

July 3, 2018

## THE VA MISSION ACT OF 2018

### AT A GLANCE

#### **The Issue:**

On June 6, President Trump signed into law the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, (S. 2372), known as the VA MISSION Act. This bipartisan legislation consolidated the Department of Veterans Affairs' (VA) community care programs into one permanent Veterans Community Care Program and made several other changes to improve the delivery of care for veterans and their families.

#### **Our Take:**

The VA MISSION Act contains several provisions that will improve continuity of care for veterans by enabling them to access care outside of the VA's medical network and decreasing confusion about eligibility criteria and covered services. However, many of these provisions still require appropriations before the VA can execute them. The AHA is especially pleased that the bill requires the VA to adopt prompt payments standards for community providers. This is a necessary requirement to ensure the VA is a more consistent and timely payer and to lessen the burden on community care providers seeking payment from the VA.

#### **What You Can Do:**

- ✓ Review this advisory and share it with your senior management team and others in your organization that are involved with community care for veterans.
- ✓ [View](#) our members-only Town Hall webcast on veterans' health and patient-centered care programs with Kameron Matthews, M.D., acting deputy undersecretary for health for community care, Veterans Health Administration.
- ✓ [Register](#) for the VA's series of webinars that will share information on its Community Care Programs and corresponding regulations.

#### **Further Questions:**

For further questions, please contact Shira Hollander, senior associate director, policy development, at (202) 626-2329 or [shollander@aha.org](mailto:shollander@aha.org).

#### **10 Key Take-Aways:**

Among other provisions, the bill:

- requires access to community care based on certain access criteria, doing away with the 40-mile or 30-day wait period currently required for the Veterans Choice Program
- establishes Medicare payment rates for community care, with certain exceptions
- requires the VA to establish prompt payment deadlines
- establishes processes to improve information sharing with community providers and adherence to VA opioid prescribing practices
- provides \$5.2 billion to extend the Veterans Choice Program for one year until the new program takes effect
- creates a commission to recommend ways to modernize or realign VA facilities
- expands the VA Post-9/11 Caregiver Program
- establishes a pilot VA residency program and loan repayment program for residents training in shortage specialties
- removes barriers for VA health care professionals to practice telemedicine
- provides additional resources for hiring and retention of VA health care professionals
- establishes mobile deployment teams for underserved and rural facilities to provide specialized and routine care

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On June 6, President Trump signed into law the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (S. 2372), known as the VA MISSION Act. This bipartisan legislation establishes a single permanent Veterans Community Care Program, requires the Department of Veterans Affairs (VA) to establish prompt payment deadlines, and addresses several other needs of the veteran population and the community providers that care for them.

A detailed summary of the bill follows.

### **TITLE I: CARING FOR OUR VETERANS ACT OF 2018**

#### **SUBTITLE A: DEVELOPING AN INTEGRATED HIGH-PERFORMING NETWORK**

#### **CHAPTER 1: ESTABLISHING COMMUNITY CARE PROGRAMS**

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

This provision establishes the Veterans Community Care Program to provide community-based care for veterans who are enrolled in the VA health care system or are otherwise entitled to VA care. This section requires the VA to coordinate veterans' care, including timely scheduling of medical appointments, ensuring continuity of care and services, coordinating coverage for veterans who access care outside of their home network, and ensuring veterans do not experience a lapse in care. This section will require appropriations before the VA can carry out its mandates, as VA care, unlike Medicare, is not a federal entitlement program.

Under this section, the VA must provide care through community providers if certain access criteria are met, doing away with the 40-mile or 30-day wait period currently required through the Veterans Choice Program. The access criteria include one the following:

- the VA does not operate a full-service medical facility in the state a veteran resides; or
- the veteran was eligible for care in the community under the 40-mile or 30-day rules in the Veterans Choice Program and meets certain other criteria; or

- the VA is not able to provide care within the designated access standards established by the VA; or
- a veteran and the veteran's referring clinician agree that providing care or services in the community would be in the best medical interest of the veteran after considering criteria such as the distance between the veteran and the facility that provides the care that the veteran needs, the nature and frequency of the required care or services, the timeliness of available appointments for that care and whether the veteran faces an unusual or excessive burden to accessing the care or services from the VA medical facility where he or she is seeking care.

