonprofit agencies that offer support to caregivers.

(B) If the Secretary certifies to the Committees on Veterans' Affairs of the Senate and the House of Representatives that funding available for a fiscal year is insufficient to fund the provision of services specified in one or more subclauses of subparagraph (A)(i), the Secretary shall not be required under subparagraph (A) to provide the services so specified in the certification during the period beginning on the date that is 180 days after the date the certification is received by the Committees and ending on the last day of the fiscal year.

(4) In providing information under paragraph (3)(A)(iv), the Secretary shall collaborate with the Assistant Secretary for Aging of the Department of Health and Human Services in order to provide caregivers access to aging and disability resource centers under the Administration on Aging of the Department of Health and Human Services.

(5) In carrying out the program required by paragraph (1), the Secretary shall conduct outreach to inform covered veterans and caregivers of covered veterans about the program. The outreach shall include an emphasis on covered veterans and caregivers of covered veterans living in rural areas.

(c) CONSTRUCTION.—(1) A decision by the Secretary under this section affecting the furnishing of assistance or support shall be considered a medical determination.

(2) Nothing in this section shall be construed to create—

(A) an employment relationship between the Secretary and an individual in receipt of assistance or support under this section; or

(B) any entitlement to any assistance or support provided under this section.

(d) DEFINITIONS.—In this section:

(1) The term "caregiver", with respect to an eligible veteran under subsection (a) or a covered veteran under subsection (b), means an individual who provides personal care services to the veteran.

(2) The term "family caregiver", with respect to an eligible veteran under subsection (a), means a family member who is a caregiver of the veteran.

(3) The term "family member", with respect to an eligible veteran under subsection (a), means an individual who—

(A) is a member of the family of the veteran, including—

(i) a parent;

(ii) a spouse;

(iii) a child;

(iv) a step-family member; and

(v) an extended family member; or

(B) lives with the veteran but is not a member of the family of the veteran.

(4) The term "personal care services", with respect to an eligible veteran under subsection (a) or a covered veteran under subsection (b), means services that provide the veteran the following:

(A) Assistance with one or more **[**independent**]** activities of daily living.

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

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

[(B)**]** *(D)* Any other non-institutional extended care (as such term is used in section 1701(6)(E) of this title).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out the programs required by subsections (a) and (b)—

(1) $60,000,000 for fiscal year 2010;

(2) $1,542,000,000 for the period of fiscal years 2011 through 2015;

(3) $625,000,000 for fiscal year 2016;

(4) $734,628,000 for fiscal year 2017; and

(5) $839,828,000 for each of fiscal years 2018 and 2019.

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§ [1712I.] *1720I*. Mental and behavioral health care for certain former members of the Armed Forces

(a) IN GENERAL.—The Secretary shall furnish to former members of the Armed Forces described in subsection (b)—

(1) an initial mental health assessment; and

(2) the mental healthcare or behavioral healthcare services authorized under this chapter that are required to treat the mental or behavioral health care needs of the former service members, including risk of suicide or harming others.

(b) ELIGIBLE INDIVIDUALS.—A former member of the Armed Forces described in this subsection is an individual who—

(1) is a former member of the Armed Forces, including the reserve components;

(2) while serving in the active military, naval, or air service, was discharged or released therefrom under a condition that is not honorable but not—

(A) a dishonorable discharge; or

(B) a discharge by court-martial;

(3) is not otherwise eligible to enroll in the health care system established by section 1705 of this title; and

(4)(A)(i) served in the Armed Forces for a period of more than 100 cumulative days; and

(ii) was deployed in a theater of combat operations, in support of a contingency operation, or in an area at a time during which hostilities are occurring in that area during such service, including by controlling an unmanned aerial vehicle from a location other than such theater or area; or

(B) while serving in the Armed Forces, was the victim of a physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment (as defined in section 1720D(f) of this title).

(c) NON-DEPARTMENT CARE.—(1) In furnishing mental or behavioral health care services to an individual under this section, the Secretary may provide such mental or behavioral health care services at a non- Department facility if—

(A) in the judgment of a mental health professional employed by the Department, the receipt of mental or behavioral health care services by that individual in facilities of the Department would be clinically inadvisable; or

(B) facilities of the Department are not capable of furnishing such mental or behavioral health care services to that individual economically because of geographical inaccessibility.

(2) The Secretary shall carry out paragraph (1) pursuant to section 1703 of this title or any other provision of law authorizing the Secretary to enter into contracts or agreements to furnish hospital care and medical services to veterans at non-Department facilities.

(d) SETTING AND REFERRALS.—In furnishing mental and behavioral health care services to individuals under this section, the Secretary shall—

(1) seek to ensure that such services are furnished in settings that are therapeutically appropriate, taking into account the circumstances that resulted in the need for such services; and

(2) provide referral services to assist former members who are not eligible for services under this chapter to obtain services from sources outside the Department.

(e) INFORMATION.—The Secretary shall provide information on the mental and behavioral health care services available under this section. Efforts by the Secretary to provide such information—

(1) shall include notification of each eligible individual described in subsection (b) about the eligibility of the individual for covered mental and behavioral health care under this section not later than the later of—

(A) 180 days after the date of the enactment of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018; or

(B) 180 days after the date on which the individual was discharged or released from the active military, naval, or air service;

(2) shall include availability of a toll-free telephone number (commonly referred to as an 800 number);

(3) shall ensure that information about the mental health care services available under this section—

(A) is revised and updated as appropriate;

(B) is made available and visibly posted at appropriate facilities of the Department; and

(C) is made available to State veteran agencies and through appropriate public information services; and

(4) shall include coordination with the Secretary of Defense seeking to ensure that members of the Armed Forces and individuals who are being separated from active military, naval, or air service are provided appropriate information about programs, requirements, and procedures for applying for mental health care services under this section.

(f) ANNUAL REPORTS.—(1) Not less frequently than once each year, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the mental and behavioral health care services provided under this section.

(2) Each report submitted under paragraph (1) shall include, with respect to the year preceding the submittal of the report, the following:

(A) The number of eligible individuals who were furnished mental or behavioral health care services under this section, disaggregated by the number of men who received such services and the number of women who received such services.

(B) The number of individuals who requested an initial mental health assessment under subsection (a)(1).

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

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SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

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§ 1725A. Access to walk-in care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) WALK-IN CARE DEFINED.—In this section, the term "walk-in care" means non-emergent care provided by a qualifying non-Department entity or provider that furnishes episodic care and not longitudinal management of conditions and is otherwise defined through regulations the Secretary shall promulgate.

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§ 1729. Recovery by the United States of the cost of certain care and services

(a)**[**(1) Subject to the provisions of this section, in any case in which a veteran is furnished 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 reasonable charges for such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the 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 by a department or agency of the United States.**]** *(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.*

(2) Paragraph (1) of this subsection applies to a non-service-connected disability—

(A) that is incurred incident to [the veteran's] *the individual's* employment and that is covered under a workers' compensation law or plan that provides for payment for the cost of health care and services provided to [the veteran] *the individual* by reason of the disability;

(B) that is incurred as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations insurance;

(C) that is incurred as the result of a crime of personal violence that occurred in a State, or a political subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such crime;

[(D) that is incurred by a veteran—

[(i) who does not have a service-connected disability; and

[(ii) who is entitled to care (or payment of the expenses of care) under a health-plan contract; or]

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

(E) for which care and services are furnished before September 30, 2019, under this chapter to a veteran who—

(i) has a service-connected disability; and

(ii) is entitled to care (or payment of the expenses of care) under a health-plan contract.

(3) In the case of a health-plan contract that contains a requirement for payment of a deductible or copayment by [the veteran] *the individual*—

(A) [the veteran's] *the individual's* not having paid such deductible or copayment with respect to care or services furnished under this chapter shall not preclude recovery or collection under this section; and

(B) the amount that the United States may collect or recover under this section shall be reduced by the appropriate deductible or copayment amount, or both.

(b)(1) As to the right provided in subsection (a) of this section, the United States shall be subrogated to any right or claim that [the veteran] *the individual* (or [the veteran's] *the individual's* personal representative, successor, dependents, or survivors) may have against a third party.

(2)(A) In order to enforce any right or claim to which the United States is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by [the veteran] *the individual* (or [the veteran's] *the individual's* personal representative, successor, dependents, or survivors) against a third party.

(B) The United States may institute and prosecute legal proceedings against the third party if—

(i) an action or proceeding described in subparagraph (A) of this paragraph is not begun within 180 days after the first day on which care or services for which recovery is sought are furnished to [the veteran] *the individual* by the Secretary under this chapter;

(ii) the United States has sent written notice by certified mail to [the veteran] *the individual* at [the veteran's] *the individual's* last-known address (or to [the veteran's] *the individual's* personal representative or successor) of the intention of the United States to institute such legal proceedings; and

(iii) a period of 60 days has passed following the mailing of such notice.

(C) A proceeding under subparagraph (B) of this paragraph may not be brought after the end of the six-year period beginning on the last day on which the care or services for which recovery is sought are furnished.

(c)(1) The Secretary may compromise, settle, or waive any claim which the United States has under this section.

(2)(A) The Secretary, after consultation with the Comptroller General of the United States, shall prescribe regulations for the purpose of determining reasonable charges for care or services under subsection (a)(1) of this section. Any determination of such charges shall be made in accordance with such regulations.

(B) Such regulations shall provide that the reasonable charges for care or services sought to be recovered or collected from a third-party liable under a health-plan contract may not exceed the amount that such third party demonstrates to the satisfaction of the Secretary it would pay for

the care or services if provided by facilities (other than facilities of departments or agencies of the United States) in the same geographic area.

(C) Not later than 45 days after the date on which the Secretary prescribes such regulations (or any amendment to such regulations), the Comptroller General shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives the Comptroller General's comments on and recommendations regarding such regulations (or amendment).

(d) Any contract or agreement into which the Secretary enters with a person under section 3718 of title 31 for collection services to recover indebtedness owed the United States under this section shall provide, with respect to such services, that such person is subject to sections 5701 and 7332 of this title.

(e) **[**A veteran**]** *An individual* eligible for care or services under this chapter—

(1) may not be denied such care or services by reason of this section; and

(2) may not be required by reason of this section to make any copayment or deductible payment in order to receive such care.

(f) No law of any State or of any political subdivision of a State, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under section 1784 of this title.

(h)(1) Subject to paragraph (3) of this subsection, the Secretary shall make available medical records of **[**a veteran**]** *an individual* described in paragraph (2) of this subsection for inspection and review by representatives of the third party concerned for the sole purposes of permitting the third party to verify—

(A) that the care or services for which recovery or collection is sought were furnished to **[**the veteran**]** *the individual*; and

(B) that the provision of such care or services to **[**the veteran**]** *the individual* meets criteria generally applicable under the health-plan contract involved.

(2) **[**A veteran**]** *An individual* described in this paragraph is **[**a veteran**]** *an individual* who is a beneficiary of a health-plan contract under which recovery or collection is sought under this section from the third party concerned for the cost of the care or services furnished to **[**the veteran**]** *the individual*.

(3) Records shall be made available under this subsection under such conditions to protect the confidentiality of such records as the Secretary shall prescribe in regulations.

(i) For purposes of this section—

(1)(A) The term "health-plan contract" means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid.

(B) Such term does not include—

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

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

(iii) a workers' compensation law or plan described in subparagraph (A) of subsection (a)(2) of this section; or

(iv) a program, plan, or policy under a law described in subparagraph (B) or (C) of such subsection.

(2) The term "payment" includes reimbursement and indemnification.

(3) The term "third party" means—

(A) a State or political subdivision of a State;

(B) an employer or an employer's insurance carrier;

(C) an automobile accident reparations insurance carrier; or

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

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§ 1730B. Access to State prescription drug monitoring programs

(a) ACCESS TO PROGRAMS.—(1) Any licensed health care provider or delegate of such a provider shall be considered an authorized recipient or user for the purpose of querying and receiving data

from the national network of State-based prescription drug monitoring programs to support the safe and effective prescribing of controlled substances to covered patients.

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

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

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

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

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

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

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

(c) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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SUBCHAPTER V—PAYMENTS TO STATE HOMES

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§ 1745. Nursing home care, adult day health care, and medications for veterans with service-connected disabilities

(a)(1) The Secretary shall enter into a contract ❙(or agreement under section 1720(c)(1) of this title)❙ *(or an agreement)* with each State home for payment by the Secretary for nursing home care provided in the home, in any case in which such care is provided to any veteran as follows:

(A) Any veteran in need of such care for a service-connected disability.

(B) Any veteran who—

(i) has a service-connected disability rated at 70 percent or more; and

(ii) is in need of such care.

(2) Payment under each contract (or agreement) between the Secretary and a State home under paragraph (1) shall be based on a methodology, developed by the Secretary in consultation with the State home, to adequately reimburse the State home for the care provided by the State home under the contract (or agreement).

(3) Payment by the Secretary under paragraph (1) to a State home for nursing home care provided to a veteran described in that paragraph constitutes payment in full to the State home for such care furnished to that veteran.

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

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

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

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

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

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

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

(b) The Secretary shall furnish such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of illness or injury to any veteran as follows:

(1) Any veteran who—

(A) is not being provided nursing home care for which payment is payable under subsection (a); and

(B) is in need of such drugs and medicines for a service-connected disability.

(2) Any veteran who—

(A) has a service-connected disability rated at 50 percent or more;

(B) is not being provided nursing home care for which payment is payable under subsection (a); and

(C) is in need of such drugs and medicines.

(c) Any State home that requests payment or reimbursement for services provided to a veteran under this section shall provide to the Secretary such information as the Secretary considers necessary to identify each individual veteran eligible for payment under such section.

(d)(1) The Secretary shall enter into an agreement with each State home for payment by the Secretary for medical supervision model adult day health care provided to a veteran described in subsection (a)(1) on whose behalf the State home is not in receipt of payment for nursing home care from the Secretary.

(2)(A) Payment under each agreement between the Secretary and a State home under paragraph (1) for each veteran who receives medical supervision model adult day health care under such agreement shall be made at a rate established through regulations prescribed by the Secretary to adequately reimburse the State home for the care provided by the State home, including necessary transportation expenses.

(B) The Secretary shall consult with the State homes in prescribing regulations under subparagraph (A).

(C) The rate established through regulations under subparagraph (A) shall not take effect until the date that is 30 days after the date on which those regulations are published in the Federal Register.

(3) Payment by the Secretary under paragraph (1) to a State home for medical supervision model adult day health care provided to a veteran described in that paragraph constitutes payment in full to the State home for such care furnished to that veteran.

(4) In this subsection, the term "medical supervision model adult day health care" means adult day health care that includes the coordination of physician services, dental services, nursing services, the administration of drugs, and such other requirements as determined appropriate by the Secretary.

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SUBCHAPTER VIII—HEALTH CARE OF PERSONS OTHER THAN VETERANS

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§ 1788. Transplant procedures with live donors and related services

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

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

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

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CHAPTER 23—BURIAL BENEFITS

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§ 2303. Death in Department facility; plot allowance

(a)(1) When a veteran dies in a facility described in paragraph (2), the Secretary shall—

(A) pay the actual cost (not to exceed $700 (as increased from time to time under subsection (c))) of the burial and funeral or, within such limits, may make contracts for such services without regard to the laws requiring advertisement for proposals for supplies and services for the Department; and

(B) when such a death occurs in a State, transport the body to the place of burial in the same or any other State.

