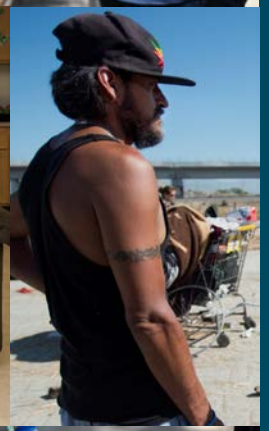


Greater Los Angeles Homeless Count

2018 Results

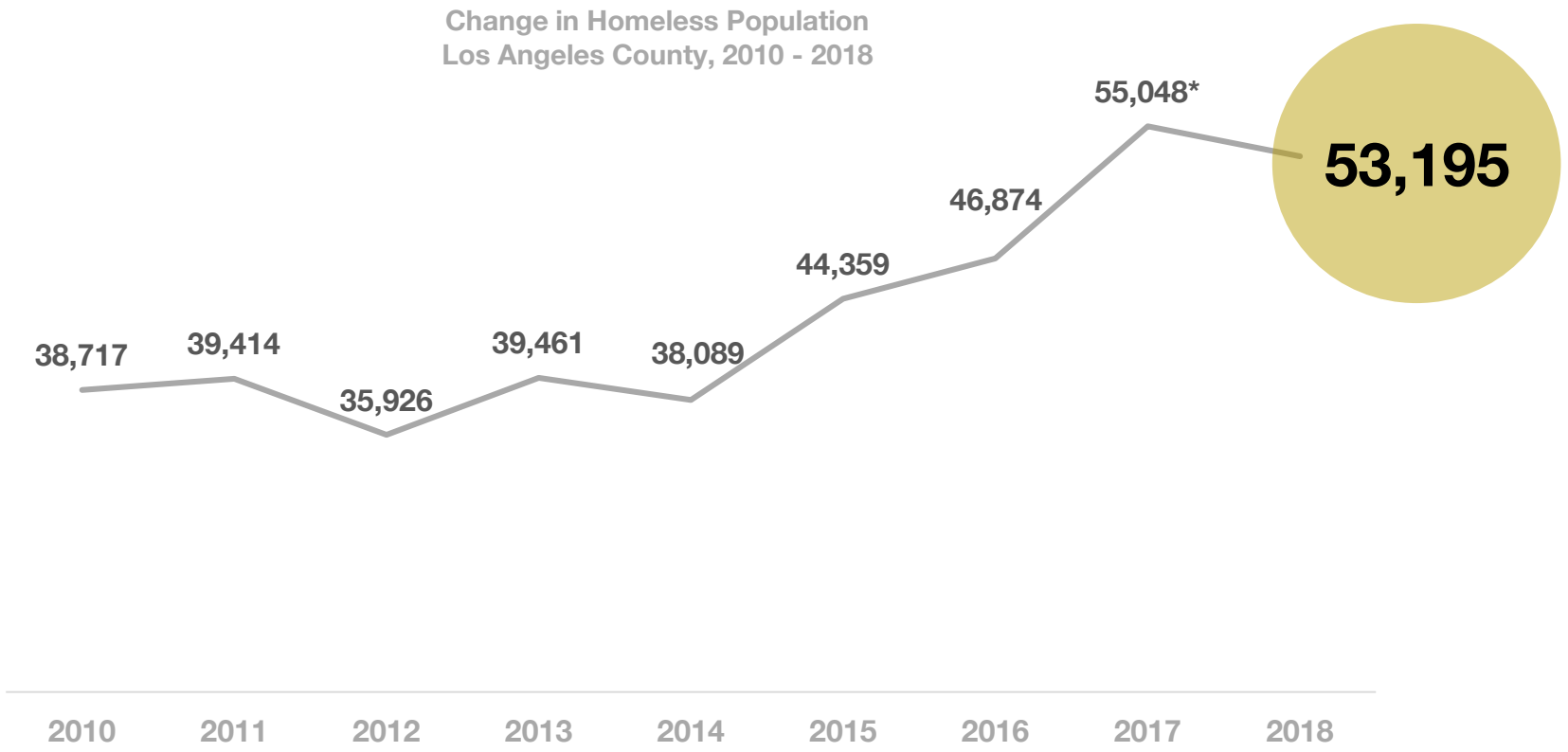
May 31, 2018

LAHSA

Behind these numbers are our neighbors. That's why we count.

THANK YOU to the over 8,500 volunteers, partners, and community service providers who make the Homeless Count possible

For the first time in 4 years homelessness decreased

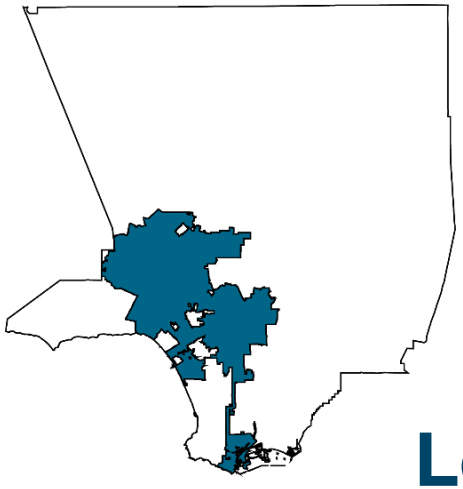


WHY?

