

## Section by Section Summary

### **Title I – DEVELOPING AN INTEGRATED HIGH-PERFORMING NETWORK**

#### **Subtitle A – Establishing the Program**

##### **Sec. 101 Establishment of Veterans Community Care Program**

This section establishes the Veterans Community Care Program to furnish hospital care, medical services and extended care services to covered veterans through health care providers in the community.

Requires the Secretary to enter into competitively bid contracts to manage networks of health care providers. Allows the Secretary to terminate contracts in the event that a contractor fails to comply with provisions of the contract.

Requires each medical facility of the Department have a care coordination team capability to oversee the continuity of care for veterans participating in the Veterans Community Care Program.

Reforms eligibility and conditions that requires the Department to furnish hospital care, medical services and extended care services through health care providers in the community, which is provided at the election of the covered veterans. The conditions in which a covered veteran would have the option to access community care are when:

- A medical facility of the Department does not offer the hospital care, medical services and extended care services the covered veteran requires.
- A medical facility of the Department cannot furnish or schedule an appointment for hospital care, medical services, or extended care services in accordance with access standards established under section 1703B of this title. (See Section 103)
- A covered veteran and a referring clinician of the covered veteran agree that furnishing hospital care, medical services, or extended care services through a non-Department entity or provider would be in the best medical interest of the covered veteran, after consideration of the standards established under sections 1703B and 1703C of this title (See Section 103 and 104) or due to a non-clinical reason, compelling circumstance, or other considerations that are in the best medical interest of the covered veteran.

Requires the Secretary to determine the capacity of medical facilities of the Department, on a case-by-case basis, to manage scheduling services and provides the flexibility to contract scheduling services as needed.

Intentionally defines medical facility to provide flexibility to the Department in providing care within the VA to a veteran versus going to the community if one particular facility, such as a CBOC, does not offer the care. It is defined as: a medical center, a community-based outpatient clinic, an outpatient clinic, or any other

facility of the Department at which hospital care, medical services, or extended care services are furnished.

**Sec. 102 Strategy Regarding the Department Of Veterans Affairs High-Performing Integrated Health Care Network**

This section requires the Department to conduct a comprehensive examination every four years (to be known as a ‘quadrennial Veterans Health Administration review’ (QVHAR)) of programs and policies of the Department regarding the delivery of health care services and the need for health care services for veterans in future years. (such as the Department of Defense Quadrennial Defense Review (QDR))

Requires that each QVHAR include a strategic plan to meet future requirements and demand for hospital care, medical services, and extended care services and develop five-year budget forecasts (such as the Department of Defense Future Year Defense Program (FYDP)). The Secretary shall ensure that the fiscal year budget request of the Department each year is reflective of the most recent QVHAR and strategic plan.

Requires the Secretary designate a Director to manage the high-performing, integrated network with the specific responsibilities of overseeing transformation and organizational change, developing and implementing the strategic plan and QVHAR, overseeing regular market assessments, and developing budget and planning processes related to the network. The Director is required to coordinate with other relevant offices within the Department, and also with relevant directors at other federal healthcare systems. The Director will also be responsible for carrying out regular briefings with Congress to oversee the network and the implementation of the new community care program.

Requires the VA to conduct a thorough market assessment every four years to assist the Department in planning and budgeting. Each market area assessment will include an assessment of the demand for hospital care, medical services, and extended care services from the Department, an inventory of the Department’s health care capacity, assessment of the capacity to be provided through the community care network, and the capacity of the providers in the market area as a whole. The assessments will be used to inform the strategic plan of the QVHAR and must be publically accessible.

**Sec. 103 Access Standards and Standard for Quality**

This section requires the Secretary to develop and implement patient-centered access standards for furnishing care to veterans based on the data collected through the market area assessments to inform the eligibility criteria in section 101 for following types of care:

- Primary
- Specialty (including services that may require a referral and services considered wellness or preventative care)
- Behavioral Health (including mental health and substance abuse)
- Urgent
- Home Health (including virtual services)
- Dental
- Additional types of service the Secretary deems appropriate

Requires that these access standards are applied with respect to a veterans residence. The Secretary must consult with other relevant cabinet secretaries, private sector entities, and nongovernmental entities when establishing these standards. They must be made public and the Secretary must review the standards every three years to ensure they are still applicable and to modify if necessary.