(2) A facility described in this paragraph is—

(A) a facility of the Department (as defined in section 1 701(3) of this title) to which the deceased was properly admitted for hospital, nursing home, or domiciliary care under section 1710 or 1711(a) of this title; or

(B) an institution at which the deceased veteran was, at the time of death, receiving—

(i) hospital care in accordance [with section 1703] *with sections 1703A, 8111, and 8153* of this title;

(ii) nursing home care under section 1720 of this title; or

(iii) nursing home care for which payments are made under section 1741 of this title.

(b) In addition to the benefits provided for under section 2302 of this title and subsection (a) of this section, in the case of a veteran who is eligible for burial in a national cemetery under section 2402 of this title and who is not buried in a national cemetery or other cemetery under the jurisdiction of the United States—

(1) if such veteran is buried (without charge for the cost of a plot or interment) in a cemetery, or a section of a cemetery, that (A) is used solely for the interment of persons who are (i) eligible for burial in a national cemetery, and (ii) members of a reserve component of the Armed Forces not otherwise eligible for such burial or former members of such a reserve component not otherwise eligible for such burial who are discharged or released from service under conditions other than dishonorable, and(B) is owned by a State or by an agency or political subdivision of a State, the Secretary shall pay to such State, agency, or political subdivision the sum of $700 (as increased from time to time under subsection (c)) as a plot or interment allowance for such veteran; and

(2) if such veteran is eligible for a burial allowance under section 2302 of this title or under subsection (a) of this section, or was discharged from the active military, naval, or air service for a disability incurred or aggravated in line of duty, and such veteran is buried in a cemetery, or a section of a cemetery, other than as described in clause (1) of this subsection, the Secretary shall pay a sum not exceeding $700 (as increased from time to time under subsection (c)) as a plot or interment allowance to such person as the Secretary prescribes, except that if any part of the plot or interment costs of a burial to which this clause applies has been paid or assumed by a State, an agency or political subdivision of a State, or a former employer of the deceased veteran, no claim for such allowance shall be allowed for more than the difference between the entire amount of the expenses incurred and the amount paid or assumed by any or all of the foregoing entities.

(c) With respect to any fiscal year, the Secretary shall provide a percentage increase (rounded to the nearest dollar) in the maximum amount of burial and funeral expenses payable under subsection (a) and in the maximum amount of the plot or interment allowance payable under subsection (b), equal to the percentage by which—

(1) the Consumer Price Index (all items, United States city average) for the 12-month period ending on the June 30 preceding the beginning of the fiscal year for which the increase is made, exceeds

(2) the Consumer Price Index for the 12-month period preceding the 12-month period described in paragraph (1).

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PART III—READJUSTMENT AND RELATED BENEFITS

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CHAPTER 37—HOUSING AND SMALL BUSINESS LOANS

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SUBCHAPTER III—ADMINISTRATIVE PROVISIONS

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§ 3729. Loan fee

(a) REQUIREMENT OF FEE.—(1) Except as provided in subsection (c), a fee shall be collected from each person obtaining a housing loan guaranteed, insured, or made under this chapter, and

each person assuming a loan to which section 3714 of this title applies. No such loan may be guaranteed, insured, made, or assumed until the fee payable under this section has been remitted to the Secretary.

(2) The fee may be included in the loan and paid from the proceeds thereof.

(b) DETERMINATION OF FEE.—(1) The amount of the fee shall be determined from the loan fee table in paragraph (2). The fee is expressed as a percentage of the total amount of the loan guaranteed, insured, or made, or, in the case of a loan assumption, the unpaid principal balance of the loan on the date of the transfer of the property.

(2) The loan fee table referred to in paragraph (1) is as follows:

LOAN FEE TABLE

Type of loan	Active duty veteran	Reservist	Other obligor
(A)(i) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710 (a) other than with 5-down or 10-down (closed before January 1, 2004)	2.00	2.75	NA
(A)(ii) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710 (a) other than with 5-down or 10-down (closed on or after January 1, 2004, and before October 1, 2004)	2.20	2.40	NA
(A)(iii) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710 (a) other than with 5-down or 10-down (closed on or after October 1, 2004, and before September 30, 【2027】 ***2028***)	2.15	2.40	NA
(A)(iv) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710 (a) other than with 5-down or 10-down (closed on or after September 30, 【2027】 ***2028***)	1.40	1.65	NA
(B)(i) Subsequent loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other subsequent loan described in section 3710 (a) (closed before September 30, 【2027】 ***2028***)	3.30	3.30	NA
(B)(ii) Subsequent loan described in section 3710 (a) to purchase or construct a dwelling with 0-down, or any other subsequent loan described in section 3710 (a) (closed on or after September 30, 【2027】 ***2028***)	1.25	1.25	NA
(C)(i) Loan described in section 3710 (a) to purchase or construct a dwelling with 5-down (closed before September 30, 【2027】 ***2028***)	1.50	1.75	NA
(C)(ii) Loan described in section 3710 (a) to purchase or construct a dwelling with 5-down (closed on or after September 30, 【2027】 ***2028***)	0.75	1.00	NA
(D)(i) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 10-down (closed before September 30, 【2027】 ***2028***)	1.25	1.50	NA
(D)(ii) Initial loan described in section 3710 (a) to purchase or construct a dwelling with 10-down (closed on or after September 30, 【2027】 ***2028***)	0.50	0.75	NA

LOAN FEE TABLE—Continued

Type of loan	Active duty veteran	Reservist	Other obligor
(E) Interest rate reduction refinancing loan	0.50	0.50	NA
(F) Direct loan under section 3711	1.00	1.00	NA
(G) Manufactured home loan under section 3712 (other than an interest rate reduction refinancing loan)	1.00	1.00	NA
(H) Loan to Native American veteran under section 3762 (other than an interest rate reduction refinancing loan)	1.25	1.25	NA
(I) Loan assumption under section 3714	0.50	0.50	0.50
(J) Loan under section 3733 (a)	2.25	2.25	2.25

(3) Any reference to a section in the "Type of loan" column in the loan fee table in paragraph (2) refers to a section of this title.

(4) For the purposes of paragraph (2):

(A) The term "active duty veteran" means any veteran eligible for the benefits of this chapter other than a Reservist.

(B) The term "Reservist" means a veteran described in section 3701 (b)(5)(A) of this title who is eligible under section 3702(a)(2)(E) of this title.

(C) The term "other obligor" means a person who is not a veteran, as defined in section 101 of this title or other provision of this chapter.

(D) The term "initial loan" means a loan to a veteran guaranteed under section 3710 or made under section 3711 of this title if the veteran has never obtained a loan guaranteed under section 3710 or made under section 3711 of this title.

(E) The term "subsequent loan" means a loan to a veteran, other than an interest rate reduction refinancing loan, guaranteed under section 3710 or made under section 3711 of this title if the veteran has previously obtained a loan guaranteed under section 3710 or made under section 3711 of this title.

(F) The term "interest rate reduction refinancing loan" means a loan described in section 3710(a)(8), 3710(a)(9)(B)(i), 3710(a)(11), 3712(a)(1)(F), or 3762(h) of this title.

(G) The term "0-down" means a downpayment, if any, of less than 5 percent of the total purchase price or construction cost of the dwelling.

(H) The term "5-down" means a downpayment of at least 5 percent or more, but less than 10 percent, of the total purchase price or construction cost of the dwelling.

(I) The term "10-down" means a downpayment of 10 percent or more of the total purchase price or construction cost of the dwelling.

(c) WAIVER OF FEE.—(1) A fee may not be collected under this section from a veteran who is receiving compensation (or who, but for the receipt of retirement pay or active service pay, would be entitled to receive compensation) or from a surviving spouse of any veteran (including a person who died in the active military, naval, or air service) who died from a service-connected disability.

(2)(A) A veteran described in subparagraph (B) shall be treated as receiving compensation for purposes of this subsection as of the date of the rating described in such subparagraph without regard to whether an effective date of the award of compensation is established as of that date.

(B) A veteran described in this subparagraph is a veteran who is rated eligible to receive compensation—

(i) as the result of a pre-discharge disability examination and rating; or

(ii) based on a pre-discharge review of existing medical evidence (including service medical and treatment records) that results in the issuance of a memorandum rating.

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PART IV—GENERAL ADMINISTRATIVE PROVISIONS

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CHAPTER 55—MINORS, INCOMPETENTS, AND OTHER WARDS

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§ 5503. Hospitalized veterans and estates of incompetent institutionalized veterans

(a)(1)(A) Where any veteran having neither spouse nor child is being furnished domiciliary care by the Department, no pension in excess of $90 per month shall be paid to or for the veteran for any period after the end of the third full calendar month following the month of admission for such care.

(B) Except as provided in subparagraph (D) of this paragraph, where any veteran having neither spouse nor child is being furnished nursing home care by the Department, no pension in excess of $90 per month shall be paid to or for the veteran for any period after the end of the third full calendar month following the month of admission for such care. Any amount in excess of $90 per month to which the veteran would be entitled but for the application of the preceding sentence shall be deposited in a revolving fund at the Department medical facility which furnished the veteran nursing care, and such amount shall be available for obligation without fiscal year limitation to help defray operating expenses of that facility.

(C) No pension in excess of $90 per month shall be paid to or for a veteran having neither spouse nor child for any period after the month in which such veteran is readmitted for care described in subparagraph (A) or (B) of this paragraph and furnished by the Department if such veteran is readmitted within six months of a period of care in connection with which pension was reduced pursuant to subparagraph (A) or (B) of this paragraph.

(D) In the case of a veteran being furnished nursing home care by the Department and with respect to whom subparagraph (B) of this paragraph requires a reduction in pension, such reduction shall not be made for a period of up to three additional calendar months after the last day of the third month referred to in such subparagraph if the Secretary determines that the primary purpose for the furnishing of such care during such additional period is for the Department to provide such veteran with a prescribed program of rehabilitation services, under chapter 17 of this title, designed to restore such veteran's ability to function within such veteran's family and community. If the Secretary determines that it is necessary, after such period, for the veteran to continue such program of rehabilitation services in order to achieve the purposes of such program and that the primary purpose of furnishing nursing home care to the veteran continues to be the provision of such program to the veteran, the reduction in pension required by subparagraph (B) of this paragraph shall not be made for the number of calendar months that the Secretary determines is necessary for the veteran to achieve the purposes of such program.

(2) The provisions of paragraph (1) shall also apply to a veteran being furnished such care who has a spouse but whose pension is payable under section 1521(b) of this title. In such a case, the Secretary may apportion and pay to the spouse, upon an affirmative showing of hardship, all or any part of the amounts in excess of the amount payable to the veteran while being furnished such care which would be payable to the veteran if pension were payable under section 1521(c) of this title.

(b) Notwithstanding any other provision of this section or any other provision of law, no reduction shall be made in the pension of any veteran for any part of the period during which the veteran is furnished hospital treatment, or institutional or domiciliary care, for Hansen's disease, by the United States or any political subdivision thereof.

(c) Where any veteran in receipt of an aid and attendance allowance described in subsection (r) or (t) of section 1114 of this title is hospitalized at Government expense, such allowance shall be discontinued from the first day of the second calendar month which begins after the date of the veteran's admission for such hospitalization for so long as such hospitalization continues. Any discontinuance required by administrative regulation, during hospitalization of a veteran by the Department, of increased pension based on need of regular aid and attendance or additional compensation based on need of regular aid and attendance as described in subsection (l) or (m) of section 1114 of this title, shall not be effective earlier than the first day of the second calendar month which begins after the date of the veteran's admission for hospitalization. In case a veteran affected by this subsection leaves a hospital against medical advice and is thereafter admitted to hospitalization within six months from the date of such departure, such allowance, increased pension, or additional compensation, as the case may be, shall be discontinued from the date of such readmission for so long as such hospitalization continues.

(d)(1) For the purposes of this subsection—

(A) the term "Medicaid plan" means a State plan for medical assistance referred to in section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)); and

(B) the term "nursing facility" means a nursing facility described in section 1919 of such Act (42 U.S.C. 1396r), other than a facility that is a State home with respect to which the Secretary makes per diem payments for nursing home care pursuant to section 1741(a) of this title.

(2) If a veteran having neither spouse nor child is covered by a Medicaid plan for services furnished such veteran by a nursing facility, no pension in excess of $90 per month shall be paid to or for the veteran for any period after the month of admission to such nursing facility.

(3) Notwithstanding any provision of title XIX of the Social Security Act, the amount of the payment paid a nursing facility pursuant to a Medicaid plan for services furnished a veteran may not be reduced by any amount of pension permitted to be paid such veteran under paragraph (2) of this subsection.

(4) A veteran is not liable to the United States for any payment of pension in excess of the amount permitted under this subsection that is paid to or for the veteran by reason of the inability or failure of the Secretary to reduce the veteran's pension under this subsection unless such inability or failure is the result of a willful concealment by the veteran of information necessary to make a reduction in pension under this subsection.

(5)(A) The provisions of this subsection shall apply with respect to a surviving spouse having no child in the same manner as they apply to a veteran having neither spouse nor child.

(B) The provisions of this subsection shall apply with respect to a child entitled to pension under section 1542 of this title in the same manner as they apply to a veteran having neither spouse nor child.

(6) The costs of administering this subsection shall be paid for from amounts available to the Department of Veterans Affairs for the payment of compensation and pension.

(7) This subsection expires on ❲September 30, 2027❳ *September 30, 2028*.

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PART I—GENERAL PROVISIONS

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CHAPTER 7—EMPLOYEES

SUBCHAPTER I —GENERAL EMPLOYEE MATTERS

Sec.
701. Placement of employees in military installations.
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726. Annual report on performance awards and bonuses awarded to certain high-level employees.
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SUBCHAPTER I—GENERAL EMPLOYEE MATTERS

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§ 726. Annual report on performance awards and bonuses awarded to certain high-level employees

(a) IN GENERAL.—Not later than 100 days after the end of each fiscal year, the Secretary shall submit to the appropriate committees of Congress a report that contains, for the most recent fiscal year ending before the submittal of the report, a description of all performance awards or bonuses awarded to each of the following:

(1) Regional Office Director of the Department.

(2) Director of a Medical Center of the Department.

(3) Director of a Veterans Integrated Service Network.

(4) Senior executive of the Department.

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

(1) The amount of each award or bonus.

(2) The job title of the individual awarded the award or bonus.

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

(c) DEFINITIONS.—In this section:

(1) The term "appropriate committees of Congress" means the Committees on Veterans' Affairs and Appropriations of the Senate and House of Representatives.

(2) The term "senior executive" means—

(A) a career appointee; or

(B) an individual—

(i) in an administrative or executive position; and

(ii) appointed under section 7306(a) or section 7401(1) of this title.

(3) The term "career appointee" has the meaning given that term in section 3132(a) of title 5, United States Code.

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PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 73—VETERANS HEALTH ADMINISTRATION - ORGANIZATION AND FUNCTIONS

SUBCHAPTER I—ORGANIZATION

Sec.
7301. Functions of Veterans Health Administration: in general.

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SUBCHAPTER II—GENERAL AUTHORITY AND ADMINISTRATION

7311. Quality assurance.

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7330C. Quadrennial Veterans Health Administration review.

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SUBCHAPTER II—GENERAL AUTHORITY AND ADMINISTRATION

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§ 7330C. Quadrennial Veterans Health Administration review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) inform and assess the appropriateness of the access standards established under section 1703B of this title and standards for quality under section 1703C and to make recommendations for any changes to such standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives.