- More people are being placed into housing than ever before
- Strategies have been developed, more resources deployed, and we're starting to see results

*Adjusted estimates resubmitted to HUD

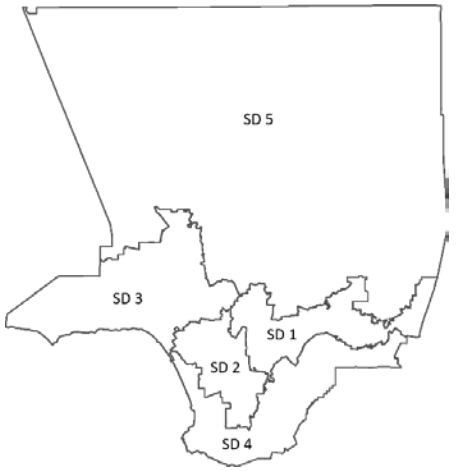
PEOPLE EXPERIENCING HOMELESSNESS



City of Los Angeles

31,516

5% Decrease



County of Los Angeles

53,195

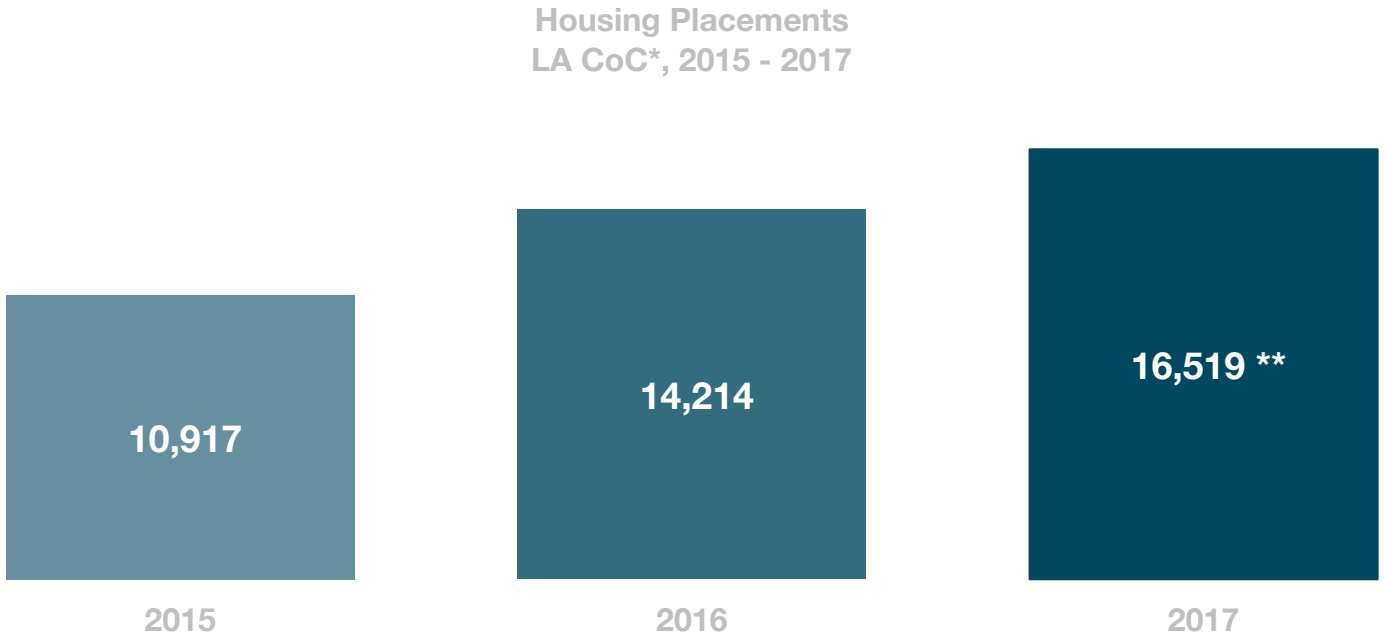
3% Decrease

The LA CoC total number was 50,385, a 4% decrease from 2017. The LA CoC is Los Angeles County excluding Glendale, Pasadena, & Long Beach CoCs.

Strategic efforts to address homelessness are beginning to make an impact

More people are moving into homes

2017 was the highest year to date



What's Working:

- ✓ Created new supportive and rapid re-housing resources
- ✓ Expanded landlord incentive programs
- ✓ Expanded move-in financial assistance

LA's Plan Moving Forward:

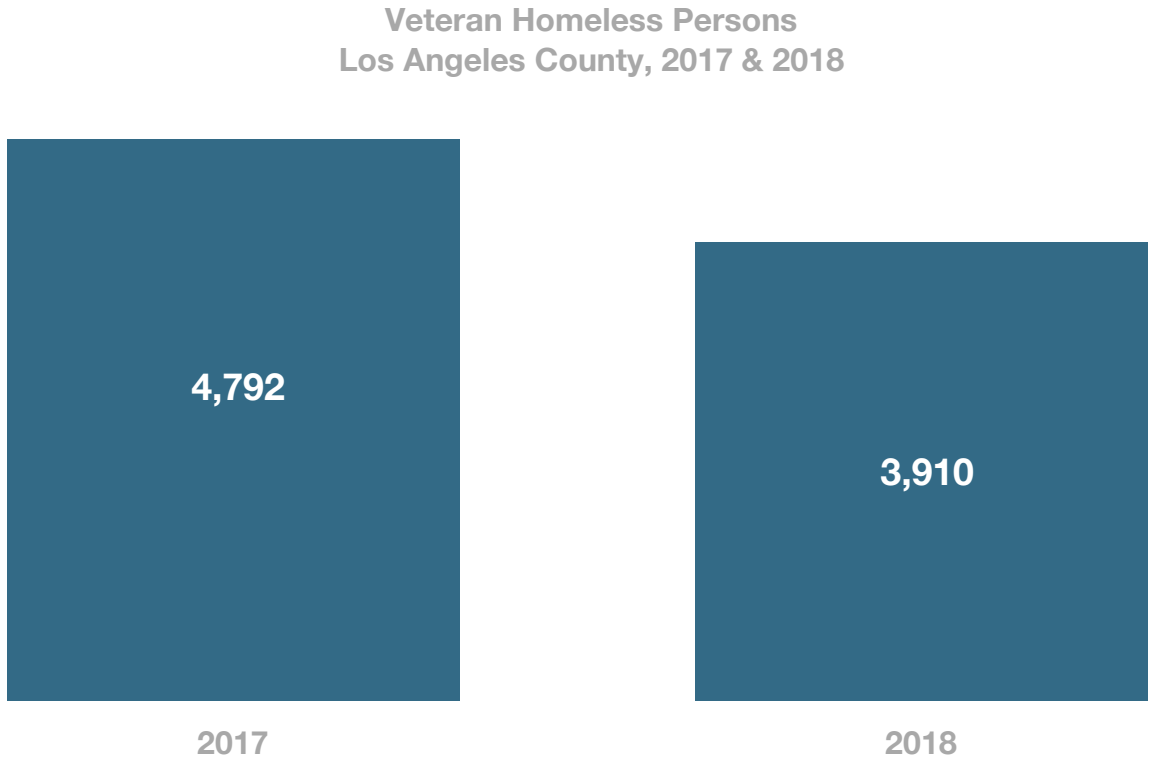
- ❑ Adding housing location services
- ❑ Linking affordable housing to the Coordinated Entry System
- ❑ Launching Shallow Subsidy program
- ❑ Implementing Year 2 of Proposition HHH and Measure H to create more housing

*LA CoC excludes Glendale, Pasadena, and Long Beach CoCs

**The HMIS data system transition caused a temporary disruption in data collection during 2017, resulting in fewer housing placements recorded in the data system. Researchers Dennis Culhane and Stephen Metraux used an historical statistical model to estimate that the total number of housing placements was 18,223

Veteran homelessness decreased 18%

Dedicated resources, continued hard work, local leadership



What's Working:

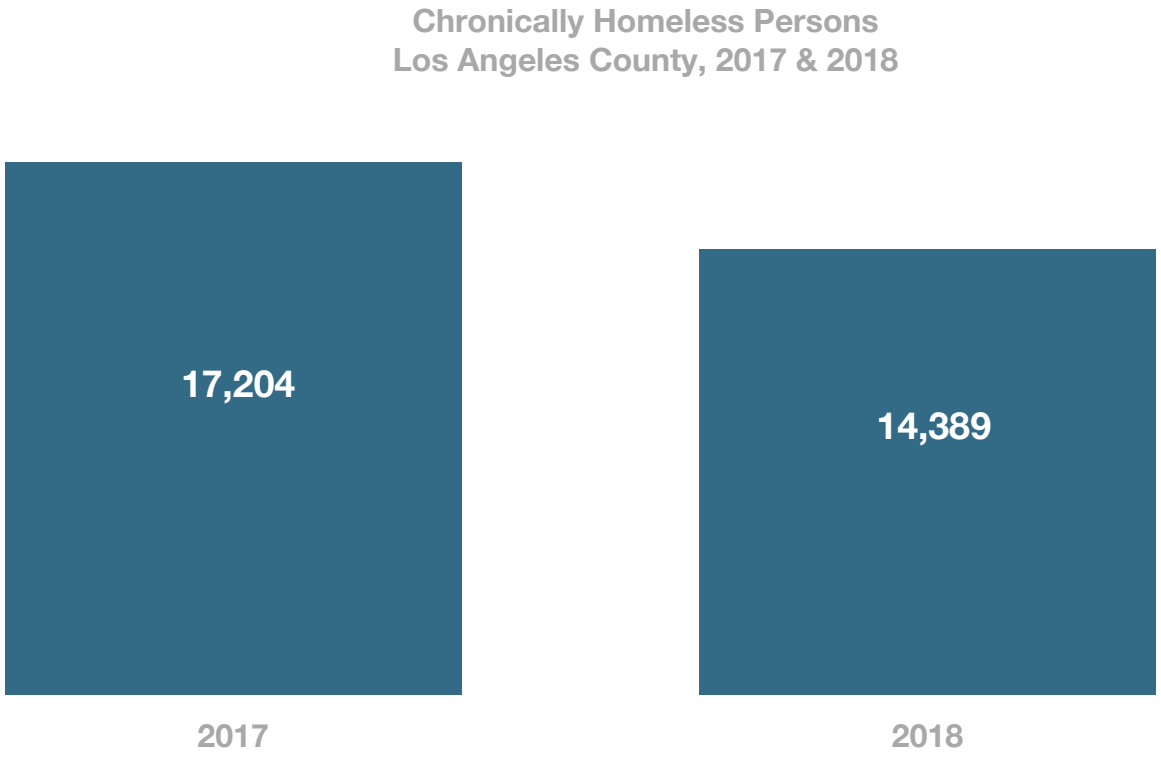
- ✓ Established a Countywide Veterans Benefit Advocacy Program
- ✓ Redesigned VA programs to target chronically homeless Veterans
- ✓ Enhanced direct-service staff collaboration
- ✓ Coordinated VA housing resources through the Coordinated Entry System