In addition, the VA may provide community-based care to veterans when it determines that VA care does not meet established timeliness or quality standards. The VA is limited in exercising this authority at no more than 36 service lines nationally and three service lines per facility.

This section also establishes mechanisms for the VA to contract with and direct care toward community providers. First, the section authorizes the VA to establish tiered provider networks as long as the VA's prioritization does not limit veterans' choice of providers. Second, this section requires the VA to enter into consolidated, competitively bid contracts to establish provider networks that will be subject to certain VA-specific requirements and authorizations.

This provision also establishes the payment rates for community care as the Medicare rate, to the extent possible. However, this provision also authorizes higher payment rates for care or services in highly rural areas, rates based on all-payer agreements in states with all-payer models, and the incorporation, to the extent possible, the use of value-based reimbursement models to promote high quality care. Regardless of the payment rates, veterans may not be required to pay more for utilizing non-VA care than the veteran would pay for comparable VA care or services.

This section also mandates that, if a veteran is eligible for and requires an organ or bone marrow transplant, and the veteran has, in the opinion of his or her primary care provider, a medically compelling reason to travel outside the region of the Organ Procurement and Transplantation Network, the Secretary must consider authorization of such transplant at a non-VA facility.

Under this provision, the VA is required to submit to Congress a review of the types and frequency of care sought under this provision, not later than 18 months after enactment and at least annually thereafter. The provision includes details on the information that the VA must monitor and gather as part of these reports. Finally, this provision allow for the continuation of existing agreements in effect on the day before enactment between the VA and the American Indian and Alaska Native health care systems established under the terms of the Department of Veterans Affairs and Indian Health Service Memorandum of Understanding, signed Oct. 1, 2010, the National Reimbursement Agreement, signed Dec. 5, 2012, arrangements under section 405 of the Indian Health Care Improvement Act, and agreements entered into under sections 102 and 103 of the Veterans Access, Choice, and Accountability Act of 2014.

**Authorization of Agreements between Department of Veterans Affairs and Non-Department Providers** (Sec. 102)

This section authorizes the VA to enter into Veterans Care Agreements (VCAs) with providers and other entities to provide care to veterans when it is not feasibly available from a VA facility or another contract or sharing agreement entered into pursuant to another provision of law, such as section 101 of this bill. Use of a VA facility or a contracted community care provider may be “impracticable” or “inadvisable” due to the veteran’s medical condition, the travel involved, or the nature of the care or services required. Veterans will be eligible for VCA-based care subject to the same terms as VA care itself, and the rates paid under VCAs, to the extent possible, will be in accordance with rates paid under the Veterans Community Care Program established in Sec. 101. The VA will be responsible for developing a certification process for VCAs and a system for monitoring the quality of care. This section also establishes the terms to which VCAs must agree in order to become a provider in the Community Care program.

**Conforming Amendments for State Veterans Homes** (Sec. 103)

Section 103 authorizes the VA to enter into VCAs with State Veterans Homes and eliminate competitive contracting actions and other requirements associated with federal contracts except those related to fraud, waste and abuse and employment law.

**Access Standards and Standards for Quality** (Sec. 104)

This provision requires the VA to establish access standards for furnishing care and services to veterans such that veterans can make informed decisions about their health care. Section 104 requires the VA to consult with federal entities (including the Department of Defense, the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services), private sector entities, and other nongovernmental entities in establishing the access standards. The VA will be required to publish the access standards in the Federal Register and on the VA’s website and to review the access standards at least every three years. This provision also allows covered veterans to contact the VA to request a determination regarding whether they are eligible to receive care or services from a community provider due to the VA being unable to furnish the care or services in compliance with the access standards.

Section 104 also requires the VA to establish quality standards for services furnished as part of the Community Care Program, after consulting with relevant federal, private sector and nongovernmental entities. This section directs the VA to collect measures of veterans’ satisfaction with the service and the quality of care at VA medical facilities within the past two years and data regarding the timeliness, effectiveness, safety and efficiency of that care. Based on these measures, the VA must publish the quality rating of VA hospitals so that veterans can compare performance measure information among VA and non-VA providers. Within two years of publishing the quality standards, the VA must solicit public comment on potential changes to the standards to ensure that they include the most up-to-date and applicable industry measures for veterans.