SUBCHAPTER III—PROTECTION OF PATIENT RIGHTS

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§ 7332. Confidentiality of certain medical records

(a)(1) Records of the identity, diagnosis, prognosis, or treatment of any patient or subject which are maintained in connection with the performance of any program or activity (including education, training, treatment, rehabilitation, or research) relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia which is carried out by or for the Department under this title shall, except as provided in subsections (e) and (f), be confidential, and (section 5701 of this title to the contrary notwithstanding) such records may be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b).

(2) Paragraph (1) prohibits the disclosure to any person or entity other than the patient or subject concerned of the fact that a special written consent is required in order for such records to be disclosed.

(b)(1) The content of any record referred to in subsection (a) may be disclosed by the Secretary in accordance with the prior written consent of the patient or subject with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed in regulations prescribed by the Secretary.

(2) Whether or not any patient or subject, with respect to whom any given record referred to in subsection (a) is maintained, gives written consent, the content of such record may be disclosed by the Secretary as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient or subject in any report of such research, audit, or evaluation, or otherwise disclose patient or subject identities in any manner.

(C)(i) In the case of any record which is maintained in connection with the performance of any program or activity relating to infection with the human immunodeficiency virus, to a Federal, State, or local public-health authority charged under Federal or State law with the protection of the public health, and to which Federal or State law requires disclosure of such record, if a qualified representative of such authority has made a written request that such record be provided as required pursuant to such law for a purpose authorized by such law.

(ii) A person to whom a record is disclosed under this paragraph may not redisclose or use such record for a purpose other than that for which the disclosure was made.

(D) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient or subject, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(E) To an entity described in paragraph (1)(B) of section 5701(k) of this title, but only to the extent authorized by such section.

(F)(i) To a representative of a patient who lacks decision-making capacity, when a practitioner deems the content of the given record necessary for that representative to make an informed decision regarding the patient's treatment.

(ii) In this subparagraph, the term "representative" means an individual, organization, or other body authorized under section 7331 of this title and its implementing regulations to give informed consent on behalf of a patient who lacks decision-making capacity.

(G) To a State controlled substance monitoring program, including a program approved by the Secretary of Health and Human Services under section 399O of the Public Health Service Act (42 U.S.C. 280g-3), to the extent necessary to prevent misuse and diversion of prescription medicines.

[(H)(i) To a non-Department entity (including private entities and other Federal agencies) that provides hospital care or medical services to veterans as authorized by the Secretary.

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

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

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

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

(3) In the event that the patient or subject who is the subject of any record referred to in subsection (a) is deceased, the content of any such record may be disclosed by the Secretary only upon the prior written request of the next of kin, executor, administrator, or other personal representative of such patient or subject and only if the Secretary determines that such disclosure is necessary for such survivor to obtain benefits to which such survivor may be entitled, including the pursuit of legal action, but then only to the extent, under such circumstances, and for such purposes as may be allowed in regulations prescribed pursuant to section 7334 of this title.

(c) Except as authorized by a court order granted under subsection (b)(2)(D), no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against, or to conduct any investigation of, a patient or subject.

(d) The prohibitions of this section shall continue to apply to records concerning any person who has been a patient or subject, irrespective of whether or when such person ceases to be a patient.

(e) The prohibitions of this section shall not prevent any interchange of records—

(1) within and among those components of the Department furnishing health care to veterans, or determining eligibility for benefits under this title; or

(2) between such components furnishing health care to veterans and the Armed Forces.

(f)(1) Notwithstanding subsection (a) but subject to paragraph (2), a physician or a professional counselor may disclose information or records indicating that a patient or subject is infected with the human immunodeficiency virus if the disclosure is made to (A) the spouse of the patient or subject, or (B) to an individual whom the patient or subject has, during the process of professional counseling or of testing to determine whether the patient or subject is infected with such virus, identified as being a sexual partner of such patient or subject.

(2)(A) A disclosure under paragraph (1) may be made only if the physician or counselor, after making reasonable efforts to counsel and encourage the patient or subject to provide the information to the spouse or sexual partner, reasonably believes that the patient or subject will not provide the information to the spouse or sexual partner and that the disclosure is necessary to protect the health of the spouse or sexual partner.

(B) A disclosure under such paragraph may be made by a physician or counselor other than the physician or counselor referred to in subparagraph (A) if such physician or counselor is unavailable by reason of absence or termination of employment to make the disclosure.

(g) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined, in the case of a first offense, up to the maximum amount provided under section 5701(f) of this title for a first offense under that section and, in the case of a subse-

quent offense, up to the maximum amount provided under section 5701(f) of this title for a subsequent offense under that section.

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CHAPTER 74—VETERANS HEALTH ADMINISTRATION - PERSONNEL

SUBCHAPTER I—APPOINTMENTS

Sec.
7401. Appointments in Veterans Health Administration.
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7413. Treatment of podiatrists; clinical oversight standards.
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SUBCHAPTER I—APPOINTMENTS

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§ 7404. Grades and pay scales

(a)(1)(A) The annual rates or ranges of rates of basic pay for positions provided in section 7306 and 7401(4) of this title shall be prescribed from time to time by Executive order as authorized by chapter 53 of title 5 or as otherwise authorized by law.

(B) Section 5377 of title 5 shall apply to a position under section 7401(4) of this title as if such position were included in the definition of "position" in section 5377(a) of title 5.

(2) The pay of physicians and dentists serving in positions to which an Executive order applies under paragraph (1) shall be determined under subchapter III of this chapter instead of such Executive order.

(3)(A) The rate of basic pay for a position to which an Executive order applies under paragraph (1) and is not described by paragraph (2) shall be set in accordance with section 5382 of title 5 as if such position were a Senior Executive Service position (as such term is defined in section 3132(a) of title 5).

(B) A rate of basic pay for a position may not be set under subparagraph (A) in excess of—

(i) in the case the position is not described in clause (ii), the rate of basic pay payable for level III of the Executive Schedule; or

(ii) in the case that the position is covered by a performance appraisal system that meets the certification criteria established by regulation under section 5307(d) of title 5, the rate of basic pay payable for level II of the Executive Schedule.

(C) Notwithstanding the provisions of subsection (d) of section 5307 of title 5, the Secretary may make any certification under that subsection instead of the Office of Personnel Management and without concurrence of the Office of Management and Budget.

(b) The grades for positions provided for in paragraph (1) of section 7401 of this title shall be as follows. The annual ranges of rates of basic pay for those grades shall be prescribed from time to time by Executive order as authorized by chapter 53 of title 5 or as otherwise authorized by law:

[PHYSICIAN AND DENTIST SCHEDULE**]** *PHYSICIAN AND SURGEON (MD/DO), PODIATRIC SURGEON (DPM), AND DENTIST AND ORAL SURGEON (DDS, DMD) SCHEDULE*

[Physician grade**]** *Physician and surgeon grade*.

Dentist grade.

NURSE SCHEDULE

Nurse V.

Nurse IV.

Nurse III.

Nurse II.

Nurse I.

CLINICAL **[**PODIATRIST, CHIROPRACTOR, AND**]** *CHIROPRACTOR AND* OPTOMETRIST SCHEDULE

Chief grade.

Senior grade.

Intermediate grade.

Full grade.
Associate grade.

(c) Notwithstanding the provisions of section 7425(a) of this title, a person appointed under section 7306 of this title who is not eligible for pay under subchapter III shall be deemed to be a career appointee for the purposes of sections 4507 and 5384 of title 5.

(d) Except as provided under subsection (e), subchapter III, and section 7457 of this title, pay for positions for which basic pay is paid under this section may not be paid at a rate in excess of the rate of basic pay authorized by section 5316 of title 5 for positions in Level V of the Executive Schedule.

(e) The position of Chief Nursing Officer, Office of Nursing Services, shall be exempt from the provisions of section 7451 of this title and shall be paid at a rate determined by the Secretary, not to exceed the maximum rate established for the Senior Executive Service under section 5382 of title 5.

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§ 7413. Treatment of podiatrists; clinical oversight standards

(a) PODIATRISTS.—Except as provided by subsection (b), a doctor of podiatric medicine who is appointed as a podiatrist under section 7401(1) of this title is eligible for any supervisory position in the Veterans Health Administration to the same degree that a physician appointed under such section is eligible for the position.

(b) ESTABLISHMENT OF CLINICAL OVERSIGHT STANDARDS.—The Secretary, in consultation with appropriate stakeholders, shall establish standards to ensure that specialists appointed in the Veterans Health Administration to supervisory positions do not provide direct clinical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties.

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CHAPTER 76—HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

SUBCHAPTER I—GENERAL

Sec.
7601. Establishment of program; purpose.

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SUBCHAPTER VIII—SPECIALTY EDUCATION LOAN REPAYMENT PROGRAM

7691. Establishment.
7692. Purpose.
7693. Eligibility; preferences; covered costs.
7694. Specialty education loan repayment.
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SUBCHAPTER I—GENERAL

§ 7601. Establishment of program; purpose

(a) There is hereby established a program to be known as the Department of Veterans Affairs Health Professionals Educational Assistance Program (hereinafter in this chapter referred to as the "Educational Assistance Program"). The program consists of—

(1) the scholarship program provided for in subchapter II of this chapter;

(2) the tuition reimbursement program provided for in subchapter III of this chapter;

(3) the Selected Reserve member stipend program provided for under subchapter V of this chapter;

(4) the employee incentive scholarship program provided for in subchapter VI of this chapter; **[**and**]**

(5) the education debt reduction program provided for in subchapter VII of this chapter**[**.**]***; and*

(6) the specialty education loan repayment program provided for in subchapter VIII of this chapter.

(b) The purpose of the Educational Assistance Program is to assist in providing an adequate supply of trained health-care personnel for the Department and the Nation.

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§ 7603. Application and acceptance

(a)(1) To apply to participate in the Educational Assistance Program under subchapter II, III, V, [or VI] *VI, or VIII* of this chapter, an individual shall submit to the Secretary an application for such participation together with an agreement described in section 7604 of this title 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 educational assistance as provided in the agreement.

(2) To apply to participate in the Educational Assistance Program under subchapter VII of this chapter, an individual shall submit to the Secretary an application for such participation.

(b)(1) An individual becomes a participant in the Educational Assistance Program upon the Secretary's approval of the individual's application and the Secretary's acceptance of the agreement (if required).

(2) Upon the Secretary's approval of an individual's participation in the program, the Secretary shall promptly notify the individual of that approval. Such notice shall be in writing.

(c)(1) In distributing application forms and agreement forms to individuals desiring to participate in the Educational Assistance Program, the Secretary shall include with such forms the following:

(A) A fair summary of the rights and liabilities of an individual whose application is approved (and whose agreement is accepted) by the Secretary, including a clear explanation of the damages to which the United States is entitled if the individual breaches the agreement.

(B) A full description of the terms and conditions that apply to participation in the Educational Assistance Program and service in the Veterans Health Administration.

(2) The Secretary shall make such application forms and other information available to individuals desiring to participate in the Educational Assistance Program on a date sufficiently early to allow such individuals adequate time to prepare and submit such forms.

(d) In selecting applicants for acceptance in the Educational Assistance Program, the Secretary shall give priority to the applications of individuals who have previously received educational assistance under the program and have not completed the course of education or training undertaken under such program.

§ 7604. Terms of agreement

An agreement between the Secretary and a participant in the Educational Assistance Program shall be in writing, shall be signed by the participant, and shall include the following provisions:

(1) The Secretary's agreement—

(A) to provide the participant with educational assistance as authorized in subchapter II, III, V, [or VI] *VI, or VIII* of this chapter and specified in the agreement; and

(B) to afford the participant the opportunity for employment in the Veterans Health Administration (subject to the availability of appropriated funds for such purpose and other qualifications established in accordance with section 7402 of this title).

(2) The participant's agreement—

(A) to accept such educational assistance;

(B) to maintain enrollment and attendance in the course of training until completed;

(C) while enrolled in such course, to maintain an acceptable level of academic standing (as determined by the educational institution offering such course of training under regulations prescribed by the Secretary); and

(D) after completion of the course of training, to serve as a full-time employee in the Veterans Health Administration as specified in the agreement in accordance with subchapter II, III, V, [or VI] *VI, or VIII* of this chapter.

(3) A provision that any financial obligation of the United States arising out of an agreement entered into under this chapter, and any obligation of the participant which is conditioned on such agreement, is contingent upon funds being appropriated for educational assistance under this chapter.

(4) A statement of the damages to which the United States is entitled under this chapter for the participant's breach of the agreement.

(5) Such other terms as are required to be included in the agreement under subchapter II, III, V, [or VI] *VI, or VIII* of this chapter or as the Secretary may require consistent with the provisions of this chapter.

SUBCHAPTER II—SCHOLARSHIP PROGRAM

* * * * * * *

§ 7612. Eligibility; application; agreement

(a)(1) Except as provided in paragraph (2) of this subsection, an individual must be accepted for enrollment or be enrolled (as described in section 7602 of this title) as a full-time student to be eligible to participate in the Scholarship Program.

(2) An individual who is an eligible Department employee may be accepted as a participant if accepted for enrollment or enrolled (as described in section 7602 of this title) for study on less than a full-time but not less than a half-time basis. (Such a participant is hereinafter in this subchapter referred to as a "part-time student".)

(3) For the purposes of paragraph (2) of this subsection, an eligible Department employee is a full-time Department employee who is permanently assigned to a Department health-care facility on the date on which the individual submits the application referred to in section 7603 of this title and on the date on which the individual becomes a participant in the Scholarship Program.

(b)(1) A scholarship may be awarded under this subchapter only in a qualifying field of education or training.

(2) A qualifying field of education or training for purposes of this subchapter is education or training leading to employment as an appointee under paragraph (1) or (3) of section 7401 of this title.

(3) The Secretary may designate additional fields of education or training as qualifying fields of education or training if the education or training leads to employment in a position which would qualify the individual for increased basic pay under subsection (a)(1) of section 7455 of this title for personnel described in subsection (a)(2)(B) of such section.

(4) Before awarding the initial scholarship in a course of education or training other than medicine or nursing, the Secretary shall notify the Committees on Veterans' Affairs of the Senate and House of Representatives of the Secretary's intent to award a scholarship in such course of education or training. The notice shall include a statement of the reasons why the award of scholarships in that course of education or training is necessary to assist in providing the Department with an adequate supply of personnel in the health profession concerned. Any such notice shall be given not less than 60 days before the first such scholarship is awarded.

(5) In selecting applicants for the Scholarship Program, the Secretary—

(A) shall give priority to applicants who will be entering their final year in a course of training;

(B) shall give priority to applicants pursuing a course of education or training toward a career in an occupation for which the Inspector General of the Department has, in the most current determination published in the Federal Register pursuant to section 7412(a) of this title, determined that there is one of the largest staffing shortages throughout the Department with respect to such occupation; and

(C) shall ensure an equitable allocation of scholarships to persons enrolled in the second year of a program leading to an associate degree in nursing.

(6)(A) Of the scholarships awarded under this subchapter, the Secretary shall ensure that not less than 50 scholarships are awarded each year to individuals who are accepted for enrollment or enrolled (as described in section 7602 of this title) in a program of education or training leading to employment as a physician or dentist until such date as the Secretary determines that the staffing shortage of physicians and dentists in the Department is less than 500.

(B) After such date, the Secretary shall ensure that of the scholarships awarded under this subchapter, a number of scholarships is awarded each year to individuals referred to in subparagraph (A) in an amount equal to not less than ten percent of the staffing shortage of physicians and dentists in the Department, as determined by the Secretary.