LA's Plan Moving Forward:

- ❑ Continuing to strengthen system collaboration between VA and the Coordinated Entry System
- ❑ Adding 800+ Veteran-specific supportive housing units
- ❑ Allocating $20 million countywide to house Veterans experiencing mental health issues
- ❑ Creating countywide Veteran Peer Support Network

Chronic homelessness decreased 16%

Prioritizing our most vulnerable



What's Working:

- ✓ Focused Coordinated Entry System services for chronic/high-need population
- ✓ Dedicated half of all HACoLA turnover housing choice vouchers
- ✓ Streamlined supportive housing process

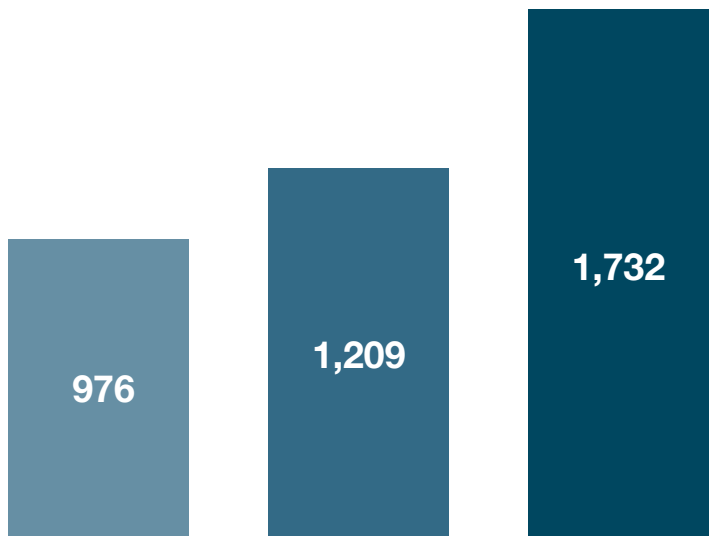
LA's Plan Moving Forward:

- ❑ Strengthening linkages to medical services
- ❑ Reducing housing barriers through legal assistance services
- ❑ Implementing Proposition HHH and Measure H resources to create new supportive housing units

Youth housing placements increased 43%

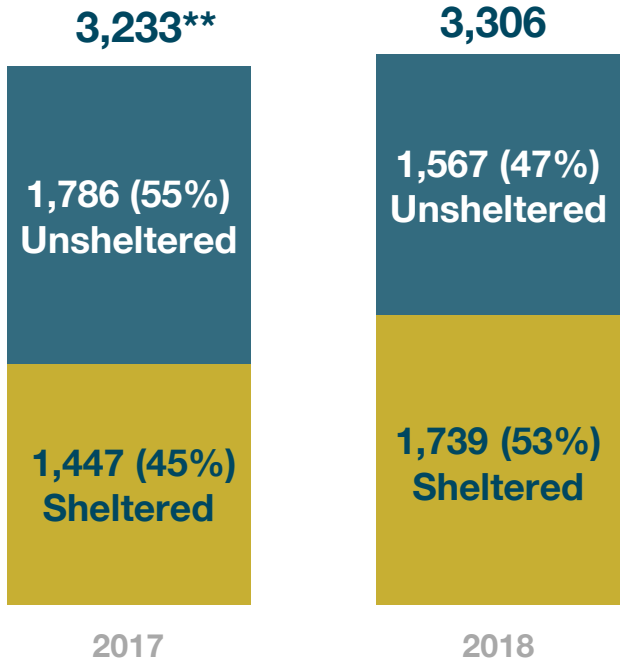
The number of sheltered youth increased 20%

Youth Placed into Housing
LA CoC*, 2015 - 2017



*LA CoC excludes Glendale, Pasadena, and Long Beach CoCs

Total Homeless Youth Population
Los Angeles County, 2017 & 2018



**Adjusted estimates resubmitted to HUD

What's Working:

- ✓ Created 276 new youth interim housing beds
- ✓ Launched youth family reconnection program
- ✓ Added 196 rapid re-housing slots dedicated for youth