This section also requires the Secretary to establish quality standards that align with DoD, CMS and Industry quality standards to improve VA facilities' ability to compare with community and other federal facilities in order to better inform the public on the state of VA healthcare.

In establishing the standard the Secretary must conduct a survey of covered veterans to assess satisfaction and the Secretary must collect relevant data sets to include general information, survey of patient experience, timely and effective care, complications, readmissions and deaths, use of medical imaging, payment and value of care and the use of telemedicine.

The standards shall be informed by existing health quality measures and must be developed according to the following health care settings:

- Inpatient hospitals
- Nursing homes
- Individual health care providers
- Dialysis facilities
- Hospice
- Inpatient rehabilitation facilities
- Long-term care hospitals
- Outpatient facilities

Requires the Secretary to publish these data sets regularly, coordinate with other entities when establishing these standards, regularly review the standards, and report on remediation efforts for service lines or facilities not meeting the standards.

## **Subtitle B – Forming Partnerships and Agreements**

### **Sec. 111      Continuity of Existing Agreements**

Authorizes continuity of existing contracts between American Indian and Alaska Native health care systems, Native Hawaiian health care systems, current Choice providers in good standing with the Department, and contracts for dialysis to continue upon enactment of this Act.

### **Sec. 112      Authorization of Agreements between Department of Veterans Affairs and Non-Department Providers.**

Authorizes Veterans Care Agreements and contracts with care providers outside of the VA who are not part of the community care network in the case that the use of a Department facility or network provider is impractical or inadvisable.

### **Sec. 113      Prevention of Certain Health Care Providers From Providing Non-Department Health Care Services to Veterans**

This section allows the Secretary to deny, suspend, or revoke the eligibility of a non-Department health care provider to participate in the community care program in the case that the provider was previously removed from employment by the Department of Veterans Affairs, or had their medical license revoked.

**Sec. 114 Conforming Amendments for State Veterans Homes**

This section would permit VA to enter into agreements with State veterans homes that are exempt from certain provisions of Federal contracting, specifically without regard for competitive procedures, for the furnishing of hospital care, medical services, and extended care services.

**Subtitle C – Paying Providers**

**Sec. 122 Prompt Payment to Providers**

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

Non-Department entities or providers would be required to submit a claim to VA within 180 days of providing care or services. Any claim that has not been denied, made pending, or paid within the specified time periods would be considered overdue and subject to interest payment penalties. The Secretary would be authorized to deduct the amount of any overpayment from payments due to an entity or provider under certain conditions. The Secretary would also be required to publish regulations for the administration of this section.

Claims processing will be removed from the VA's purview and allows either a contracted third party administrator or other entity to conduct these administrative functions. This section would also require that the Secretary set up a mechanism for the contractor to access VA funds to pay claims.

**Sec. 123 Payment Rates for Community Care**

This section would, to the extent practicable, allow VA to pay Medicare rates to community providers and entities for the same care or services. The section would also authorize VA to pay higher rates in certain cases, such as in highly rural areas, in the State of Alaska, and in a State with an All-Payer Model. This section will also allow the Secretary to incorporate value-based reimbursements models to promote high-quality care. This section also requires the VA to pay Critical Access Hospitals providing care through the community care program at the Critical Access Hospital rate established by Medicare versus the service-based Medicare rate used at larger facilities.

**Sec. 124 Authority to Pay for Authorized Care Not Subject to an Agreement**

This section would allow the Secretary to pay a provider for services rendered even if the Secretary has not entered into a contract, agreement, or other arrangement for the furnishing of such care and services with that specific provider. The Secretary would be required to report to congress in these instances, and should take reasonable efforts to enter into a contract, agreement, or other arrangement with the provider.

**Title II – STREAMLINING COMMUNITY CARE PROGRAMS**

**Subtitle A – Streamlining Community Care Programs**

**Sec. 201 Access to Walk-In Care**

This section would provide Veterans access to walk-in care from community providers that are part of VA’s community care network to ensure their access to care when minor injury or illness arises.

All eligible Veterans would be required to pay a copayment for each episode of care and services provided under this section, although VA would be allowed to adjust the copayment of a Veteran based upon the priority group of enrollment of the Veteran, the number of episodes of care furnished under this section, and other factors the Secretary considers appropriate.