(C) Notwithstanding subsection (c)(1), the agreement between the Secretary and a participant in the Scholarship Program who receives a scholarship pursuant to this paragraph shall provide the following:

(i) The Secretary's agreement to provide the participant with a scholarship under this subchapter for a specified number (from two to four) of school years during which the participant is pursuing a course of education or training leading to employment as a physician or dentist.

(ii) The participant's agreement to serve as a full-time employee in the Veterans Health Administration for a period of time (hereinafter in this subchapter referred to as the "period of obligated service") of 18 months for each school year or part thereof for which the participant was provided a scholarship under the Scholarship Program.

(D) In providing scholarships pursuant to this paragraph, the Secretary may provide a preference for applicants who are veterans.

(E) On an annual basis, the Secretary shall provide to appropriate educational institutions informational material about the availability of scholarships under this paragraph.

(c)(1) An agreement between the Secretary and a participant in the Scholarship Program shall (in addition to the requirements set forth in section 7604 of this title) include the following:

(A) The Secretary's agreement to provide the participant with a scholarship under this subchapter for a specified number (from one to four) of school years during which the participant is pursuing a course of education or training described in section 7602 of this title.

(B) The participant's agreement to serve as a full-time employee in the Veterans Health Administration for a period of time (hereinafter in this subchapter referred to as the "period of obligated service") of one calendar year for each school year or part thereof for which the participant was provided a scholarship under the Scholarship Program, but for not less than two years.

(2) In a case in which an extension is granted under section 7614(3) of this title, the number of years for which a scholarship may be provided under this subchapter shall be the number of school years provided for as a result of the extension.

(3) In the case of a participant who is a part-time student—

(A) the period of obligated service shall be reduced in accordance with the proportion that the number of credit hours carried by such participant in any such school year bears to the number of credit hours required to be carried by a full-time student in the course of training being pursued by the participant, but in no event to less than one year; and

(B) the agreement shall include the participant's agreement to maintain employment, while enrolled in such course of education or training, as a Department employee permanently assigned to a Department health-care facility.

(4) If a participant's period of obligated service is deferred under section 7616(b)(3)(A)(i) of this title, the agreement terms under paragraph (1) of this subsection shall provide for the participant to serve any additional period of obligated service that is prescribed by the Secretary under section 7616(b)(4)(B) of this title.

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§ 7617. Breach of agreement: liability

(a) A participant in the Scholarship Program (other than a participant described in subsection (b) of this section) who fails to accept payment, or instructs the educational institution in which the participant is enrolled not to accept payment, in whole or in part, of a scholarship under the agreement entered into under section 7603 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.

(b) A participant in the Scholarship Program shall be liable to the United States for the amount which has been paid to or on behalf of the participant under the agreement if any of the following occurs:

(1) The participant fails to maintain an acceptable level of academic standing in the educational institution in which the participant is enrolled (as determined by the educational institution under regulations prescribed by the Secretary).

(2) The participant is dismissed from such educational institution for disciplinary reasons.

(3) The participant voluntarily terminates the course of training in such educational institution before the completion of such course of training.

(4) In the case of a participant who is enrolled in a program or education or training leading to employment as a physician, the participant fails to successfully complete post-graduate training leading to eligibility for board certification in a specialty.

[(4)] *(5)* The participant fails to become licensed to practice medicine, osteopathy, dentistry, podiatry, or optometry in a State, fails to become licensed as a registered nurse in a State, or fails to meet any applicable licensure requirement in the case of any other health-care personnel who provide either direct patient-care services or services incident to direct patient-care services, during a period of time determined under regulations prescribed by the Secretary.

[(5)] *(6)* In the case of a participant who is a part-time student, the participant fails to maintain employment, while enrolled in the course of training being pursued by such participant, as a Department employee permanently assigned to a Department health-care facility.

Liability under this subsection is in lieu of any service obligation arising under the participant's agreement.

(c)(1) If a participant in the Scholarship Program breaches the agreement by failing (for any reason) to complete such participant's period of obligated service, the United States shall be entitled to recover from the participant an amount determined in accordance with the following formula: A=3<phi>(t-s/t)

In such formula:

(A) "A" is the amount the United States is entitled to recover.

(B) "<phi>" is the sum of (i) the amounts paid under this subchapter to or on behalf of the participant, and (ii) the interest on such amounts which 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.

(C) "t" is the total number of months in the participant's period of obligated service, including any additional period of obligated service in accordance with section 7616(b)(4) of this title.

(D) "s" is the number of months of such period served by the participant in accordance with section 7613 of this title.

(2) Any amount of damages which the United States is entitled to recover under this section shall be paid to the United States within the one-year period beginning on the date of the breach of the agreement.

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§ 7619. Expiration of program

The Secretary may not furnish scholarships to new participants in the Scholarship Program after [December 31, 2019] *December 31, 2033*.

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SUBCHAPTER IV—ADMINISTRATIVE MATTERS

§ 7631. Periodic adjustments in amount of assistance

(a)(1) Whenever there is a general Federal pay increase, the Secretary shall increase the maximum monthly stipend amount, the maximum tuition reimbursement amount, the maximum Selected Reserve member stipend amount, the maximum employee incentive scholarship amount, [and] the maximum education debt reduction payments amount*, and the maximum specialty education loan repayment amount*. Any such increase shall take effect with respect to any school year that ends in the fiscal year in which the pay increase takes effect.

(2) The amount of any increase under paragraph (1) of this subsection is the previous maximum amount under that paragraph multiplied by the overall percentage of the adjustment in the rates of pay under the General Schedule made under the general Federal pay increase. Such amount shall be rounded to the next lower multiple of $1.

(b) For purposes of this section:

(1) The term "maximum monthly stipend amount" means the maximum monthly stipend that may be paid to a participant in the Scholarship Program specified in section 7613(b) of this title and as previously adjusted (if at all) in accordance with this section.

(2) The term "maximum tuition reimbursement amount" means the maximum amount of tuition reimbursement provided to a participant in the Tuition Reimbursement Program specified in section 7622(e) of this title and as previously adjusted (if at all) in accordance with this section.

(3) The term "maximum Selected Reserve member stipend amount" means the maximum amount of assistance provided to a person receiving assistance under subchapter V of this

chapter, as specified in section 7653 of this title and as previously adjusted (if at all) in accordance with this section.

(4) The term "maximum employee incentive scholarship amount" means the maximum amount of the scholarship payable to a participant in the Department of Veterans Affairs Employee Incentive Scholarship Program under subchapter VI of this chapter, as specified in section 7673(b)(1) of this title and as previously adjusted (if at all) in accordance with this section.

(5) The term "maximum education debt reduction payments amount" means the maximum amount of education debt reduction payments payable to a participant in the Department of Veterans Affairs Education Debt Reduction Program under subchapter VII of this chapter, as specified in section 7683(d)(1) of this title and as previously adjusted (if at all) in accordance with this section.

(6) The term "general Federal pay increase" means an adjustment (if an increase) in the rates of pay under the General Schedule under subchapter III of chapter 53 of title 5.

(7) The term "specialty education loan repayment amount" means the maximum amount of specialty education loan repayment payments payable to or for a participant in the Department of Veterans Affairs Specialty Education Loan Repayment Program under subchapter VIII of this chapter, as specified in section 7694(c)(1) of this title and as previously adjusted (if at all) in accordance with this section.

§ 7632. Annual report

Not later than March 1 of each year, the Secretary shall submit to Congress a report on the Educational Assistance Program. Each such report shall include the following information:

(1) The number of students receiving educational assistance under the Educational Assistance Program, showing the numbers of students receiving assistance under the Scholarship Program, the Tuition Reimbursement Program, the Employee Incentive Scholarship Program, ⟦and the Education Debt Reduction Program⟧ *the Education Debt Reduction Program, and the Specialty Education Loan Repayment Program* separately, and the number of students (if any) enrolled in each type of health profession training under each program.

(2) The education institutions (if any) providing such training to students in each program.

(3) The number of applications filed under each program, by health profession category, during the school year beginning in such year and the total number of such applications so filed for all years in which the Educational Assistance Program (or predecessor program) has been in existence.

(4) The average amounts of educational assistance provided per participant in the Scholarship Program, per participant in the Tuition Reimbursement Program, per participant in the Employee Incentive Scholarship Program, ⟦and per participant in the Education Debt Reduction Program⟧ *per participant in the Education Debt Reduction Program, and per participant in the Specialty Education Loan Repayment Program*.

(5) The amount of tuition and other expenses paid, by health profession category, in the aggregate and at each educational institution for the school year beginning in such year and for prior school years.

(6) The number of scholarships accepted, by health profession category, during the school year beginning in such year and the number, by health profession category, which were offered and not accepted.

(7) The number of participants who complete a course or course of training in each program each year and for all years that such program (or predecessor program) has been in existence.

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SUBCHAPTER VII—EDUCATION DEBT REDUCTION PROGRAM

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§ 7683. Education debt reduction

(a) IN GENERAL.—Education debt reduction payments under the Education Debt Reduction Program shall consist of—

(1) payments to individuals selected to participate in the program of principal and interest on loans described in section 7682(a)(2) of this title; or

(2) payments for the principal and interest on such loans of such individuals to the holders of such loans.

(b) FREQUENCY OF PAYMENT.—(1) The Secretary may make education debt reduction payments to or for any given participant in the Education Debt Reduction Program on a monthly or annual basis, as determined by the Secretary.

(2) The Secretary shall make such payments at the end of the period determined by the Secretary under paragraph (1).

(c) PERFORMANCE REQUIREMENT.—The Secretary may make education debt reduction payments to or for a participant in the Education Debt Reduction Program for a period only if the Secretary determines that the individual maintained an acceptable level of performance in the position or positions served by the participant during the period.

(d) MAXIMUM ANNUAL AMOUNT.—(1) The amount of education debt reduction payments made to or for a participant under the Education Debt Reduction Program may not exceed ⟦$120,000⟧ *$200,000* over a total of five years of participation in the Program, of which not more than ⟦$24,000⟧ *$40,000* of such payments may be made in each year of participation in the Program.

(2)(A) The Secretary may waive the limitations under paragraph (1) in the case of a participant described in subparagraph (B). In the case of such a waiver, the total amount of education debt repayments payable to or for that participant is the total amount of the principal and the interest on the participant's loans referred to in subsection (a).

(B) A participant described in this subparagraph is a participant in the Program who the Secretary determines serves in a position for which there is a shortage of qualified employees by reason of either the location or the requirements of the position.

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SUBCHAPTER VIII—SPECIALTY EDUCATION LOAN REPAYMENT PROGRAM

§ 7691. Establishment

As part of the Educational Assistance Program, the Secretary may carry out a student loan repayment program under section 5379 of title 5. The program shall be known as the Department of Veterans Affairs Specialty Education Loan Repayment Program (in this chapter referred to as the "Specialty Education Loan Repayment Program").

§ 7692. Purpose

The purpose of the Specialty Education Loan Repayment Program is to assist, through the establishment of an incentive program for certain individuals employed in the Veterans Health Administration, in meeting the staffing needs of the Veterans Health Administration for physicians in medical specialties for which the Secretary determines recruitment or retention of qualified personnel is difficult.

§ 7693. Eligibility; preferences; covered costs

(a) ELIGIBILITY.—An individual is eligible to participate in the Specialty Education Loan Repayment Program if the individual—

(1) is hired under section 7401 of this title to work in an occupation described in section 7692 of this title;

(2) owes any amount of principal or interest under a loan, the proceeds of which were used by or on behalf of that individual to pay costs relating to a course of education or training which led to a degree that qualified the individual for the position referred to in paragraph (1); and

(3) is—

(A) recently graduated from an accredited medical or osteopathic school and matched to an accredited residency program in a medical specialty described in section 7692 of this title; or

(B) a physician in training in a medical specialty described in section 7692 of this title with more than two years remaining in such training.

(b) PREFERENCES.—In selecting individuals for participation in the Specialty Education Loan Repayment Program under this subchapter, the Secretary may give preference to the following:

(1) Individuals who are, or will be, participating in residency programs in health care facilities—

(A) located in rural areas;

(B) operated by Indian tribes, tribal organizations, or the Indian Health Service; or

(C) affiliated with underserved health care facilities of the Department.

(2) Veterans.

(c) COVERED COSTS.—For purposes of subsection (a)(2), costs relating to a course of education or training include—

(1) tuition expenses;

(2) all other reasonable educational expenses, including expenses for fees, books, equipment, and laboratory expenses; and

(3) reasonable living expenses.

§ 7694. Specialty education loan repayment

(a) IN GENERAL.—Payments under the Specialty Education Loan Repayment Program shall consist of payments for the principal and interest on loans described in section 7682(a)(2) of this title for individuals selected to participate in the Program to the holders of such loans.

(b) FREQUENCY OF PAYMENT.—The Secretary shall make payments for any given participant in the Specialty Education Loan Repayment Program on a schedule determined appropriate by the Secretary.

(c) MAXIMUM AMOUNT; WAIVER.—(1) The amount of payments made for a participant under the Specialty Education Loan Repayment Program may not exceed $160,000 over a total of four years of participation in the Program, of which not more than $40,000 of such payments may be made in each year of participation in the Program.

(2)(A) The Secretary may waive the limitations under paragraph (1) in the case of a participant described in subparagraph (B). In the case of such a waiver, the total amount of payments payable to or for that participant is the total amount of the principal and the interest on the participant's loans referred to in subsection (a).

(B) A participant described in this subparagraph is a participant in the Program who the Secretary determines serves in a position for which there is a shortage of qualified employees by reason of either the location or the requirements of the position.

§ 7695. Choice of location

Each participant in the Specialty Education Loan Repayment Program who completes residency may select, from a list of medical facilities of the Veterans Health Administration provided by the Secretary, at which such facility the participant will work in a medical specialty described in section 7692 of this title.

§ 7696. Term of obligated service

(a) IN GENERAL.—In addition to any requirements under section 5379(c) of title 5, a participant in the Specialty Education Loan Repayment Program must agree, in writing and before the Secretary may make any payment to or for the participant, to—

(1) obtain a license to practice medicine in a State;

(2) successfully complete post-graduate training leading to eligibility for board certification in a specialty;

(3) serve as a full-time clinical practice employee of the Veterans Health Administration for 12 months for every $40,000 in such benefits that the employee receives, but in no case for fewer than 24 months; and

(4) except as provided in subsection (b), to begin such service as a full-time practice employee by not later than 60 days after completing a residency.

(b) FELLOWSHIP.—In the case of a participant who receives an accredited fellowship in a medical specialty other than a medical specialty described in section 7692 of this title, the Secretary, on written request of the participant, may delay the term of obligated service under subsection (a) for the participant until after the participant completes the fellowship, but in no case later than 60 days after completion of such fellowship.

(c) PENALTY.—(1) An employee who does not complete a period of obligated service under this section shall owe the Federal Government an amount determined in accordance with the following formula: $A = B \times ((T - S) \div T)$).

(2) In the formula in paragraph (1):

(A) "A" is the amount the employee owes the Federal Government.

(B) "B" is the sum of all payments to or for the participant under the Specialty Education Loan Repayment Program.

(C) "T" is the number of months in the period of obligated service of the employee.

(D) "S" is the number of whole months of such period of obligated service served by the employee.

§ 7697. Relationship to Educational Assistance Program

Assistance under the Specialty Education Loan Repayment Program may be in addition to other assistance available to individuals under the Educational Assistance Program.

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED-USE LEASES OF REAL PROPERTY

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

Sec.
8101. Definitions.

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SUBCHAPTER IV—SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

8151. Statement of congressional purpose.

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

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SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

§ 8101. Definitions

For the purposes of this subchapter:

(1) The term "alter", with respect to a medical facility, means to repair, remodel, improve, or extend such medical facility.