LA's Plan Moving Forward:

- ❑ Enhancing youth drop-in centers
- ❑ Adding 350 new interim housing beds dedicated for youth
- ❑ Adding 129 supportive housing units dedicated for youth


However, the economic factors driving people into homelessness persist

Los Angeles has a growing affordable housing crisis

Los Angeles County needs over 565,000 new affordable housing units for low income renters—16,000 more than the previous year

Since 2000, median rent in Los Angeles County has increased 32% while median renter household income has decreased 3%*

Los Angeles County has the highest poverty rate across all counties in the state at nearly 25%**

When accounting for housing costs and cost-of-living, California has the highest poverty rate in the country at over 20%***

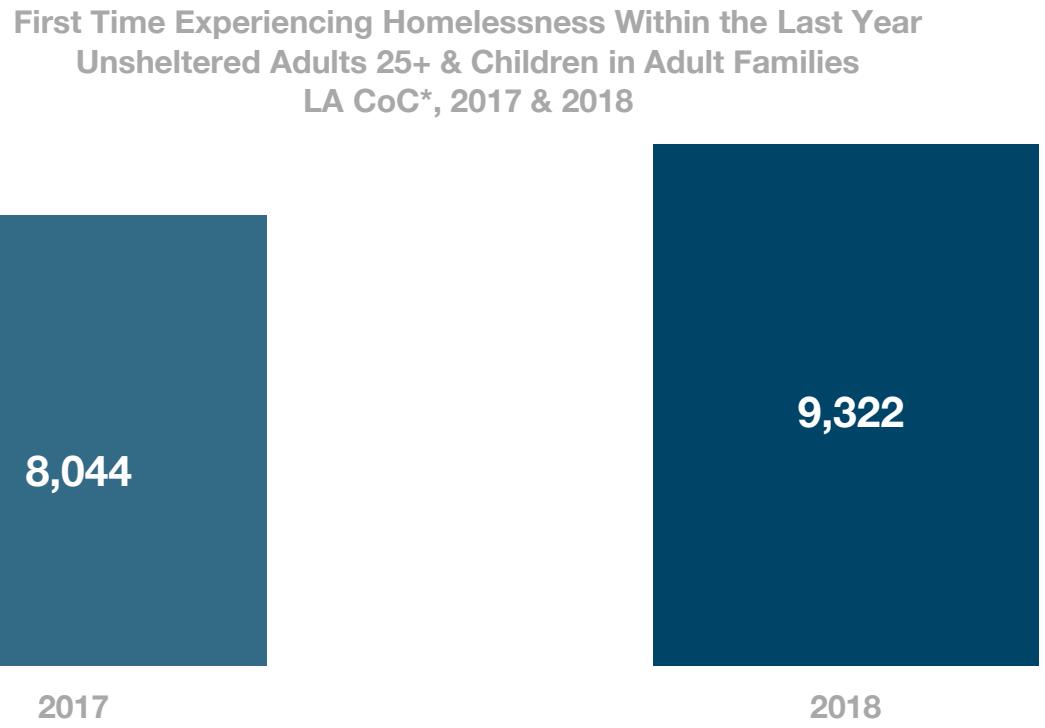
Source: California Housing Partnership Corporation. (May 2018). Los Angeles County's Housing Emergency and Proposed Solutions.

*Adjusted for inflation
Source: California Housing Partnership Corporation (May 2017). Los Angeles County Renters in Crisis: A Call for Action.

**California Poverty Measure (CPM), a measure developed by the Public Policy Institute of California (PPIC) and the Stanford Center on Poverty and Inequality, average poverty rates from 2013-2015
***US Census Bureau Supplemental Poverty Measure (SPM), average poverty rates from 2014-2016

More people are falling into homelessness for the first time

46% of the 9,322 people experiencing homelessness for the first time said it was due to a loss of employment or other financial reasons



Current Strategies:

- ✓ Expanded family homelessness prevention services
- ✓ Launched youth and adult prevention services
- ✓ Targeted services to people exiting jails, foster care, and hospitals who would otherwise become homeless
- ✓ Supporting the development and preservation of affordable housing

LA's Plan Moving Forward:

- ❑ Launching prevention pilot in a high-eviction neighborhood
- ❑ Expanding services for people at-risk of experiencing homelessness
- ❑ Creating new affordable housing

*LA CoC excludes Glendale, Pasadena, and Long Beach CoCs

Homelessness remains visible on our streets

3 out of 4 people remain unsheltered

39,826
(75%) Unsheltered

13,369
(25%) Sheltered

The number of

- Vehicles
- Tents
- Makeshift shelters

increased 5%* from last year and 32%* since 2016

Current Strategies:

- ✓ Doubled the amount of outreach workers to 500
- ✓ Implemented a holistic outreach strategy

LA's Plan Moving Forward:

- ❑ Launching Centralized Outreach Referral Portal
- ❑ Adding more outreach workers
- ❑ Adding 3,250 interim housing units
- ❑ Expanding use of technology and data