**Access to Walk-In Care** (Sec. 105)

This section authorizes walk-in care at non-VA facilities for veterans who have used VA health care services in the 24 months prior to seeking walk-in care. This section requires the VA to ensure continuity of care for veterans that seek walk-in care,

including establishing a mechanism to receive medical records from, and share medical records with, walk-in care providers. For their first two walk-in visits, veterans will be entitled to the same cost sharing arrangements that they have at VA facilities. For subsequent visits, the VA may charge a copayment for veterans not required to pay a copayment at VA facilities and a higher copayment for those required to pay a copayment for VA facility visits.

***Strategy Regarding the Department of Veterans Affairs High-Performing Integrated Health Care Network*** (Sec. 106)

Section 106 requires the VA to perform “market area assessments” at least once every four years that evaluate the following:

- demand for health care from the VA disaggregated by geographic market areas, including requests for VA services;
- an inventory of the VA’s health care capacity across all medical facilities;
- an assessment of the capacity provided by contracted private providers, including the number of providers, the geographic location of the providers, and the categories or types of health care services provided by the providers;
- an assessment obtained from other federal direct delivery systems of their capacity to provide health care to veterans;
- an assessment of the health care capacity of non-contracted providers where there is insufficient network supply;
- an assessment of the health care capacity of academic affiliates and other VA collaborations as it relates to providing health care to veterans;
- an assessment of the effects on VA health care capacity by the access and quality standards established under this bill; and
- the number of appointments for health care services, disaggregated by VA medical facilities and non-VA health care providers.

The VA must provide the market area assessment to Congress and use them to determine the capacity of the health care provider networks established under Section 101 of this bill, inform the VA’s budget, inform and assess the appropriateness of the access and quality standards established under this bill, and develop recommendations for changes to those standards.

This section also requires the VA to submit a strategic plan to Congress within a year of enactment and at least every four years thereafter that specifies a four-year forecast of demand for health care, capacity at each VA medical center and capacity at each community care provider. To prepare the strategic plan, the VA must consider a variety of factors, including the access and quality standards established under this bill, the market area assessments described above, veterans’ satisfaction with VA care and the needs of veterans with service-connected disabilities.

Lastly, this section holds the VA responsible for overseeing the transformation and organizational change to achieve a high performing integrated health care network, developing the capital infrastructure planning and procurement processes required, and

developing a multiyear budget process that is capable of forecasting future budget year requirements.

***Applicability of Directive of Office of Federal Contract Compliance Programs*** (Sec. 107)

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

***Prevention of Certain Health Care Providers from Providing Non-Department Health Care Services to Veterans*** (Sec. 108)

This section allows the VA to deny, suspend, or revoke the eligibility of a non-VA health care provider to participate in the Community Care Program if the provider was previously removed from VA employment or had their medical license revoked. This section also requires the Government Accountability Office (GAO) to report on the implementation of this section two years after enactment.

***Remediation of Medical Service Lines*** (Sec. 109)

Section 109 requires the VA to submit to Congress a plan to remediate medical service lines that the VA determines do not comply with its quality standards. This section outlines specific actions that the plan must include and requires the VA to identify the individuals who will be responsible for overseeing the progress of the medical service line remediation. This section also requires interim and annual reports with an analysis of the remediation actions and the costs of such actions.

## **CHAPTER 2: PAYING PROVIDERS AND IMPROVING COLLECTIONS**

***Prompt Payment to Providers*** (Sec. 111)

Section 111 requires the VA to pay or deny claims within 30 calendar days upon receipt of a clean electronic claim or within 45 calendar days of receipt of a clean paper claim. If it denies a claim, the VA is required to notify the provider of the reason for the denial and what, if any, additional information is required to process the claim. Upon receipt of the additional information, the VA will have 30 days to pay, deny, or otherwise adjudicate the claim. The requirements discussed in this section apply only to payments made on an invoice basis and not to payments made on a capitated basis or to other forms of periodic payment. Non-VA health care providers have 180 days from the date of service to submit claims to the VA.

Claims that are not denied, made pending, or paid within the specified time periods will be considered overdue and subject to interest payment penalties. This section requires the VA to report to Congress at least annually on the number and amount of overdue claims and to provide a list of information and documentation that is required to establish a clean claim to all providers under the community care program.