(2) The terms "construct" and "alter", with respect to a medical facility, include such engineering, architectural, legal, fiscal, and economic investigations and studies and such surveys, designs, plans, construction documents, specifications, procedures, and other similar actions as are necessary for the construction or alteration, as the case may be, of such medical facility and as are carried out after the completion of the advanced planning (including the development of project requirements and design development) for such facility.

(3) The term "medical facility" means any facility or part thereof which is, or will be, under the jurisdiction of the **[**Secretary for the provision of health-care services (including hospital, nursing home,**]** *Secretary, or as otherwise authorized by law, for the provision of health-care services (including hospital, outpatient clinic, nursing home,* or 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.

(4) The term "committee" means the Committee on Veterans' Affairs of the House of Representatives or the Committee on Veterans' Affairs of the Senate, and the term "committees" means both such committees.

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§ 8103. Authority to construct and alter, and to acquire sites for, medical facilities

(a) Subject to section 8104 of this title, the Secretary—

(1) may construct or alter any medical facility and may acquire, by purchase, lease, condemnation, donation, exchange, or otherwise, such land or interests in land as the Secretary considers necessary for use as the site for such construction or alteration;

(2) may acquire, by purchase, lease, condemnation, donation, exchange, or otherwise, any facility (including the site of such facility) that the Secretary considers necessary for use as a medical facility; and

(3) in order to assure compliance with section 8110(a)(2) of this title, in the case of any outpatient medical facility for which it is proposed to lease space and for which a qualified lessor and an appropriate leasing arrangement are available, shall execute a lease for such facility within 12 months after funds are made available for such purpose.

(b) Whenever the Secretary considers it to be in the interest of the United States to construct a new medical facility to replace an existing medical facility, the Secretary (1) may demolish the existing facility and use the site on which it is located for the site of the new medical facility, or (2) if in the judgment of the Secretary it is more advantageous to construct such medical facility on a different site in the same locality, may exchange such existing facility and the site of such existing facility for the different site.

(c) Whenever the Secretary determines that any site acquired for the construction of a medical facility is not suitable for that purpose, the Secretary may exchange such site for another site to be used for that purpose or may sell such site.

(d)(1) The Secretary may provide for the acquisition of not more than three facilities for the provision of outpatient services or nursing home care through lease-purchase arrangements on real property under the jurisdiction of the Department of Veterans Affairs.

(2)(A) In carrying out this subsection and notwithstanding any other provision of law, the Secretary may lease, with or without compensation and for a period of not to exceed 35 years, to another party any of the real property described in paragraph (1) of this subsection.

(B) Such real property shall be used as the site of a facility referred to in paragraph (1) of this subsection—

(i) constructed and owned by the lessee of such real property; and

(ii) leased under paragraph (3)(A) of this subsection to the Department for such use and for such other activities as the Secretary determines are appropriate.

(3)(A) The Secretary may enter into a lease for the use of any facility described in paragraph (2)(B) of this subsection for not more than 35 years under such terms and conditions as may be in the best interests of the Department.

(B) Each agreement to lease a facility under subparagraph (A) of this paragraph shall include a provision that—

(i) the obligation of the United States to make payments under the agreement is subject to the availability of appropriations for that purpose; and

(ii) the ownership of such facility shall vest in the United States at the end of such lease.

(4)(A) The Secretary may sublease any space in such a facility to another party at a rate not less than—

(i) the rental rate paid by the Secretary for such space under paragraph (3) of this subsection; plus

(ii) the amount the Secretary pays for the costs of administering such facility (including operation, maintenance, utility, and rehabilitation costs) which are attributable to such space.

(B) In any such sublease, the Secretary shall include such terms relating to default and nonperformance as the Secretary considers appropriate to protect the interests of the United States.

(5) The Secretary shall use the receipts of any payment for the lease of real property under paragraph (2) for the payment of the lease of a facility under paragraph (3).

(6) The authority to enter into an agreement under this subsection—

(A) shall not take effect until the Secretary has entered into agreements under section 316 of this title to carry out at least three collocations; and

(B) shall expire on October 1, 1993.

(e)(1) In the case of any super construction project, the Secretary shall enter into an agreement with an appropriate non-Department Federal entity to provide full project management services for the super construction project, including management over the project design, acquisition, construction, and contract changes.

(2) An agreement entered into under paragraph (1) with a Federal entity shall provide that the Secretary shall reimburse the Federal entity for all costs associated with the provision of project management services under the agreement.

(3) In this subsection, the term "super construction project" means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $100,000,000.

(f) To the maximum extent practicable, the Secretary shall use industry standards, standard designs, and best practices in carrying out the construction of medical facilities.

[(g) The Secretary shall ensure that each employee of the Department with responsibilities, as determined by the Secretary, relating to the infrastructure construction or alteration of medical facilities, including such construction or alteration carried out pursuant to contracts or agreements, undergoes a program of ongoing professional training and development. Such program shall be designed to ensure that employees maintain adequate expertise relating to industry standards and best practices for the acquisition of design and construction services. The Secretary may provide the program under this subsection directly or through a contract or agreement with a non-Federal entity or with a non-Department Federal entity.]

(g)(1)(A) Not later than September 30 of the fiscal year following the fiscal year during which the VA Asset and Infrastructure Review Act of 2018 is enacted, the Secretary shall implement the covered training curriculum and the covered certification program.

(B) In designing and implementing the covered training curriculum and the covered certification program under paragraph (1), the Secretary shall use as models existing training curricula and certification programs that have been established under chapter 87 of title 10, United States Code, as determined relevant by the Secretary.

(2) The Secretary may develop the training curriculum under paragraph (1)(A) in a manner that provides such training in any combination of—

(A) training provided in person;

(B) training provided over an internet website; or

(C) training provided by another department or agency of the Federal Government.

(3) The Secretary may develop the certification program under paragraph (1)(A) in a manner that uses—

(A) one level of certification; or

(B) more than one level of certification, as determined appropriate by the Secretary with respect to the level of certification for different grades of the General Schedule.

(4) The Secretary may enter into a contract with an appropriate entity to provide the covered training curriculum and the covered certification program under paragraph (1)(A).

(5)(A) Not later than September 30 of the second fiscal year following the fiscal year during which the VA Asset and Infrastructure Review Act of 2018 is enacted, the Secretary shall ensure that the majority of employees subject to the covered certification program achieve the certification or the appropriate level of certification pursuant to paragraph (3), as the case may be.

(B) After carrying out subparagraph (A), the Secretary shall ensure that each employee subject to the covered certification program achieves the certification or the appropriate level of certification pursuant to paragraph (3), as the case may be, as quickly as practicable.

(6) In this subsection:

(A) The term "covered certification program" means, with respect to employees of the Department of Veterans Affairs who are members of occupational series relating to construction or facilities management, or employees of the Department who award or administer contracts for major construction, minor construction, or nonrecurring maintenance, including as contract specialists or contracting officers' representatives, a program to certify knowledge and skills relating to construction or facilities management and to ensure that such employees maintain adequate expertise relating to industry standards and best practices for the acquisition of design and construction services.

(B) The term "covered training curriculum" means, with respect to employees specified in subparagraph (A), a training curriculum relating to construction or facilities management.

§ 8104. Congressional approval of certain medical facility acquisitions

(a)(1) The purpose of this subsection is to enable Congress to ensure the equitable distribution of medical facilities throughout the United States, taking into consideration the comparative urgency of the need for the services to be provided in the case of each particular facility.

(2) No funds may be appropriated for any fiscal year, and the Secretary may not obligate or expend funds (other than for advance planning and design), for any major medical facility project or any major medical facility lease unless funds for that project or lease have been specifically authorized by law.

[(3) For the purpose of this subsection:

[(A) The term "major medical facility project" means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $10,000,000, but such term does not include an acquisition by exchange.

[(B) The term "major medical facility lease" means a lease for space for use as a new medical facility at an average annual rental of more than $1,000,000.]

(3) For purposes of this subsection, the term "major medical facility project" means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $20,000,000, but such term does not include an acquisition by exchange, nonrecurring maintenance projects of the Department, or the construction, alteration, or acquisition of a shared Federal medical facility for which the Department's estimated share of the project costs does not exceed $20,000,000.

(b) Whenever the President or the Secretary submit to the Congress a request for the funding of a major medical facility project (as defined in subsection (a)(3)(A)) or a major medical facility lease (as defined in subsection (a)(3)(B)), the Secretary shall submit to each committee, on the same day, a prospectus of the proposed medical facility. Any such prospectus shall include the following:

(1) A detailed estimate of the total costs of the medical facility to be constructed, altered, leased, or otherwise acquired under this subchapter, including a description of the location of such facility and, in the case of a prospectus proposing the construction of a new or replacement medical facility, a detailed report of the consideration that was given to acquiring an existing facility by lease or purchase and to the sharing of health-care resources with the Department of Defense under section 8111 of this title. Such detailed estimate shall include an identification of each of the following:

(A) Total construction costs.

(B) Activation costs.

(C) Special purpose alterations (lump-sum payment) costs.

(D) Number of personnel.

(E) Total costs of ancillary services, equipment, and all other items.

(2) Demographic data applicable to such facility, including information on projected changes in the population of veterans to be served by the facility over a five-year period, a ten-year period, and a twenty-year period.

(3) Current and projected workload and utilization data regarding the facility, including information on projected changes in workload and utilization over a five-year period, a ten-year period, and a twenty-year period.

(4) Projected operating costs of the facility, including both recurring and non-recurring costs (including and identifying both recurring and non-recurring costs (including activation costs and total costs of ancillary services, equipment and all other items)) over a five-year period, a ten-year period, and a twenty-year period.

(5) The priority score assigned to the project or lease under the Department's prioritization methodology and, if the project or lease is being proposed for funding before a project or lease with a higher score, a specific explanation of the factors other than the priority score that were considered and the basis on which the project or lease is proposed for funding ahead of projects or leases with higher priority scores.

(6) In the case of a prospectus proposing the construction of a new or replacement medical facility, each of the following:

(A) A detailed estimate of the total costs (including total construction costs, activation costs, special purpose alterations (lump-sum payment) costs, number of personnel and total costs of ancillary services, equipment and all other items) for each alternative to construction of the facility that was considered.

(B) A comparison of total costs to total benefits for each such alternative.

(C) An explanation of why the preferred alternative is the most effective means to achieve the stated project goals and the most cost-effective alternative.

(7) In the case of a prospectus proposing funding for a major medical facility lease, a detailed analysis of how the lease is expected to comply with Office of Management and Budget Circular A-11 and section 1341 of title 31 (commonly referred to as the "Anti-Deficiency Act"). Any such analysis shall include—

(A) an analysis of the classification of the lease as a "lease-purchase", "capital lease", or "operating lease" as those terms are defined in Office of Management and Budget Circular A-11;

(B) an analysis of the obligation of budgetary resources associated with the lease; and

(C) an analysis of the methodology used in determining the asset cost, fair market value, and cancellation costs of the lease.

(c)(1) Not less than 30 days before obligating funds for a major medical facility project approved by a law described in subsection (a)(2) of this section in an amount that would cause the total amount obligated for that project to exceed the amount specified in the law for that project (or would add to total obligations exceeding such specified amount) by more than 10 percent, the Secretary shall provide the committees with notice of the Secretary's intention to do so and the reasons for the specified amount being exceeded.

(2) The Secretary shall—

(A) enter into a contract or agreement with an appropriate non-department Federal entity with the ability to conduct forensic audits on medical facility projects for the conduct of an external forensic audit of the expenditures relating to any major medical facility or super construction project for which the total expenditures exceed the amount requested in the initial budget request for the project submitted to Congress under section 1105 of title 31 by more than 25 percent; and

(B) enter into a contract or agreement with an appropriate non-department Federal entity with the ability to conduct forensic audits on medical facility projects for the conduct of an external audit of the medical center construction project in Aurora, Colorado.

(d)(1) Except as provided in paragraph (2), in any case in which the Secretary proposes that funds be used for a purpose other than the purpose for which such funds were appropriated, the Secretary shall promptly notify each committee, in writing, of the particulars involved and the reasons why such funds were not used for the purpose for which appropriated.

(2)(A) In any fiscal year, unobligated amounts in the Construction, Major Projects account that are a direct result of bid savings from a major construction project may only be obligated for major construction projects authorized for that fiscal year or a previous fiscal year.

(B) Whenever the Secretary obligates amounts for a major construction project under subparagraph (A), the Secretary shall submit to the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate and the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives notice of the following:

(i) The major construction project that is the source of the bid savings.

(ii) If the major construction project that is the source of the bid savings is not complete—

(I) the amount already obligated by the Department or available in the project reserve for such project;

(II) the percentage of such project that has been completed; and

(III) the amount available to the Department to complete such project.

(iii) The other major construction project for which the bid savings amounts are being obligated.

(iv) The bid savings amounts being obligated for such other major construction project.

(C) The Secretary may not obligate an amount under subparagraph (A) to expand the purpose of a major construction project except pursuant to a provision of law enacted after the date on which the Secretary submits to the committees described in subparagraph (B) notice of the following:

(i) The major construction project that is the source of the bid savings.

(ii) The major construction project for which the Secretary intends to expand the purpose.

(iii) A description of such expansion of purpose.

(iv) The amounts the Secretary intends to obligate to expand the purpose.

(e) The Secretary may accept gifts or donations for any of the purposes of this subchapter.

(f) The Secretary may not obligate funds in an amount in excess of $500,000 from the Advance Planning Fund of the Department toward design or development of a major medical facility project (as defined in subsection (a)(3)(A)) until—

(1) the Secretary submits to the committees a report on the proposed obligation; and

(2) a period of 30 days has passed after the date on which the report is received by the committees.

(g) The limitation in subsection (f) does not apply to a project for which funds have been authorized by law in accordance with subsection (a)(2).

(h)(1) Not less than 30 days before entering into a major medical facility lease, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives—

(A) notice of the Secretary's intention to enter into the lease;

(B) a detailed summary of the proposed lease;

(C) a description and analysis of any differences between the prospectus submitted pursuant to subsection (b) and the proposed lease; and

(D) a scoring analysis demonstrating that the proposed lease fully complies with Office of Management and Budget Circular A-11.

(2) Each committee described in paragraph (1) shall ensure that any information submitted to the committee under such paragraph is treated by the committee with the same level of confidentiality as is required by law of the Secretary and subject to the same statutory penalties for unauthorized disclosure or use as the Secretary.

(3) Not more than 30 days after entering into a major medical facility lease, the Secretary shall submit to each committee described in paragraph (1) a report on any material differences between the lease that was entered into and the proposed lease described under such paragraph, including how the lease that was entered into changes the previously submitted scoring analysis described in subparagraph (D) of such paragraph.

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SUBCHAPTER IV—SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

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

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

(b) NEW CONTRACTS AND AGREEMENTS.—The Secretary shall take reasonable efforts to enter into a contract, agreement, or other arrangement with a provider described in subsection (a) to ensure that future care and services authorized by the Secretary and furnished by the provider are subject to such a contract, agreement, or other arrangement.