*LA CoC excludes Glendale, Pasadena, and Long Beach CoCs

Demographic snapshot

Health Conditions
(LA County):

27% report a serious mental illness

15% report a substance use disorder

10% report both substance use disorder and serious mental illness

Domestic Violence
(LA CoC*):

6%

of people report experiencing homelessness because they are fleeing domestic/intimate partner violence

Household Types
(LA County):

80% of households are single adults only

Age
(LA CoC*):

22%

increase in people aged 62 and older

There was a decrease in all other age groups

Gender
(LA County):

2/3

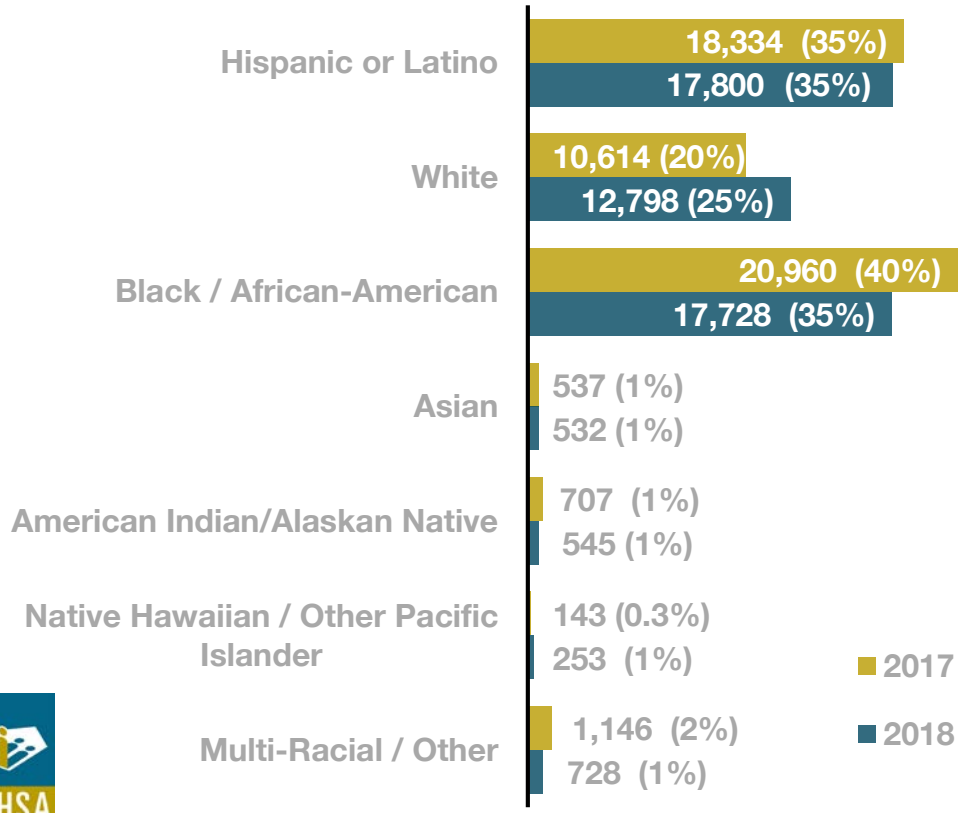
of people experiencing homelessness identify as male

*LA CoC excludes Glendale, Pasadena, and Long Beach CoCs

Race/Ethnicity: (LA CoC*)

While the Black/African-American population experiencing homelessness decreased 15%, they continue to be overrepresented. Black/African-Americans make up 35% of the homeless population while only making up 9% of the general population in the county.

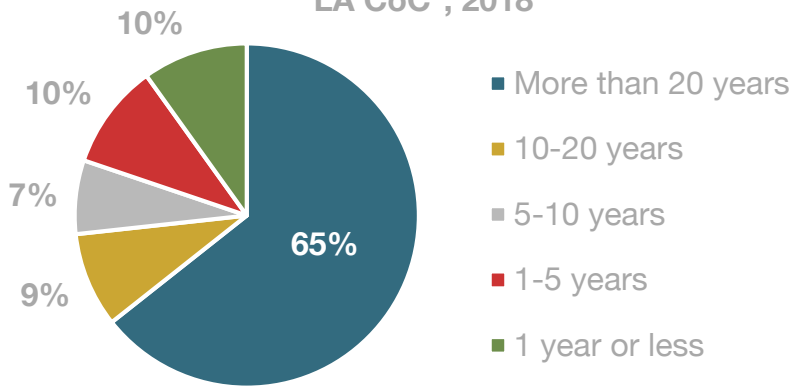
Homeless Population by Race and Ethnicity
LA CoC*, 2017 & 2018



Origin: (LA CoC*)