Qualifying non-Department entities or providers would include any non-Department entity or provider with whom VA has entered into a contract or other agreement to provide services under this section. Walk-in care would be defined through regulation and would only include non-emergent episodic care and not longitudinal management of conditions.

**Sec. 202 Veterans Choice Fund Flexibility**

This proposal would amend section 802 of the Veterans Access, Choice, and Accountability Act of 2014 to authorize VA to use the existing Veterans Choice Fund to pay for any health care services under Chapter 17 of Title 38 at non-VA facilities or through non-Department providers furnishing care in VA facilities, including care for certain dependents and extended care services. This would permanently provide VA with similar flexibility to what was temporarily provided through the VA Budget and Choice Improvement Act (Public Law 114-41) and would facilitate VA’s efforts to consolidate and streamline the Department’s non-VA care authorities.

**Sec. 203 Conforming Amendments**

This section would consolidate all community care authorities into a singular program.

**Subtitle B – Improving Information Sharing with Providers**

**Sec. 211 Improving Information Sharing with Community Providers**

This section would clarify that VA could share records with non-Department providers for the purpose of furnishing care and enhance VA’s ability to recover funds from other responsible third parties for care furnished by VA.

**Sec. 212 Establishment of Process to Ensure Safe Opioid Prescribing Practices by Non-Department of Veterans Affairs Health Care Providers**

This section ensures that contracted providers have reviewed the evidence-based guidelines for prescribing opioids set forth in the Jason Simcakoski Memorial and Promise Act before providing care through the community care program. This section will also require the Secretary to implement a process to make certain community care providers have access to relevant medical history of the patient, including a list of all medication prescribed to the veteran.

This section would require that opioid prescriptions, to the extent practicable, be sent to pharmacies of the Department for dispensing. Instances of exception would be; the urgent and emergent fill program, the provider determines there is an immediate medical need for the prescription, the Department pharmacy is unable to fill the prescription in a timely manner, or the requirement to go to a pharmacy of the Department would impose an undue hardship on the veteran. In the case that a provider uses the exception authority, they would be required to notify the Department of an opioid prescription on the same day the prescription is written and explaining their use of the exception authority.

In the case that a medical center director or VISN director determines that a community health care provider is not complying with the VA Opioid Safety Initiative Guidelines, the director is authorized to refuse authorization of care by such health care providers and direct their removal from the community care network.

**Subtitle C – Improving Collections**

**Sec. 221 Aligning with Best Practices on Collection of Health Insurance Information**

This proposal would require an applicant or anyone who seeks VA medical care and services to provide his or her health plan contract information to VA. It would also authorize the Secretary to charge an individual with reasonable charges for the provision of such care and services if the person does not provide the required information.

**Sec. 222 Improving Authority to Collect**

This section would clarify that VA could seek collections in the event that VA pays for care, rather than just furnishes it.

- Clarifies that the absence of an agreement with a third party would not prevent or reduce the amount of any recovery or collection and that the Secretary would be authorized to recover as if it were a participating provider of such a plan.
- Expands what constitutes a health plan contract, and would amend similarly as well as expand the definition of what constitutes a third party. Finally, it would clarify the meaning of the term “reasonable charges” for which the Secretary could seek reimbursement.
- It would clarify that the coordination of benefits is third parties’ responsibility, including ensuring that the veteran has completed the third party’s claims paperwork.

**Title III – IMPROVING DEPARTMENT OF VETERANS AFFAIRS CARE DELIVERY**

## **Subtitle A – Improving Personnel Practices**

### **Sec. 302 Licensure of Health Care Professionals of the Department of Veterans Affairs Providing Treatment via Telemedicine**

This section would expand authority for VA health care professionals to practice in any state, including by telemedicine, notwithstanding the location of the health care provider or the patient.

This section would specifically invoke Federal supremacy such that this section would prevail over any general or specific provisions of law, rule, or regulation of a State that are inconsistent with this section. It would also prohibit any State from denying or revoking the license, registration, or certification of a VA health care professional who otherwise meets the requirements of the State for such license, registration, or certification, on the basis of practicing under this authority.

Covered health care professionals would include VA employees who are authorized to furnish health care and are required to adhere to all quality standards relating to the provision of medicine in accordance with VA policies.