SUBCHAPTER V—ENHANCED-USE LEASES OF REAL PROPERTY

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§ 8162. Enhanced-use leases

(a)(1) The Secretary may in accordance with this subchapter enter into leases with respect to real property that is under the jurisdiction or control of the Secretary. Any such lease under this subchapter may be referred to as an "enhanced-use lease". The Secretary may dispose of any such property that is leased to another party under this subchapter in accordance with section 8164 of this title. The Secretary may exercise the authority provided by this subchapter notwithstanding section 8122 of this title, subchapter II of chapter 5 of title 40, sections 541-555 and 1302 of title 40, or any other provision of law (other than Federal laws relating to environmental and historic preservation) inconsistent with this section. The applicability of this subchapter to section 421(b) of the Veterans' Benefits and Services Act of 1988 (Public Law 100-322; 102 Stat. 553) is covered by subsection (c).

(2) The Secretary may enter into an enhanced-use lease only for the provision of supportive housing and if the lease is not inconsistent with and will not adversely affect the mission of the Department.

(3) The provisions of sections 3141-3144, 3146, and 3147 of title 40 shall not, by reason of this section, become inapplicable to property that is leased to another party under an enhanced-use lease.

(4) A property that is leased to another party under an enhanced-use lease may not be considered to be unutilized or underutilized for purposes of section 501 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11411).

(b)(1) If the Secretary has determined that a property should be leased to another party through an enhanced-use lease, the Secretary shall, at the Secretary's discretion, select the party

with whom the lease will be entered into using such selection procedures as the Secretary considers appropriate.

(2) The term of an enhanced-use lease may not exceed 75 years.

(3)(A) For any enhanced-use lease entered into by the Secretary, the lease consideration provided to the Secretary shall consist solely of cash at fair value as determined by the Secretary.

(B) The Secretary shall receive no other type of consideration for an enhanced-use lease besides cash.

(C) The Secretary may enter into an enhanced-use lease without receiving consideration.

(D) The Secretary may not waive or postpone the obligation of a lessee to pay any consideration under an enhanced-use lease, including monthly rent.

(4) The terms of an enhanced-use lease may provide for the Secretary to use minor construction funds for capital contribution payments.

(5) The terms of an enhanced-use lease may not provide for any acquisition, contract, demonstration, exchange, grant, incentive, procurement, sale, other transaction authority, service agreement, use agreement, lease, or lease-back by the Secretary or Federal Government.

[(6) The Secretary may not enter into an enhanced-use lease without certification in advance in writing by the Director of the Office of Management and Budget that such lease complies with the requirements of this subchapter.**]**

(6) The Office of Management and Budget shall review each enhanced-use lease before the lease goes into effect to determine whether the lease is in compliance with paragraph (5).

(c) The entering into an enhanced-use lease covering any land or improvement described in section 421(b)(2) of the Veterans' Benefits and Services Act of 1988 (Public Law 100-322; 102 Stat. 553) or section 224(a) of the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008, other than an enhanced-use lease under the Los Angeles Homeless Veterans Leasing Act of 2016, shall be considered to be prohibited by such sections unless specifically authorized by law.

(d)(1) Nothing in this subchapter authorizes the Secretary to enter into an enhanced-use lease that provides for, is contingent upon, or otherwise authorizes the Federal Government to guarantee a loan made by a third party to a lessee for purposes of the enhanced-use lease.

(2) Nothing in this subchapter shall be construed to abrogate or constitute a waiver of the sovereign immunity of the United States with respect to any loan, financing, or other financial agreement entered into by the lessee and a third party relating to an enhanced-use lease.

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VETERANS ACCESS, CHOICE, AND ACCOUNTABILITY ACT OF 2014

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TITLE I—IMPROVEMENT OF ACCESS TO CARE FROM NON-DEPARTMENT OF VETERANS AFFAIRS PROVIDERS

SEC. 101. EXPANDED AVAILABILITY OF HOSPITAL CARE AND MEDICAL SERVICES FOR VETERANS THROUGH THE USE OF AGREEMENTS WITH NON-DEPARTMENT OF VETERANS AFFAIRS ENTITIES.

(a) EXPANSION OF AVAILABLE CARE AND SERVICES.—

(1) FURNISHING OF CARE.—

(A) IN GENERAL.—Hospital care and medical services under chapter 17 of title 38, United States Code, shall be furnished to an eligible veteran described in subsection (b), at the election of such veteran, through agreements authorized under subsection (d), or any other law administered by the Secretary of Veterans Affairs, with entities specified in subparagraph (B) for the furnishing of such care and services to veterans.

(B) ENTITIES SPECIFIED.—The entities specified in this subparagraph are the following:

(i) 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 program.

(ii) 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))).

(iii) The Department of Defense.

(iv) The Indian Health Service.

(v) Subject to subsection (d)(5), a health care provider not otherwise covered under any of clauses (i) through (iv).

(2) CHOICE OF PROVIDER.—An eligible veteran who makes an election under subsection (c) to receive hospital care or medical services under this section may select a provider of such care or services from among the entities specified in paragraph (1)(B) that are accessible to the veteran.

(3) COORDINATION OF CARE AND SERVICES.—The Secretary shall coordinate, through the Non-VA Care Coordination Program of the Department of Veterans Affairs, the furnishing of care and services under this section to eligible veterans, including by ensuring that an eligible veteran receives an appointment for such care and services within the wait-time goals of the Veterans Health Administration for the furnishing of hospital care and medical services.

(b) ELIGIBLE VETERANS.—A veteran is an eligible veteran for purposes of this section if—

(1) the veteran is enrolled in the patient enrollment system of the Department of Veterans Affairs established and operated under section 1705 of title 38, United States Code, including any such veteran who has not received hospital care or medical services from the Department and has contacted the Department seeking an initial appointment from the Department for the receipt of such care or services; and

(2) the veteran—

(A) attempts, or has attempted, to schedule an appointment for the receipt of hospital care or medical services under chapter 17 of title 38, United States Code, but is unable to schedule an appointment within—

(i) the wait-time goals of the Veterans Health Administration for the furnishing of such care or services; or

(ii) with respect to such care or services that are clinically necessary, the period determined necessary for such care or services if such period is shorter than such wait-time goals;

(B) resides more than 40 miles (as calculated based on distance traveled) from—

(i) with respect to a veteran who is seeking primary care, a medical facility of the Department, including a community-based outpatient clinic, that is able to provide such primary care by a full-time primary care physician; or

(ii) with respect to a veteran not covered under clause (i), the medical facility of the Department, including a community-based outpatient clinic, that is closest to the residence of the veteran;

(C) resides—

(i) in a State without a medical facility of the Department that provides—

(I) hospital care;

(II) emergency medical services; and

(III) surgical care rated by the Secretary as having a surgical complexity of standard; and

(ii) more than 20 miles from a medical facility of the Department described in clause (i); or

(D)(i) resides in a location, other than a location in Guam, American Samoa, or the Republic of the Philippines, that is 40 miles or less from a medical facility of the Department, including a community-based outpatient clinic; and

(ii)(I) is required to travel by air, boat, or ferry to reach each medical facility described in clause (i) that is 40 miles or less from the residence of the veteran; or

(II) faces an unusual or excessive burden in traveling to such a medical facility of the Department based on—

(aa) geographical challenges;

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

(cc) a medical condition that impacts the ability to travel; or

(dd) other factors, as determined by the Secretary.

(c) ELECTION AND AUTHORIZATION.—

(1) IN GENERAL.—In the case of an eligible veteran described in subsection (b)(2)(A), the Secretary shall, at the election of the eligible veteran—

(A) provide the veteran an appointment that exceeds the wait-time goals described in such subsection or place such eligible veteran on an electronic waiting list described in paragraph (2) for an appointment for hospital care or medical services the veteran has elected to receive under this section; or

(B)(i) authorize that such care or services be furnished to the eligible veteran under this section for a period of time specified by the Secretary; and

(ii) notify the eligible veteran by the most effective means available, including electronic communication or notification in writing, describing the care or services the eligible veteran is eligible to receive under this section.

(2) ELECTRONIC WAITING LIST.—The electronic waiting list described in this paragraph shall be maintained by the Department and allow access by each eligible veteran via www.myhealth.va.gov or any successor website (or other digital channel) for the following purposes:

(A) To determine the place of such eligible veteran on the waiting list.

(B) To determine the average length of time an individual spends on the waiting list, disaggregated by medical facility of the Department and type of care or service needed, for purposes of allowing such eligible veteran to make an informed election under paragraph (1).

(d) CARE AND SERVICES THROUGH AGREEMENTS.—

(1) AGREEMENTS.—

(A) IN GENERAL.—The Secretary shall enter into agreements for furnishing care and services to eligible veterans under this section with entities specified in subsection (a)(1)(B). An agreement entered into pursuant to this subparagraph may not be treated as a Federal contract for the acquisition of goods or services and is not subject to any provision of law governing Federal contracts for the acquisition of goods or services. Before entering into an agreement pursuant to this subparagraph, the Secretary shall, to the maximum extent practicable and consistent with the requirements of this section, furnish such care and services to such veterans under this section with such entities pursuant to sharing agreements, existing contracts entered into by the Secretary, or other processes available at medical facilities of the Department.

(B) AGREEMENT DEFINED.—In this paragraph, the term "agreement" includes contracts, intergovernmental agreements, and provider agreements, as appropriate.

(2) RATES AND REIMBURSEMENT.—

(A) IN GENERAL.—In entering into an agreement under paragraph (1) with an entity specified in subsection (a)(1)(B), the Secretary shall—

(i) negotiate rates for the furnishing of care and services under this section; and

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

(B) LIMIT ON RATES.—

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

(ii) EXCEPTION.—

(I) IN GENERAL.—The Secretary may negotiate a rate that is more than the rate paid by the United States as described in clause (i) with respect to the furnishing of care or services under this section to an eligible veteran who resides in a highly rural area.

(II) HIGHLY RURAL AREA DEFINED.—In this clause, 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.

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

nished under this section in a State with an All-Payer Model Agreement under the Social Security Act that became effective on January 1, 2014, the Medicare payment rates under clause (i) shall be calculated based on the payment rates under such agreement.

(C) LIMIT ON COLLECTION.—For the furnishing of care or services pursuant to an agreement under paragraph (1), an entity specified in subsection (a)(1)(B) may not collect any amount that is greater than the rate negotiated pursuant to subparagraph (A)(i).

(3) CERTAIN PROCEDURES.—

(A) IN GENERAL.—In entering into an agreement under paragraph (1) with an entity described in subparagraph (B), the Secretary may use the procedures, including those procedures relating to reimbursement, available for entering into provider agreements under section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)) and participation agreements under section 1842(h) of such Act (42 U.S.C. 1395u(h)). During the period in which such entity furnishes care or services pursuant to this section, such entity may not be treated as a Federal contractor or subcontractor by the Office of Federal Contract Compliance Programs of the Department of Labor by virtue of furnishing such care or services.

(B) ENTITIES DESCRIBED.—The entities described in this subparagraph are the following:

(i) In the case of the Medicare program, any provider of services that has 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 entered into a participation agreement under section 1842(h) of such Act (42 U.S.C. 1395u(h)); and

(ii) In the case of the Medicaid program, any provider participating under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.).

(4) INFORMATION ON POLICIES AND PROCEDURES.—The Secretary shall provide to any entity with which the Secretary has entered into an agreement under paragraph (1) the following:

(A) Information on applicable policies and procedures for submitting bills or claims for authorized care or services furnished to eligible veterans under this section.

(B) Access to a telephone hotline maintained by the Department that such entity may call for information on the following:

(i) Procedures for furnishing care and services under this section.

(ii) Procedures for submitting bills or claims for authorized care and services furnished to eligible veterans under this section and being reimbursed for furnishing such care and services.

(iii) Whether particular care or services under this section are authorized, and the procedures for authorization of such care or services.

(5) AGREEMENTS WITH OTHER PROVIDERS.—In accordance with the rates determined pursuant to paragraph (2), the Secretary may enter into agreements under paragraph (1) for furnishing care and services to eligible veterans under this section with an entity specified in subsection (a)(1)(B)(v) if the entity meets criteria established by the Secretary for purposes of this section.

(e) RESPONSIBILITY FOR COSTS OF CERTAIN CARE.—

(1) SUBMITTAL OF INFORMATION ON HEALTH-CARE PLANS.—Before receiving hospital care or medical services under this section, an eligible veteran shall provide to the Secretary information on any health-care plan described in paragraph (2) under which the eligible veteran is covered.

(2) HEALTH-CARE PLAN.—A health-care plan described in this paragraph—

(A) is an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement not administered by the Secretary of Veterans Affairs, under which health services for individuals are provided or the expenses of such services are paid; and

(B) does not include any such policy, contract, agreement, or similar arrangement pursuant to title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.) or chapter 55 of title 10, United States Code.

(3) RECOVERY OF COSTS FOR CERTAIN CARE.—

(A) IN GENERAL.—In any case in which an eligible veteran is furnished hospital care or medical services under this section for a non-service-connected disability described in subsection (a)(2) of section 1729 of title 38, United States Code, 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 Public Law 87–693, commonly known as the "Federal Medical Care Recovery Act" (42 U.S.C. 2651 et seq.), the Secretary shall recover or collect from a third party (as defined in subsection (i) of such section 1729) reasonable charges for such care or services to the extent that the veteran (or the 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 by a department or agency of the United States.

(B) USE OF AMOUNTS.—Amounts collected by the Secretary under subparagraph (A) shall be deposited in the Medical Community Care account of the Department. Amounts so deposited shall remain available until expended.

(f) VETERANS CHOICE CARD.—

(1) IN GENERAL.—For purposes of receiving care and services under this section, the Secretary shall, not later than 90 days after the date of the enactment of this Act, issue to each veteran described in subsection (b)(1) a card that may be presented to a health care provider to facilitate the receipt of care or services under this section.

(2) NAME OF CARD.—Each card issued under paragraph (1) shall be known as a "Veterans Choice Card".

(3) DETAILS OF CARD.—Each Veterans Choice Card issued to a veteran under paragraph (1) shall include the following:

(A) The name of the veteran.

(B) An identification number for the veteran that is not the social security number of the veteran.

(C) The contact information of an appropriate office of the Department for health care providers to confirm that care or services under this section are authorized for the veteran.

(D) Contact information and other relevant information for the submittal of claims or bills for the furnishing of care or services under this section.

(E) The following statement: "This card is for qualifying medical care outside the Department of Veterans Affairs. Please call the Department of Veterans Affairs phone number specified on this card to ensure that treatment has been authorized.".

(4) INFORMATION ON USE OF CARD.—Upon issuing a Veterans Choice Card to a veteran, the Secretary shall provide the veteran with information clearly stating the circumstances under which the veteran may be eligible for care or services under this section.

(g) INFORMATION ON AVAILABILITY OF CARE.—The Secretary shall provide information to a veteran about the availability of care and services under this section in the following circumstances:

(1) When the veteran enrolls in the patient enrollment system of the Department under section 1705 of title 38, United States Code.

(2) When the veteran attempts to schedule an appointment for the receipt of hospital care or medical services from the Department but is unable to schedule an appointment within the wait-time goals of the Veterans Health Administration for the furnishing of such care or services.

(3) When the veteran becomes eligible for hospital care or medical services under this section under subparagraph (B), (C), or (D) of subsection (b)(2).

(h) FOLLOW-UP CARE.—In carrying out this section, the Secretary shall ensure that, at the election of an eligible veteran who receives hospital care or medical services from a health care provider in an episode of care under this section, the veteran receives such hospital care and medical services from such health care provider through the completion of the episode of care, including all specialty and ancillary services deemed necessary as part of the treatment recommended in the course of such hospital care or medical services.