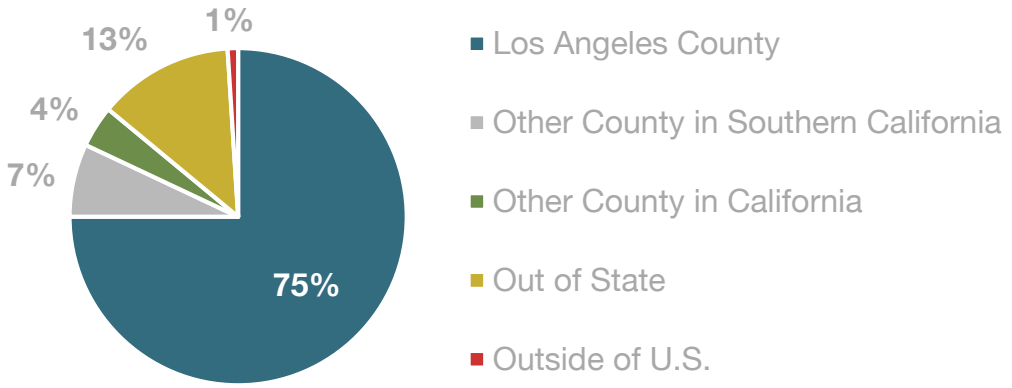
65% have been in LA County for more than 20 years

Length of Time in LA County, Unsheltered Adults
25+ & Children in Adult Families
LA CoC*, 2018



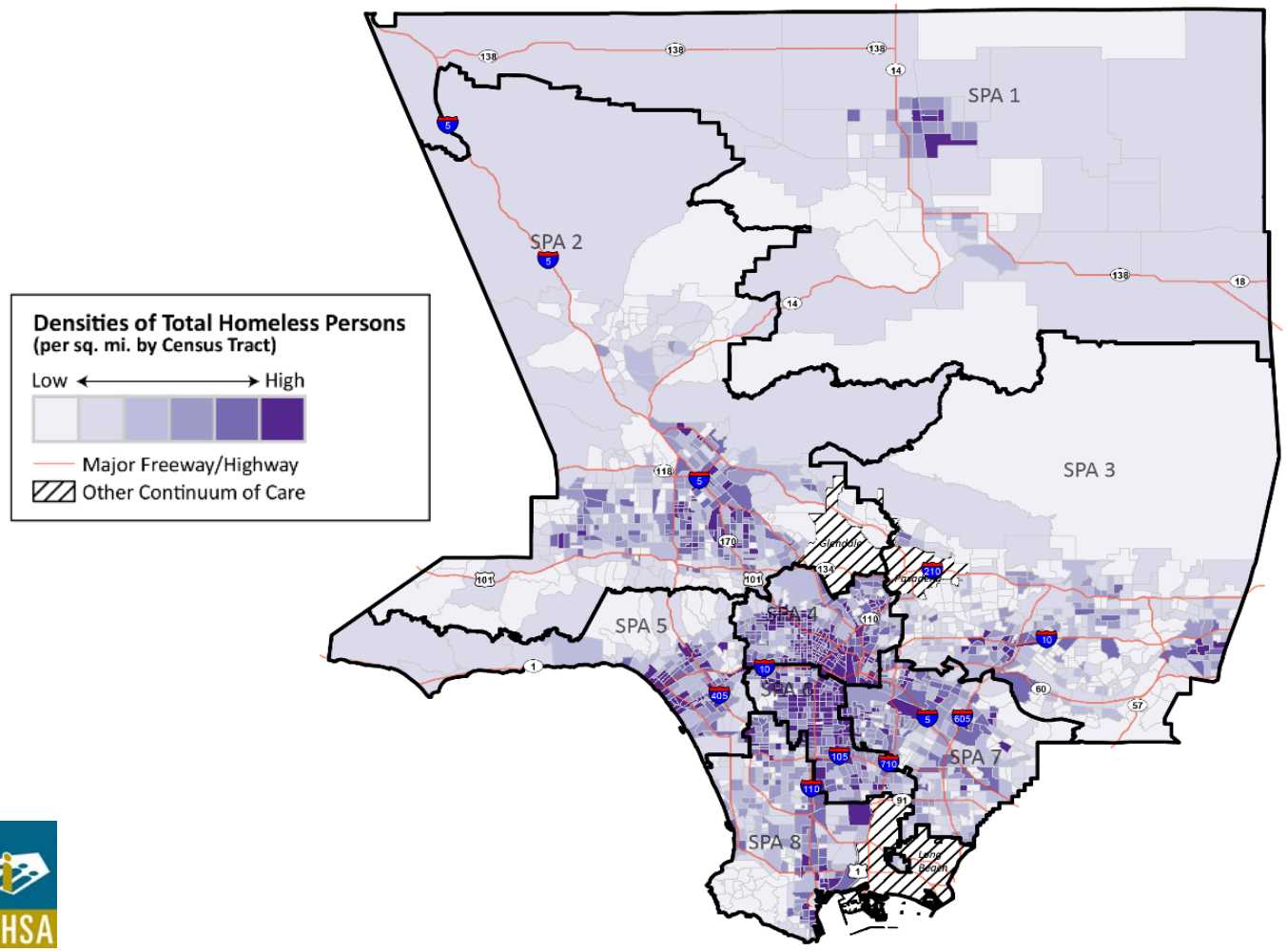
75% lived in Los Angeles before becoming homeless