To process claims, this section allows the VA to work with a contracted third party administrator or another entity to conduct necessary administrative functions. This

section also requires the Secretary to contract with an independent third party to conduct a review of the VA's capacity to process claims in a timely manner and a cost benefit analysis comparing the capacity of the VA to that of a third party entity capable of processing these claims. This provision also requires the VA to submit to Congress a report on whether to establish a funding mechanism – similar to what is used by other federal agencies – for a VA contractor to act as a fiscal intermediary for the federal government to pay claims.

***Authority to Pay for Authorized Care Not Subject to an Agreement*** (Sec. 112)

This provision authorizes the VA to pay for necessary care provided pursuant to an agreement with the VA by a provider who is not a party to that agreement, but requires the VA to then take reasonable efforts to enter into an agreement with any such provider to ensure that future services are covered.

***Improvement of Authority to Recover the Cost of Services Furnished for Non-Service-Connected Disabilities*** (Sec. 113)

This section expands the VA's authority to recover payment from a third party for care provided to non-veterans by amending the statute to refer to "individuals" instead of "veterans." This section also authorizes the VA to recover payment for care when the agency pays for, rather than furnishes, care and removes duplicative language regarding VA's authority to recover from other health insurance for treatment of a non-service-connected disability.

***Processing of Claims for Reimbursement through Electronic Interface*** (Sec. 114)

Section 114 authorizes the VA to enter into an agreement with a third-party entity to electronically process claims from non-VA providers.

### **CHAPTER 3: EDUCATION AND TRAINING PROGRAMS**

***Education Program on Health Care Options*** (Sec. 121)

Section 121 requires the VA to develop and administer an education program that teaches veterans about their health care options, including their eligibility for care and any cost sharing responsibilities they may have and about the interaction between health insurance and VA health care. The education program must also provide veterans with information about how to utilize the access and quality standards established in Section 104 and how to file a complaint about care received from the VA. The VA is required to evaluate and report on the education program at least once per year.

***Training Program for Administration of Non-Department of Veterans Affairs Health Care*** (Sec. 122)

This section requires the VA to develop and administer a training program for employees and contractors of the VA on how to administer non-VA health care programs and the management of opioid prescriptions as established under Section 131. The VA is required to evaluate and report on the training program at least once per year.

***Continuing Medical Education for Non-Department Medical Professionals*** (Sec. 123)

This provision requires the VA to establish a program for continuing medical education for non-VA medical professionals at no cost to them. The program must be focused on the VA health care system and on identifying and treating common mental and physical conditions of veterans and their family members. The VA is required to evaluate and report on the continuing medical education program at least once per year.

**CHAPTER 4: OTHER MATERIALS RELATING TO NON-DEPARTMENT OF VETERANS AFFAIRS PROVIDERS**

***Establishment of Processes to Ensure Safe Opioid Prescribing Practices by Non-Department of Veterans Affairs Health Care Providers*** (Sec. 131)

This section requires the VA to ensure that its contracted health care providers receive and review the evidence-based guidelines for prescribing opioids set forth by the VA's Opioid Safety Initiative. The secretary must also implement a process whereby community care providers have access to the relevant medical history of patients and a list of all medications prescribed to the veteran as known by the VA.

This section further requires contracted providers to submit medical records of any care they provide, including opioid prescriptions, to the VA in a timeframe and format specified by the VA. The VA must then record the prescriptions in the veterans' electronic health records and enable other monitoring of the prescriptions as outlined in the Opioid Safety Initiative. The VA must also submit to Congress an annual report evaluating the compliance of contracted providers with the requirements of this subsection.

Finally, if the VA determines that a community provider is not complying with the Opioid Safety Initiative, this section also authorizes the VA to refuse authorization of care by such provider and direct their removal from the community care network.

***Improving Information Sharing with Community Providers*** (Sec. 132)

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

***Competency Standards for non-Department of Veterans Affairs Health Care Providers*** (Sec. 133)

Section 133 requires the VA to establish competency standards and requirements for the provision of care by non-VA providers in clinical areas for which the VA has special expertise, including post-traumatic stress disorder, military sexual trauma-related conditions, and traumatic brain injuries. This section also directs non-VA providers, to the extent practicable, to meet these standards before furnishing care.