(i) PROVIDERS.—To be eligible to furnish care or services under this section, a health care provider must—

(1) maintain at least the same or similar credentials and licenses as those credentials and licenses that are required of health care providers of the Department, as determined by the Secretary for purposes of this section; and

(2) submit, not less frequently than once each year during the period in which the Secretary is authorized to carry out this section pursuant to subsection (p), verification of such licenses and credentials maintained by such health care provider.

(j) COST-SHARING.—

(1) IN GENERAL.—The Secretary shall require an eligible veteran to pay a copayment for the receipt of care or services under this section only if such eligible veteran would be required to pay a copayment for the receipt of such care or services at a medical facility of the Depart-

ment or from a health care provider of the Department pursuant to chapter 17 of title 38, United States Code.

(2) LIMITATION.—The amount of a copayment charged under paragraph (1) may not exceed the amount of the copayment that would be payable by such eligible veteran for the receipt of such care or services at a medical facility of the Department or from a health care provider of the Department pursuant to chapter 17 of title 38, United States Code.

(3) COLLECTION OF COPAYMENT.—A health care provider that furnishes care or services to an eligible veteran under this section shall collect the copayment required under paragraph (1) from such eligible veteran at the time of furnishing such care or services.

(k) CLAIMS PROCESSING SYSTEM.—

(1) IN GENERAL.—The Secretary shall provide for an efficient nationwide system for processing and paying bills or claims for authorized care and services furnished to eligible veterans under this section.

(2) REGULATIONS.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall prescribe regulations for the implementation of such system.

(3) OVERSIGHT.—The Chief Business Office of the Veterans Health Administration shall oversee the implementation and maintenance of such system.

(4) ACCURACY OF PAYMENT.—

(A) IN GENERAL.—The Secretary shall ensure that such system meets such goals for accuracy of payment as the Secretary shall specify for purposes of this section.

(B) QUARTERLY REPORT.—

(i) IN GENERAL.—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 quarterly report on the accuracy of such system.

(ii) ELEMENTS.—Each report required by clause (i) shall include the following:

(I) A description of the goals for accuracy for such system specified by the Secretary under subparagraph (A).

(II) An assessment of the success of the Department in meeting such goals during the quarter covered by the report.

(iii) DEADLINE.—The Secretary shall submit each report required by clause (i) not later than 20 days after the end of the quarter covered by the report.

(l) MEDICAL RECORDS.—

(1) IN GENERAL.—The Secretary shall ensure that any health care provider that furnishes care or services under this section to an eligible veteran submits to the Department a copy of any medical record related to the care or services provided to such eligible veteran by such health care provider for inclusion in the electronic medical record of such eligible veteran maintained by the Department upon the completion of the provision of such care or services to such eligible veteran.

(2) ELECTRONIC FORMAT.—Any medical record submitted to the Department under paragraph (1) shall, to the extent possible, be in an electronic format.

(m) TRACKING OF MISSED APPOINTMENTS.—The Secretary shall implement a mechanism to track any missed appointments for care or services under this section by eligible veterans to ensure that the Department does not pay for such care or services that were not furnished to an eligible veteran.

(n) IMPLEMENTATION.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall prescribe interim final regulations on the implementation of this section and publish such regulations in the Federal Register.

(o) INSPECTOR GENERAL REPORT.—Not later than 30 days after the date on which the Secretary determines that 75 percent of the amounts deposited in the Veterans Choice Fund established by section 802 have been exhausted, the Inspector General of the Department shall submit to the Secretary a report on the results of an audit of the care and services furnished under this section to ensure the accuracy and timeliness of payments by the Department for the cost of such care and services, including any findings and recommendations of the Inspector General.

[(p) AUTHORITY TO FURNISH CARE AND SERVICES.—

[(1) IN GENERAL.—The Secretary may not use the authority under this section to furnish care and services after the date specified in paragraph (2).

[(2) DATE SPECIFIED.—The date specified in this paragraph is the date on which the Secretary has exhausted all amounts deposited in the Veterans Choice Fund established by section 802.

[(3) PUBLICATION.—The Secretary shall publish such date in the Federal Register and on an Internet website of the Department available to the public not later than 30 days before such date.]

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

(q) REPORTS.—

(1) INITIAL REPORT.—Not later than 90 days after the publication of the interim final regulations under subsection (n), the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the furnishing of care and services under this section that includes the following:

(A) The number of eligible veterans who have received care or services under this section.

(B) A description of the types of care and services furnished to eligible veterans under this section.

(2) FINAL REPORT.—Not later than 30 days after the date on which the Secretary determines that 75 percent of the amounts deposited in the Veterans Choice Fund established by section 802 have been exhausted, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the furnishing of care and services under this section that includes the following:

(A) The total number of eligible veterans who have received care or services under this section, disaggregated by—

(i) eligible veterans described in subsection (b)(2)(A);

(ii) eligible veterans described in subsection (b)(2)(B);

(iii) eligible veterans described in subsection (b)(2)(C); and

(iv) eligible veterans described in subsection (b)(2)(D).

(B) A description of the types of care and services furnished to eligible veterans under this section.

(C) An accounting of the total cost of furnishing care and services to eligible veterans under this section.

(D) The results of a survey of eligible veterans who have received care or services under this section on the satisfaction of such eligible veterans with the care or services received by such eligible veterans under this section.

(E) An assessment of the effect of furnishing care and services under this section on wait times for appointments for the receipt of hospital care and medical services from the Department.

(F) An assessment of the feasibility and advisability of continuing furnishing care and services under this section after the termination date specified in subsection (p).

(r) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to alter the process of the Department for filling and paying for prescription medications.

(s) WAIT-TIME GOALS OF THE VETERANS HEALTH ADMINISTRATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), in this section, the term "wait-time goals of the Veterans Health Administration" means not more than 30 days from the date on which a veteran requests an appointment for hospital care or medical services from the Department.

(2) ALTERNATE GOALS.—If the Secretary submits to Congress, not later than 60 days after the date of the enactment of this Act, a report stating that the actual wait-time goals of the Veterans Health Administration are different from the wait-time goals specified in paragraph (1)—

(A) for purposes of this section, the wait-time goals of the Veterans Health Administration shall be the wait-time goals submitted by the Secretary under this paragraph; and

(B) the Secretary shall publish such wait-time goals in the Federal Register and on an Internet website of the Department available to the public.

(t) WAIVER OF CERTAIN PRINTING REQUIREMENTS.—Section 501 of title 44, United States Code, shall not apply in carrying out this section.

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TITLE VII—OTHER VETERANS MATTERS

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SEC. 705. LIMITATION ON AWARDS AND BONUSES PAID TO EMPLOYEES OF DEPARTMENT OF VETERANS AFFAIRS.

(a) LIMITATION.—The Secretary of Veterans Affairs shall ensure that the aggregate amount of awards and bonuses paid by the Secretary in a fiscal year under chapter 45 or 53 of title 5, United States Code, or any other awards or bonuses authorized under such title or title 38, United States Code, does not exceed the following amounts:

(1) With respect to each of fiscal years 2017 through 2018, ⟦$230,000,000⟧ *$250,000,000, of which not less than $20,000,000 shall be for recruitment, relocation, and retention bonuses*.

(2) With respect to each of fiscal years 2019 through 2021, ⟦$225,000,000⟧ *$290,000,000, of which not less than $20,000,000 shall be for recruitment, relocation, and retention bonuses*.

(3) With respect to each of fiscal years 2022 through 2024, $360,000,000.

(b) SENSE OF CONGRESS.—It is the sense of Congress that the limitation under subsection (a) should not disproportionately impact lower-wage employees and that the Department of Veterans Affairs is encouraged to use bonuses to incentivize high-performing employees in areas in which retention is challenging.

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TITLE VIII—OTHER MATTERS

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SEC. 802. VETERANS CHOICE FUND.

(a) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the Veterans Choice Fund.

(b) ADMINISTRATION OF FUND.—The Secretary of Veterans Affairs shall administer the Veterans Choice Fund established by subsection (a).

(c) USE OF AMOUNTS.—

(1) IN GENERAL.—Except as provided ⟦by paragraph (3)⟧ *in paragraphs (3) and (4)*, any amounts deposited in the Veteran Choice Fund shall be used by the Secretary of Veterans Affairs to carry out section 101, including, subject to paragraph (2), any administrative requirements of such section.

(2) AMOUNT FOR ADMINISTRATIVE REQUIREMENTS.—

(A) LIMITATION.—Except as provided by subparagraph (B), of the amounts deposited in the Veterans Choice Fund, not more than $300,000,000 may be used for administrative requirements to carry out section 101.

(B) INCREASE.—The Secretary may increase the amount set forth in subparagraph (A) with respect to the amounts used for administrative requirements if—

(i) the Secretary determines that the amount of such increase is necessary to carry out section 101;

(ii) the Secretary submits to the Committees on Veterans' Affairs and Appropriations of the House of Representatives and the Committees on Veterans' Affairs and Appropriations of the Senate a report described in subparagraph (C); and

(iii) a period of 60 days has elapsed following the date on which the Secretary submits the report under clause (ii).

(C) REPORT.—A report described in this subparagraph is a report that contains the following:

(i) A notification of the amount of the increase that the Secretary determines necessary under subparagraph (B)(i).

(ii) The justifications for such increased amount.

(iii) The administrative requirements that the Secretary will carry out using such increased amount.

(3) TEMPORARY AUTHORITY FOR OTHER USES.—

(A) OTHER NON-DEPARTMENT CARE.—In addition to the use of amounts described in paragraph (1), of the amounts deposited in the Veterans Choice Fund, not more than $3,348,500,000 may be used by the Secretary during the period described in subparagraph (C) for amounts obligated by the Secretary on or after May 1, 2015, to furnish health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities, including pursuant to non-Department provider programs other than the program established by section 101.

(B) HEPATITIS C.—Of the amount specified in subparagraph (A), not more than $500,000,000 may be used by the Secretary during the period described in subparagraph (C) for pharmaceutical expenses relating to the treatment of Hepatitis C.

(C) PERIOD DESCRIBED.—The period described in this subparagraph is the period beginning on the date of the enactment of the VA Budget and Choice Improvement Act and ending on October 1, 2015.

(D) REPORTS.—Not later than 14 days after the date of the enactment of the VA Budget and Choice Improvement Act, and not less frequently than once every 14-day period thereafter during the period described in subparagraph (C), the Secretary shall submit to the appropriate congressional committees a report detailing—

(i) the amounts used by the Secretary pursuant to subparagraphs (A) and (B); and

(ii) an identification of such amounts listed by the non-Department provider program for which the amounts were used.

(E) DEFINITIONS.—In this paragraph:

(i) The term "appropriate congressional committees" means—

(I) the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives; and

(II) the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate.

(ii) The term "non-Department facilities" has the meaning given that term in section 1701 of title 38, United States Code.

(iii) The term "non-Department provider program" has the meaning given that term in section 4002(d) of the VA Budget and Choice Improvement Act.

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

(d) APPROPRIATION AND DEPOSIT OF AMOUNTS.—

(1) IN GENERAL.—There is authorized to be appropriated, and is appropriated, to the Secretary of Veterans Affairs, out of any funds in the Treasury not otherwise appropriated $10,000,000,000 to be deposited in the Veterans Choice Fund established by subsection (a). Such funds shall be available for obligation or expenditure without fiscal year limitation, and only for the program created under section 101(or for hospital care and medical services pursuant ❙to subsection (c)(3)❙ *to paragraphs (3) and (4) of subsection (c)* of this section).

(2) AVAILABILITY.—The amount appropriated under paragraph (1) shall remain available until expended.

(e) SENSE OF CONGRESS.—It is the sense of Congress that the Veterans Choice Fund is a supplement to but distinct from the Department of Veterans Affairs' current and expected level of non-Department care currently part of Department's medical care budget. Congress expects that the Department will maintain at least its existing obligations of non-Department care programs in addition to but distinct from the Veterans Choice Fund for each of fiscal years 2015 through 2017.

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SOCIAL SECURITY ACT

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART E—MISCELLANEOUS PROVISIONS

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AGREEMENTS WITH PROVIDERS OF SERVICES; ENROLLMENT PROCESSES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A)(i) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and (ii) not to impose any charge that is prohibited under section 1902(n)(3),

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1862(a), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of title XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1886, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a quality improvement organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, with-

out regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews),

(ii) in the case of hospitals, critical access hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a quality improvement organization (which has a contract with the Secretary under part B of title XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A),

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2),

(H)(i) in the case of hospitals which provide services for which payment may be made under this title and in the case of critical access hospitals which provide critical access hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14), and other than services described by section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (I) that are furnished to an individual who is a patient of the hospital, and (II) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

(I) that are furnished to an individual who is a resident of the skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1861(s)(2)(D), that are furnished to such an individual without regard to such period), and

(II) for which the individual is entitled to have payment made under this title,

to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,

(I) in the case of a hospital or critical access hospital—

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1867 and to meet the requirements of such section,

(ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition,

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code,

(K) not to charge any individual or any other person for items or services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B),

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care ⟦under section 603⟧ *under chapter 17* of title 38, United States Code, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of such section,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a person acting on the individual's behalf), at or about the time of the individual's

admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,—and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals and critical access hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1842(h)(4)) for the area served by the hospital or critical access hospital,

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services,

(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1867 with respect to examination and treatment for emergency medical conditions and women in labor, and

(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicaid program under a State plan approved under title XIX,

(O) to accept as payment in full for services that are covered under this title and are furnished to any individual enrolled with a Medicare+Choice organization under part C, with a PACE provider under section 1894 or 1934, or with an eligible organization with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, which does not have a contract (or, in the case of a PACE provider, contract or other agreement) establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this title (less any payments under sections 1886(d)(11) and 1886(h)(3)(D)) if the individuals were not so enrolled,

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy car (described in section 1861(m)(5)), to offer to furnish such supplies to such an individual as part of their furnishing of home health services,

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives),

(R) to contract only with a health care clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the health care clearinghouse is required to comply with the standard or specification,

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1861(ee)(2)(H)(ii), or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

(i) the nature of such financial interest,

(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

(iii) the percentage of such individuals who received such services from such provider (or another such provider),

(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1886(d)(12) to carry out such section,

(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care both—

(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services,

(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated),

(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data to the Secretary in accordance with subsection (k),

(X) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary, and

(Y) beginning 12 months after the date of the enactment of this subparagraph, in the case of a hospital or critical access hospital, with respect to each individual who receives observation services as an outpatient at such hospital or critical access hospital for more than 24 hours, to provide to such individual not later than 36 hours after the time such individual begins receiving such services (or, if sooner, upon release)—

(i) such oral explanation of the written notification described in clause (ii), and such documentation of the provision of such explanation, as the Secretary determines to be appropriate;

(ii) a written notification (as specified by the Secretary pursuant to rulemaking and containing such language as the Secretary prescribes consistent with this paragraph) which—

(I) explains the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reasons for such status of such individual;

(II) explains the implications of such status on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as implications for cost-sharing requirements under this title and for subsequent eligibility for coverage under this title for services furnished by a skilled nursing facility;

(III) includes such additional information as the Secretary determines appropriate;

(IV) either—

(aa) is signed by such individual or a person acting on such individual's behalf to acknowledge receipt of such notification; or

(bb) if such individual or person refuses to provide the signature described in item (aa), is signed by the staff member of the hospital or critical access hospital who presented the written notification and includes the name and title of such staff member, a certification that the notification was presented, and the date and time the notification was presented; and

(V) is written and formatted using plain language and is made available in appropriate languages as determined by the Secretary.