Finally, VA would be required to submit a report to Congress within 1 year of enactment on VA's telemedicine program, including provider and patient satisfaction, the effect of telemedicine on wait-times and utilization, and other measures.

### **Sec. 303 Graduate Medical Education and Residency**

This section would authorize VA to increase the number of graduate medical education residency positions at covered facilities by not fewer than 1,500 positions in the 10 year period following enactment of this Act. The Secretary would be authorized to provide a stipend and other benefits for residents appointed under this section, whether they are assigned in a Department facility or not. Individuals would be required to apply to participate and agree to serve a period of obligated service in return for payment of educational assistance. The Secretary would be authorized to prescribe the conditions of employment for persons appointed under this section. If a resident breached the service obligation, the resident would be liable for the value of the balance of the obligation still owed. Finally, VA would be authorized to pay for residency positions at VA facilities and certain other designated facilities. These benefits and requirements would apply solely to the new positions and will assist the Department in determining whether such a program is attractive to graduate medical education residents.

### **Sec. 306 Annual Report on Awards or Bonuses Awarded to Certain High-Level Employees of the Department of Veterans Affairs**

This section requires that the Secretary submit a report to the appropriate committees of Congress, not later than 30 days after the end of each fiscal year, on the awards and bonuses awarded to regional office directors, medical center directors, VISN directors and other employees of the Department.

## **Subtitle B – Facilities, Construction, and Leases**

### **Sec. 311 Facilitating Sharing of Medical Facilities with Other Federal Agencies**

This section would create a new section 8111B to authorize the Secretary to enter into agreements with other Federal agencies for planning, designing, constructing, and/or leasing shared medical facilities. It would authorize the Secretary to transfer to another Federal agency amounts appropriated for minor construction projects, major construction projects, and leased projects. Funds transferred to VA from other Federal agencies could be used for planning, designing, or constructing a shared medical facility for minor construction projects, major construction projects, and leased projects.

### **Sec. 312 Review of Enhanced Use Leases**

This section would improve VA's Enhanced-Use Lease (EUL) authority in instances that adversely affect the Department's mission and will either enhance the use of the property or be for the provision of "supportive housing". It would also require the Office of Management and Budget to review each EUL prior to execution to ensure it complies with all necessary parameters.

## **Title IV – INNOVATIVE PILOT PROGRAMS**

### **Sec. 401 Pilot Program to Establish or Affiliate with Graduate Medical Residency Programs at the Facilities Operated by Indian Tribes, Tribal Organizations, and the Indian Health Service in Rural Areas.**

This section directs the Secretary to consult with the Director of the Indian Health Service on a pilot program to create or affiliate with a graduate medical education residency training program, specific to rural or remote areas. The pilot shall begin at not more than 4 locations and will extend 8 years beyond bill enactment. Individuals who enter the program will receive loan repayment.

No later than three years before the date on which the pilot program terminates, the Secretary of Veterans Affairs shall submit a report on the feasibility and advisability of expanding or making permanent this program.

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

This section would authorize the VA to carry out such pilot programs to develop new, innovative approaches to testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished by the Department.

The Secretary has 5 years to use this authority and shall publish information about these programs in the Federal Register as well as advertise these programs to the veteran population for use.

## **Title V – OTHER MATTERS**

**Sec. 501 Authorization of Appropriations for Health Care from Department of Veterans Affairs.**

This section authorizes appropriations for increased access to care for covered veterans of the Department to be used for hiring medical professionals and improving physical infrastructure. The Secretary shall report on intentions to obligate the amounts appropriated as it relates to the strategy required by section 102.

**Sec. 502 Appropriation of Amounts for Veterans Choice Program**

This section authorizes funds for the Choice Program to continue care until the implementation of this Act.

**Sec. 503 Applicability of Directive of Office of Federal Contract Compliance Programs**

Applies the Department of Labor Office of Federal Contract Compliance Program Directive 2014-01 to entities entering into agreements under this act in the same manner as the directive applies to subcontractors under the TRICARE program.

**Sec. 504 Amending Statutory Requirements for the Position of the Chief Officer of the Readjustment Counseling Service**

This section amends the statutory requirements for the position of the Chief Officer of the Readjustment Counseling Service.

**Sec. 505 Authorization of Certain Major Medical Facility Projects of the Department of Veterans Affairs.**

This section authorizes the Secretary to carry out the realignment of medical facilities in Livermore, California.