***Department of Veterans Affairs Participation in National Network of State-Based Prescription Drug Monitoring Programs*** (Sec. 134)

This provision allows any licensed health care provider or his or her delegate to query and receive 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. Under this authority, licensed health care providers and their delegates must query the network in accordance with applicable VA regulations and policies and no state may restrict the access of licensed health care providers or delegates from accessing that state's prescription drug monitoring programs.

**CHAPTER 5: OTHER NON-DEPARTMENT HEALTH CARE MATTERS**

***Plan for Use of Supplemental Appropriations Required*** (Sec. 141)

This section requires the VA to submit to Congress a justification for any new supplemental appropriations request that the agency submits outside the standard budget process, in accordance with certain additional requirements. The justification must include details regarding how the VA intends to use the requested fund and how long the requested appropriation is expected to meet the needs of the VA.

***Veterans Choice Fund Flexibility*** (Sec. 142)

Section 142 amends the Veterans Access, Choice, and Accountability Act of 2014 to authorize the VA, beginning March 1, 2019, to use amounts remaining in the Veterans Choice Fund to pay for care furnished pursuant to the veterans' benefits detailed in Chapter 17 of Title 38 of the United States Code at non-VA facilities or through non-VA providers furnishing care in VA facilities.

***Sunset of Veterans Choice Program*** (Sec. 143)

Section 143 sunsets the Veterans Choice Program one year after the date of enactment of this legislation.

***Conforming Amendments*** (Sec. 144)

Section 144 repeals and replaces existing authorities to account for changes made by section 101 of this bill to consolidate and create the Veterans Community Care program.

**SUBTITLE B: IMPROVING DEPARTMENT OF VETERANS AFFAIRS  
HEALTH CARE DELIVERY**

***Licensure of Health Care Professionals at the Department of Veterans Affairs Providing Treatment via Telemedicine*** (Sec. 151)

This section creates a new authority to authorize VA health care professionals to provide care via telemedicine regardless of the location of the provider and patient during the treatment. To ensure uniform delivery of care across the nation, this section invokes federal supremacy regarding state telemedicine delivery laws and regulations. This section also requires the VA to submit a report to Congress within one year of enactment, providing data on provider and patient satisfaction, the effect of telemedicine on patient wait-times, health care utilization, and other measures.

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

This provision establishes a VA Center for Innovation for Care and Payment to carry out pilot programs that 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 VA. This provision requires the VA, acting through the Center, to test payment and service delivery models to determine whether these models improve access to, and quality, timeliness, and patient satisfaction of care and services; and create cost savings for the VA. The VA is also required to test models where it determines there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures and where models are expected to reduce program costs while preserving or enhancing the quality of or access to care that the VA provides. The models may not be designed to allow the U.S. to recover or collect reasonable charges from Medicare, Medicaid, and TRICARE for care furnished by the VA to veterans.

This provision authorizes the VA to consider a number of factors in selecting models for testing, but requires the VA to limit each pilot program to no more than five years and a maximum of 10 programs at any one time. The provision also requires the VA to carry out pilot programs, to the extent practicable in geographically diverse areas. Funding for the pilot programs will come from appropriations provided in advance in appropriations acts for the Veterans Health Administration (VHA) and from appropriations provided for information technology systems. The provision prohibits VA from spending more than \$50 million per fiscal year without express written consent from Congress.

In order to execute these programs, this provision authorizes the VA to waive certain requirements as may be necessary to test models under this program, but requires the agency to submit to Congress a report explaining the authorities to be waived and the reasons for such waivers, along with other information. Congress must approve the waiver request before the VA can act upon it. The waiver provisions in this section are available only if the VA submits the first proposal for a waiver for a pilot program within 18 months of the date of enactment of this bill.

Section 152 also provides the VA with the authority to modify or terminate pilot programs that it determines are not improving the quality of or access to care or producing cost savings within 30 days of submitting an interim report to Congress. The VA must evaluate each model that it tests to determine, at a minimum, the quality of care furnished under the model, including based on patient-level outcomes and patient-centeredness criteria determined appropriate by the VA and the changes in spending attributed to that model.

Finally, to move beyond demonstrations, this provision authorizes the VA to undertake rulemaking to expand the duration and scope of successful pilot programs to the extent the VA determines that such an expansion will reduce spending without reducing the quality of care or improve the quality of care without increasing spending. The VA must also to determine that such expansion would not deny or limit the coverage or provision of benefits for applicable individuals.