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A) and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in section 1834(a)(1)(B). In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5). In the case of services described in section 1833(a)(8) or section 1833(a)(9) for which payment is made under part B under section 1834(k), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2), except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of subparagraph (C), whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1813(a)(2).

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of section 1866(a)(2)(B)(ii), charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this title if the admitting physician has a direct or indirect financial interest in such provider.

(3)(A) Under the agreement required under paragraph (1)(F)(ii), the quality improvement organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1154(a)(4)(A) and under section 1154(a)(14) with respect to services, furnished by the hospital, critical access hospital, facility, or agency involved, for which payment may be made under this title.

(B) For purposes of payment under this title, the cost of such an agreement to the hospital, critical access hospital, facility, or agency shall be considered a cost incurred by such hospital, critical access hospital, facility, or agency in providing covered services under this title and shall be paid directly by the Secretary to the quality improvement organization on behalf of such hospital, critical access hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for a fiscal year—

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, critical access hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, critical access hospitals, or agencies under part B of title XI.

(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861,

(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A, or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this title becomes effective under section 1128(c).

(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(V) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(U) by a hospital that is subject to the provisions of such Act.

(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(c)(1) Where the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur.

(2) Where the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of such termination or nonrenewal.

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital, he may, in lieu of terminating his agreement with such hospital, decide that, with respect to any individual admitted to such hospital after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services. Such decision may be made effective only after such notice to the hospital and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) For purposes of this section, the term "provider of services" shall include—

(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1861), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1861), but only with respect to the furnishing of outpatient physical therapy services (as therein defined), (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services, or (through the operation of section 1861(ll)(2)) with respect to the furnishing of outpatient speech-language pathology; and

(2) a community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)).

(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819(c)(2)(E), 1833(s), 1855(i), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services, Medicare+Choice organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the written policies of the provider or organization respecting the implementation of such rights;

(B) to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a skilled nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of an eligible organization (as defined in section 1876(b)) or an organization provided payments under section 1833(a)(1)(A) or a Medicare+Choice organization, at the time of enrollment of the individual with the organization.

(3) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(4) For construction relating to this subsection, see section 7 of the Assisted Suicide Funding Restriction Act of 1997 (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(g) Except as permitted under subsection (a)(2), any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(h)(1)(A) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.

(C)(i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which—

(I) the remedy of termination of participation has been imposed;

(II) a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) has been imposed, but only if such remedy has been imposed on an immediate basis; or

(III) a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a skilled nursing facility's nurse aide training program.

(ii) Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).

(iii) Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.

(i)(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this title and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this title with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this title—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this title with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this title with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this title.

(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

(1) ENROLLMENT PROCESS.—

(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title. Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (5), the imposition of temporary enrollment moratoria in accordance with paragraph (7), and the establishment of compliance programs in accordance with paragraph (9).

(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

(2) PROVIDER SCREENING.—

(A) PROCEDURES.—Not later than 180 days after the date of enactment of this paragraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

(B) LEVEL OF SCREENING.—The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

(i) shall include a licensure check, which may include such checks across States; and

(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

(I) a criminal background check;

(II) fingerprinting;

(III) unscheduled and unannounced site visits, including preenrollment site visits;

(IV) database checks (including such checks across States); and

(V) such other screening as the Secretary determines appropriate.

(C) APPLICATION FEES.—

(i) INSTITUTIONAL PROVIDERS.—Except as provided in clause (ii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

(I) for 2010, $500; and

(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(ii) HARDSHIP EXCEPTION; WAIVER FOR CERTAIN MEDICAID PROVIDERS.—The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

(iii) USE OF FUNDS.—Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1128J.

(D) APPLICATION AND ENFORCEMENT.—

(i) NEW PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this title, title XIX, or title XXI as of the date of enactment of this paragraph, on or after the date that is 1 year after such date of enactment.

(ii) CURRENT PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enactment, on or after the date that is 2 years after such date of enactment.

(iii) REVALIDATION OF ENROLLMENT.—Effective beginning on the date that is 180 days after such date of enactment, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this title, title XIX, or title XXI.

(iv) LIMITATION ON ENROLLMENT AND REVALIDATION OF ENROLLMENT.—In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this title, title XIX, or title XXI on or after the date that is 3 years after such date of enactment.

(E) USE OF INFORMATION FROM THE DEPARTMENT OF TREASURY CONCERNING TAX DEBTS.—In reviewing the application of a provider of services or supplier to enroll or reenroll under the program under this title, the Secretary shall take into account the information supplied by the Secretary of the Treasury pursuant to section 6103(l)(22) of the Internal Revenue Code of 1986, in determining whether to deny such application or to apply enhanced oversight to such provider of services or supplier pursuant to paragraph (3) if the Secretary determines such provider of services or supplier owes such a debt.

(F) EXPEDITED RULEMAKING.—The Secretary may promulgate an interim final rule to carry out this paragraph.

(3) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND SUPPLIERS.—

(A) IN GENERAL.—The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this title, the Medicaid program under title XIX. and the CHIP program under title XXI.

(B) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

(4) 90-DAY PERIOD OF ENHANCED OVERSIGHT FOR INITIAL CLAIMS OF DME SUPPLIERS.—For periods beginning after January 1, 2011, if the Secretary determines that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, in the case of a supplier of durable medical equipment who is within a category or geographic area under title XVIII identified pursuant to such determination and who is initially enrolling under such title, the Secretary shall, notwithstanding sections 1816(c), 1842(c), and 1869(a)(2), withhold payment under such title with respect to durable medical equipment furnished by such supplier during the 90-day period beginning on the date of the first submission of a claim under such title for durable medical equipment furnished by such supplier.

(5) INCREASED DISCLOSURE REQUIREMENTS.—

(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this title, title XIX, or title XXI on or after the date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in section 1128B(f)), has been excluded from participation under the program under this title, the Medicaid program under title XIX, or the CHIP program under title XXI, or has had its billing privileges denied or revoked.

(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

(6) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR MEDICARE OBLIGATIONS.—

(A) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any amount described in subparagraph (B)(ii) due from such obligated provider of services or supplier.

(B) DEFINITIONS.—In this paragraph:

(i) IN GENERAL.—The term "applicable provider of services or supplier" means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this title than is assigned to the obligated provider of services or supplier.

(ii) OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term "obligated provider of services or supplier" means a provider of services or supplier that owes an amount that is more than the amount required to be paid under the program under this title (as determined by the Secretary).

(7) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS; NONPAYMENT.—

(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or otherwise, of a temporary moratorium imposed under subparagraph (A).

(C) NONPAYMENT.—

(i) IN GENERAL.—No payment may be made under this title or under a program described in subparagraph (A) with respect to an item or service described in clause (ii) furnished on or after October 1, 2017.

(ii) ITEM OR SERVICE DESCRIBED.—An item or service described in this clause is an item or service furnished—

(I) within a geographic area with respect to which a temporary moratorium imposed under subparagraph (A) is in effect; and

(II) by a provider of services or supplier that meets the requirements of clause (iii).

(iii) REQUIREMENTS.—For purposes of clause (ii), the requirements of this clause are that a provider of services or supplier—

(I) enrolls under this title on or after the effective date of such temporary moratorium; and

(II) is within a category of providers of services and suppliers (as described in subparagraph (A)) subject to such temporary moratorium.

(iv) PROHIBITION ON CHARGES FOR SPECIFIED ITEMS OR SERVICES.—In no case shall a provider of services or supplier described in clause (ii)(II) charge an individual or other person for an item or service described in clause (ii) furnished on or after October 1, 2017, to an individual entitled to benefits under part A or enrolled under part B or an individual under a program specified in subparagraph (A).

(8) COMPLIANCE PROGRAMS.—

(A) IN GENERAL.—On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.

(9) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

(k) QUALITY REPORTING BY CANCER HOSPITALS.—

(1) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

(2) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(3) QUALITY MEASURES.—

(A) IN GENERAL.—Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

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VETERANS' BENEFITS IMPROVEMENTS ACT OF 1994

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TITLE I—PERSIAN GULF WAR VETERANS

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SEC. 104. DEVELOPMENT OF MEDICAL EVALUATION PROTOCOL.

(a) UNIFORM MEDICAL EVALUATION PROTOCOL.—(1) The Secretary of Veterans Affairs shall develop and implement a uniform and comprehensive medical evaluation protocol that will ensure appropriate medical assessment, diagnosis, and treatment of Persian Gulf War veterans who are suffering from illnesses the origins of which are (as of the date of the enactment of this Act) un-

known and that may be attributable to service in the Southwest Asia theater of operations during the Persian Gulf War. The protocol shall include an evaluation of complaints relating to illnesses involving the reproductive system.

(2) If such a protocol is not implemented before the end of the 120-day period beginning on the date of the enactment of this Act, the Secretary shall, before the end of such period, submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report as to why such a protocol has not yet been developed.

(3)(A) The Secretary shall ensure that the evaluation under the protocol developed under this section is available at all Department medical centers that have the capability of providing the medical assessment, diagnosis, and treatment required under the protocol.

(B) The Secretary may enter into contracts with non-Department medical facilities for the provision of the evaluation under the protocol.

(C) In the case of a veteran whose residence is distant from a medical center described in subparagraph (A), the Secretary may provide the evaluation through a Department medical center described in that subparagraph and, in such a case, may provide the veteran the travel and incidental expenses therefor pursuant to the provisions of section 111 of title 38, United States Code.

(4)(A) If the Secretary is unable to diagnose the symptoms or illness of a veteran provided an evaluation, or if the symptoms or illness of a veteran do not respond to treatment provided by the Secretary, the Secretary may use the authority [in section 1703] *in sections 1703A, 8111, and 8153* of title 38, United States Code, in order to provide for the veteran to receive diagnostic tests or treatment at a non-Department medical facility that may have the capability of diagnosing or treating the symptoms or illness of the veteran. The Secretary may provide the veteran the travel and incidental expenses therefor pursuant to the provisions of section 111 of title 38, United States Code.

(B) The Secretary shall request from each non-Department medical facility that examines or treats a veteran under this paragraph such information relating to the diagnosis or treatment as the Secretary considers appropriate.

(5) In each year after the implementation of the protocol, the Secretary shall enter into an agreement with the National Academy of Sciences under which agreement appropriate experts shall review the adequacy of the protocol and its implementation by the Department of Veterans Affairs.

(b) RELATIONSHIP TO OTHER COMPREHENSIVE CLINICAL EVALUATION PROTOCOLS.—The Secretary, in consultation with the Secretary of Defense, shall ensure that the information collected through the protocol described in this section is collected and maintained in a manner that permits the effective and efficient cross-reference of that information with information collected and maintained through the comprehensive clinical protocols of the Department of Defense for Persian Gulf War veterans.

(c) CASE DEFINITIONS AND DIAGNOSES.—The Secretary shall develop case definitions or diagnoses for illnesses associated with the service described in subsection (a)(1). The Secretary shall develop such definitions or diagnoses at the earliest possible date.

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CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2010

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TITLE I—CAREGIVER SUPPORT

SEC. 101. ASSISTANCE AND SUPPORT SERVICES FOR CAREGIVERS.

(a) ASSISTANCE AND SUPPORT SERVICES.—

(1) (Amendatory-Omitted)

(2) (Amendatory-Omitted)

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by this subsection shall take effect on the date that is 270 days after the date of the enactment of this Act.

(B) IMPLEMENTATION.—The Secretary of Veterans Affairs shall commence the programs required by subsections (a) and (b) of section 1720G of title 38, United States Code, as added by paragraph (1) of this subsection, on the date on which the amendments made by this subsection take effect.

(b) IMPLEMENTATION PLAN AND REPORT.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall—

(A) develop a plan for the implementation of the program of comprehensive assistance for family caregivers required by section 1720G(a)(1) of title 38, United States Code, as added by subsection (a)(1) of this section; and

(B) submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on such plan.

(2) CONSULTATION.—In developing the plan required by paragraph (1)(A), the Secretary shall consult with the following:

(A) Individuals described in section 1720G(a)(2) of title 38, United States Code, as added by subsection (a)(1) of this section.

(B) Family members of such individuals who provide personal care services to such individuals.

(C) The Secretary of Defense with respect to matters concerning personal care services for members of the Armed Forces undergoing medical discharge from the Armed Forces who are eligible to benefit from personal care services furnished under the program of comprehensive assistance required by section 1720G(a)(1) of such title, as so added.

(D) Veterans service organizations, as recognized by the Secretary for the representation of veterans under section 5902 of such title.

(E) National organizations that specialize in the provision of assistance to individuals with the types of disabilities that family caregivers will encounter while providing personal care services under the program of comprehensive assistance required by section 1720G(a)(1) of such title, as so added.

(F) National organizations that specialize in provision of assistance to family members of veterans who provide personal care services to such veterans.

(G) Such other organizations with an interest in the provision of care to veterans and assistance to family caregivers as the Secretary considers appropriate.

(3) REPORT CONTENTS.—The report required by paragraph (1)(B) shall contain the following:

(A) The plan required by paragraph (1)(A).

(B) A description of the individuals, caregivers, and organizations consulted by the Secretary of Veterans Affairs under paragraph (2).

(C) A description of such consultations.

(D) The recommendations of such individuals, caregivers, and organizations, if any, that were not adopted and incorporated into the plan required by paragraph (1)(A), and the reasons the Secretary did not adopt such recommendations.

(c) ANNUAL EVALUATION REPORT.—

(1) IN GENERAL.—Not later than 2 years after the date described in subsection (a)(3)(A) and annually thereafter, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a comprehensive report on the implementation of section 1720G of title 38, United States Code, as added by subsection (a)(1).

(2) CONTENTS.—The report required by paragraph (1) shall include the following:

(A) With respect to the program of comprehensive assistance for family caregivers required by subsection (a)(1) of such section 1720G and the program of general caregiver support services required by subsection (b)(1) of such section—

(i) the number of caregivers that received assistance under such programs;

(ii) the cost to the Department of providing assistance under such programs;

(iii) a description of the outcomes achieved by, and any measurable benefits of, carrying out such programs;

(iv) an assessment of the effectiveness and the efficiency of the implementation of such programs*, including a description of any barriers to accessing and receiving care and services under such programs*; and

(v) such recommendations, including recommendations for legislative or administrative action, as the Secretary considers appropriate in light of carrying out such programs.

(B) With respect to the program of comprehensive assistance for family caregivers required by such subsection (a)(1)—

(i) a description of the outreach activities carried out by the Secretary under such program**[**; and**]***;*

(ii) an assessment of the manner in which resources are expended by the Secretary under such program, particularly with respect to the provision of monthly personal caregiver stipends under paragraph (3)(A)(ii)(v) of such subsection (a)**[**.**]***; and*

(iii) an evaluation of the sufficiency and consistency of the training provided to family caregivers under such program in preparing family caregivers to provide care to veterans under such program.

(C) With respect to the provision of general caregiver support services required by such subsection (b)(1)—

(i) a summary of the support services made available under the program;

(ii) the number of caregivers who received support services under the program;

(iii) the cost to the Department of providing each support service provided under the program; and

(iv) such other information as the Secretary considers appropriate.

(d) REPORT ON EXPANSION OF FAMILY CAREGIVER ASSISTANCE.—

(1) IN GENERAL.—Not later than 2 years after the date described in subsection (a)(3)(A), the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the feasibility and advisability of expanding the provision of assistance under section 1720G(a) of title 38, United States Code, as added by subsection (a)(1), to family caregivers of veterans who have a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service before September 11, 2001.

(2) RECOMMENDATIONS.—The report required by paragraph (1) shall include such recommendations as the Secretary considers appropriate with respect to the expansion described in such paragraph.

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