***Authorization to Provide for Operations on Live Donors for Purposes of Conducting Transplant Procedures for Veterans*** (Sec. 153)

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

**SUBTITLE C: FAMILY CAREGIVERS**

***Expansion of Family Caregiving Program of Department of Veterans Affairs*** (Sec. 161)

This section expands the VA's Program of Comprehensive Assistance for Family Caregivers by expanding veteran eligibility for the program as well as the services provided under the program.

***Implementation of Information Technology System of the Department of Veterans Affairs to Assess and Improve the Family Caregiver Program*** (Sec. 162)

This section requires the VA to implement an information technology system that fully supports the Family Caregiver Program and allows for data assessment and comprehensive monitoring of the Program by Oct. 1, 2018.

***Modifications to Annual Evaluation Report on Caregiver Program of Department of Veterans Affairs*** (Sec. 163)

This provision amends requirements for the VA's annual evaluation report on the Program of Comprehensive Assistance for Family Caregivers and the Program of General Caregiver Support to include a description of any barriers to accessing and receiving care and services. The report on the Program of Comprehensive Assistance for Family Caregivers also would include an evaluation of the sufficiency and consistency of the training provided to family caregivers.

**TITLE II: VA ASSET AND INFRASTRUCTURE (AIR) REVIEW ACT**

**SUBTITLE A: ASSET AND INFRASTRUCTURE REVIEW**

***The Commission*** (Sec. 202)

Section 202 establishes an independent, nine member Asset and Infrastructure Review (AIR) Commission. The president, in consultation with congressional leaders and congressionally-chartered, membership-based veterans services organizations (VSOs), and in accordance with various sub-provisions in this section, must transmit nominations for the AIR commissioners by May 31, 2021. The commission will hold public meetings in 2022 and 2023 and will be terminated on Dec. 31, 2023.

***Procedure for Making Recommendations*** (Sec. 203)

This section outlines the process by which the VA will be required to draft the criteria to be used to assess and make recommendations regarding the modernization or alignment of VHA facilities. The draft criteria will be subject to notice-and-comment rulemaking and must be published in final form in the Federal Register by May 31, 2021.

By Jan. 31, 2022, the VA must publish in the Federal Register and transmit to Congress and the AIR commission a report detailing the agency's recommendations regarding the modernization or realignment of VHA facilities on the basis of those final criteria. The VA is required to consider the following factors in making recommendations:

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

This section also requires the VA to assess the capacity of each Veterans Integrated Service Network (VISN) and VA medical facility to furnish hospital care or medical services to veterans. Each assessment is required to:

- Identify existing deficiencies in the furnishing of care and services to veterans and how such deficiencies may be filled by entering into contracts or agreements with community health care providers or other entities under other provisions of law and changing the way care and services are furnished at such VISNs or VA medical facilities (including through extending hours of operation, adding personnel, and expanding treatment space through construction, leasing, or sharing of health care facilities);
- Forecast both the short-term and long-term demand in furnishing care and services at such VISN or VA medical facility;
- Consider how demand affects the need to enter into contracts or agreements;
- Consider the commercial health care market of designated catchment areas in an assessment conducted by a non-governmental entity; and

- Consider the unique ability of the federal government to retain a presence in a rural area otherwise devoid of commercial health care providers or from which such providers are at risk of leaving.

In executing its assessments, the VA is required to consult with VSOs and veterans served by each VISN and medical facility affected by the assessment. This provision also imposes on the VA requirements for submitting its assessments and the recommendations arising out of the assessments to Congress, the AIR Commission and the Comptroller General of the U.S. Upon receiving the VA's recommendations, the AIR commission is required to hold public hearings in regions affected by a VA recommendation to close a facility, and, to the greatest extent possible, in regions affected by a VA recommendation to modernize or realign such a facility. Each public hearing must include, at a minimum, a local veteran who is enrolled in the VA health care system and identified by a local VSO and a local elected official.

On or before Jan. 31, 2023, the AIR Commission must send the president a report and analysis of the VA's recommendations, as well as the commission's own recommendations, for modernizing and realigning VHA facilities. This section includes the authority for the commission to modify the VA's recommendations, subject to several requirements and the commission's inclusion of justifications for the changes. Not later than Feb. 15, 2023, the president must send the commission and Congress his or her approval or disapproval of the commission's recommendations. The commission has the opportunity to transmit additional information to the president, but if the president does not transmit any certification of approval to Congress by March 30, 2023, the process for modernization or realignment of VHA facilities will be terminated.

### ***Actions Regarding Infrastructure and Facilities of the Veterans Health Administration*** (Sec. 204)

This section requires the VA to begin implementing the AIR Commission's recommendations as approved by the president within three years of the date of the president's approval, unless Congress enacts a joint resolution in accordance with section 207, in which case the VA would be prohibited from carrying out any action recommended by the commission.

### ***Implementation*** (Sec. 205)

Section 205 authorizes the VA to take such action as may be necessary to modernize or realign any VHA facility and requires the VA, in doing so, to undertake additional steps and consult with specified parties.

### ***Department of Veterans Affairs Asset and Infrastructure Review Account*** (Sec. 206)

Section 206 establishes a VA Air account to be administered by VA for the purpose of carrying out the AIR Act, covering property management and disposal costs incurred at VHA facilities, covering costs associated with construction projects undertaken under the AIR Act, and other purposes the VA determines support its mission and operations. This section also requires the VA to develop budget justifications in support of its use of this account and report to Congress on the funds in the account.

***Congressional Consideration of Commission Report*** (Sec. 207)

This section defines certain expedited procedures for the congressional consideration of the AIR Commission report.

***Other Matters*** (Sec. 208)

This provision requires the VA to publish online any information transmitted or received by the agency, the Commission or the president regarding the AIR Act within 24 hours of receipt. This provision also prohibits the VA from pausing construction activities as a result of the AIR Act.

**SUBTITLE B: OTHER INFRASTRUCTURE MATTERS**

***Improvement to Training of Construction Personnel*** (Sec. 211)

This section requires the VA to implement a training and certification program for construction and facilities management personnel and includes several requirements for the program and authorities through which the VA can execute the program.

***Review of Enhanced Use Leases*** (Sec. 212)

This section requires the Office of Management and Budget to review each enhanced-used lease before it goes into effect to determine whether the lease is in compliance with relevant laws.

***Assessment of Health Care Furnished by the Department to Veterans who live in the Pacific Territories*** (Sec. 213)

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

**TITLE III: IMPROVEMENTS TO RECRUITMENT OF HEALTH CARE PROFESSIONALS**

***Designated Scholarships for Physicians and Dentists under Department of Veterans Affairs Health Professional Scholarship Program*** (Sec. 301)

Section 301 alters the VA health professional scholarship program that provides scholarships to medical students in exchange for VA service. Specifically, this section ties the number of available medical and dental scholarships to the shortage of professionals in those positions. This section also discusses the obligation requirement for these scholarships and authorizes the VA to provide preference to applicants who are veterans.

***Increase in Maximum Amount of Debt that may be reduced under Education Debt Reduction Program of Department of Veterans Affairs*** (Sec. 302)

This provision increases the amount of education debt reduction available through the Education Debt Reduction Program from \$120,000 to \$200,000 over five years and \$24,000 to \$40,000 annually.

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

This provision establishes a new loan repayment program for certain medical and osteopathic students who are training in specialties deemed by VA to be experiencing a shortage. In exchange for loan repayment, participants must service in clinical practice at a VA facility for at least two years.

***Veterans Healing Veterans Medical Access and Scholarship Program*** (Sec. 304)

Section 304 establishes a pilot program for supporting medical school education costs for two veterans at each of the five Teague-Cranston Schools and the four traditional black medical schools. Eligible veteran scholarship recipients are those within ten years of military discharge who are not eligible for GI Bill benefits but who meet the minimum admission requirement for medical school and apply for the entering class of 2019. The recipients will be required to complete post-graduate training in a specialty applicable to VA and serve in clinical practice at a VA facility for four years.

***Bonuses for Recruitment, Relocation, and Retention*** (Sec. 305)

Section 305 repeals the recruitment, retention, and relocation bonus offset from the Comprehensive Addiction and Recovery Act.

***Inclusion of Vet Center Employees in Education Debt Reduction Program of Department of Veterans Affairs*** (Sec. 306)

This section requires the VA to ensure the clinical staff working at Vet Centers are eligible to participate in the Education Debt Reduction Program.

## **TITLE IV: HEALTH CARE IN UNDERSERVED AREAS**

***Development of Criteria for Designation of Certain Medical Facilities of the Department of Veterans Affairs as Underserved Facilities and Plan to address Problem of Underserved Facilities*** (Sec. 401)

This provision requires the VA develop criteria to designate VA medical facilities as underserved facilities by considering the ratio of veterans to providers, the range of specialties covered, whether the local community is medically underserved, the type, number, and age of open consults and whether the facility is meeting the VA's wait time goals. This provision also requires the VA to analyze at least once a year which facilities qualify as underserved; and submit a plan to Congress, within one year of enactment and not less frequently than annually, to address underserved facilities.

***Pilot Program to Furnish Medical Deployment Teams to Underserved Facilities*** (Sec. 402)

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

***Pilot Program on Graduate Medical Education and Residency*** (Sec. 403)

Under Section 403, the VA is required to establish a pilot program to establish medical residency positions at covered facilities, including VA facilities, a facility operated by an Indian tribe or tribal organization, an Indian Health Service facility, a Federally Qualified Health Center, or a Department of Defense facility. The VA is also required to consider a number of factors with respect to clinical need for providers when determining facilities at which to place residents and to report regularly to Congress on the implementation of the pilot.

**TITLE V: OTHER MATTERS**

***Annual Report on Performance Awards and Bonuses Awarded to Certain High-Level Employees of the Department*** (Sec. 501)

This section requires the VA to submit an annual report to Congress on performance awards and bonuses presented to certain high-level employees.

***Role of Podiatrists in Department of Veterans Affairs*** (Sec. 502)

This provision stipulates that VA podiatrists are eligible to be appointed to a supervisory position to the same degree that a VA physician is eligible to be appointed to such a position and are equal to doctors of osteopathy and VA medical doctors with respect to pay within the VA health care system. The provision also requires the VA to work with appropriate stakeholders to ensure that specialists appointed to supervisory positions do not provide direct clinical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties.

***Definition of a Major Medical Facility Project*** (Sec. 503)

This section modifies the definition of a VA major medical facility project as a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of \$20 million (was previously \$10 million).

***Authorization of Certain major medical facility projects of the Department of Veterans Affairs*** (Sec. 504)

This section authorizes a VA major medical facility project in Livermore, CA, in an amount not to exceed \$117.3 million.

***Department of Veterans Affairs Personnel Transparency*** (Sec. 505)

Section 505 requires the VA to make certain personnel information, including vacancies and new hires, publicly available on a VA website and requires certain review of the website and reporting to Congress on the steps the VA is taking to achieve full staffing capacity.

***Program on Establishment of Peer Specialists in Patient Aligned Care Team Settings within Medical Centers of Department of Veterans Affairs*** (Sec. 506)

This section requires the VA to roll out a pilot program to place peer specialists within patient aligned care teams in certain VA medical centers to promote the use and integration of services for mental health, substance use disorder, and behavioral health in a primary care setting.

***Department of Veterans Affairs Medical Scribe Pilot Program*** (Sec. 507)

Section 507 creates a two-year pilot program under which the VA will increase the use of medical scribes in emergency department and specialty care settings at 10 VA medical centers. VA is required to regularly report on the effectiveness of the program on provider efficiency, patient satisfaction, average wait time, the number of patients seen per day and the amount of time required to train an employee to perform medical scribe functions under the pilot program.

***Extension of Requirement to Collect Fees for Housing Loans Guaranteed by Secretary of Veterans Affairs*** (Sec. 508)

This provision extends the VA's authority to collect certain funding fees for housing loans guaranteed by the VA through Sept. 30, 2028.

***Extension of Reduction in Amount of Pension Furnished by Department of Veterans Affairs for Certain Veterans Covered by Medicaid Plans for Services Furnished by Nursing Facilities*** (Sec. 509)

This provision extends current eligibility restrictions for recipients of a VA pension who receive Medicaid-covered nursing home care through Sept. 30, 2028.

***Appropriation of Amounts*** (Sec. 510)

Section 510 authorizes and appropriates \$5.2 billion to the Veterans Choice Fund.

***Technical Correction*** (Sec. 511)

This section redesignates section 1712I of title 38 U.S.C. as section 1720I of such title.