Place of Residence Before Becoming Homeless
Unsheltered Persons
LA CoC*, 2018



*LA CoC excludes Glendale, Pasadena, and Long Beach CoCs

A snapshot of where our homeless neighbors were found 3 days in January

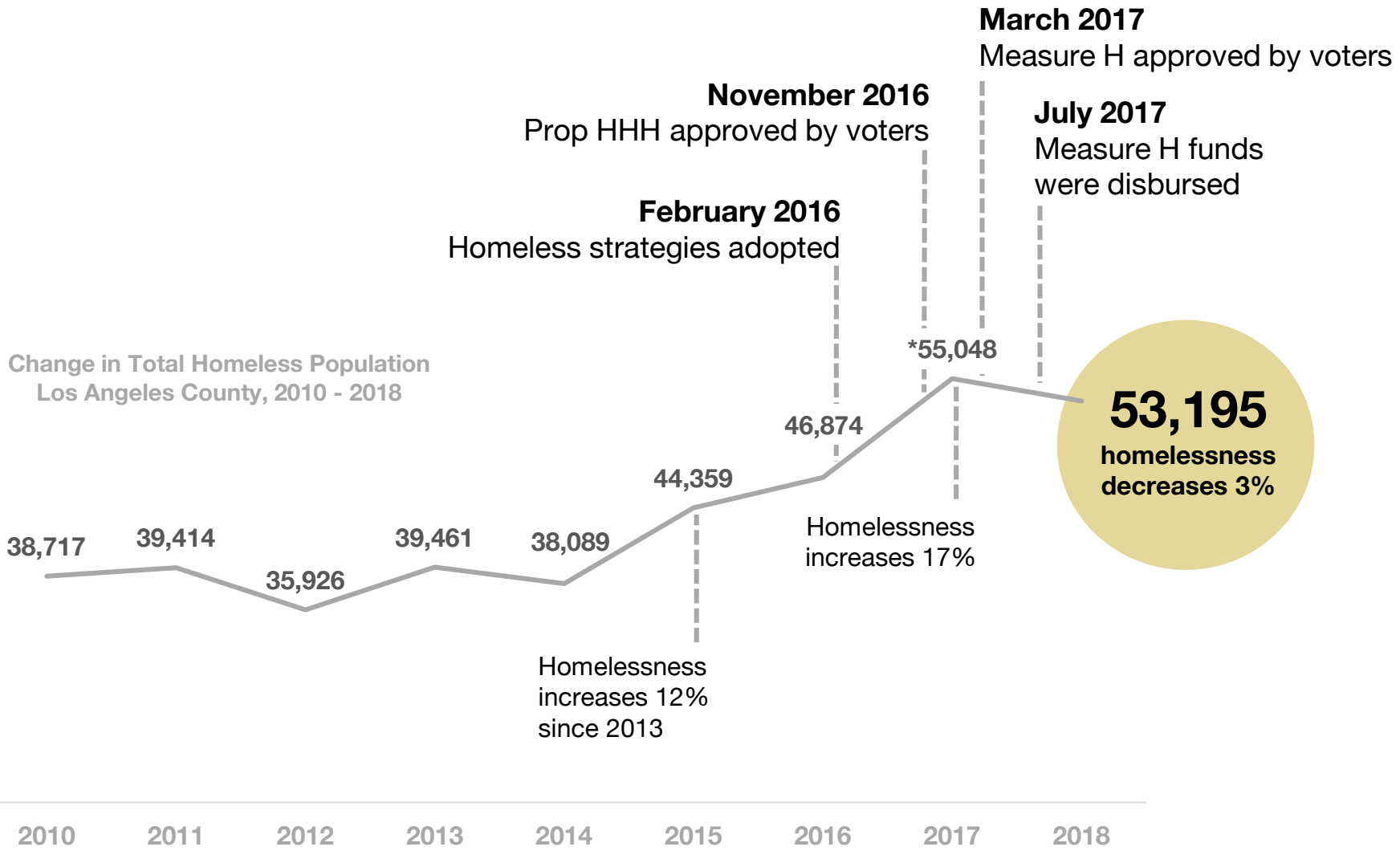


Service Planning Area (SPA)	2017	2018	% Change
1- Antelope Valley	3,825	3,203	-16%*
2- San Fernando Valley	7,341	7,773	+6%*
3- San Gabriel Valley	4,094	4,292	+5%*
4- Metro LA	14,844	14,425	-3%
5- West LA	5,411	4,485	-17%*
6- South LA	9,036	8,317	-8%*
7- East LA County	4,533	4,581	+1%
8- South Bay	5,964	6,119	+3%*
Totals	55,048	53,195	3%

*Change is statistically significant

Los Angeles is investing, responding, and working together

Our work is making a difference



WHERE WE ARE GOING:

$3.5 billion in LA County Measure H funds and $1.2 billion in LA City Proposition HHH dollars will be invested to address homelessness over the next 10 years

*Adjusted estimates resubmitted to HUD

GET INVOLVED

1. Support more interim and supportive housing in your local community
2. Advocate for expanded state and federal funding for affordable housing and homeless services
3. Join the Everyone In Campaign at everyoneinla.org
4. Volunteer at your local homeless service agency and for the 2019 Street Count

SAVE THE DATE

2019 Street Count

January 22, 23 & 24

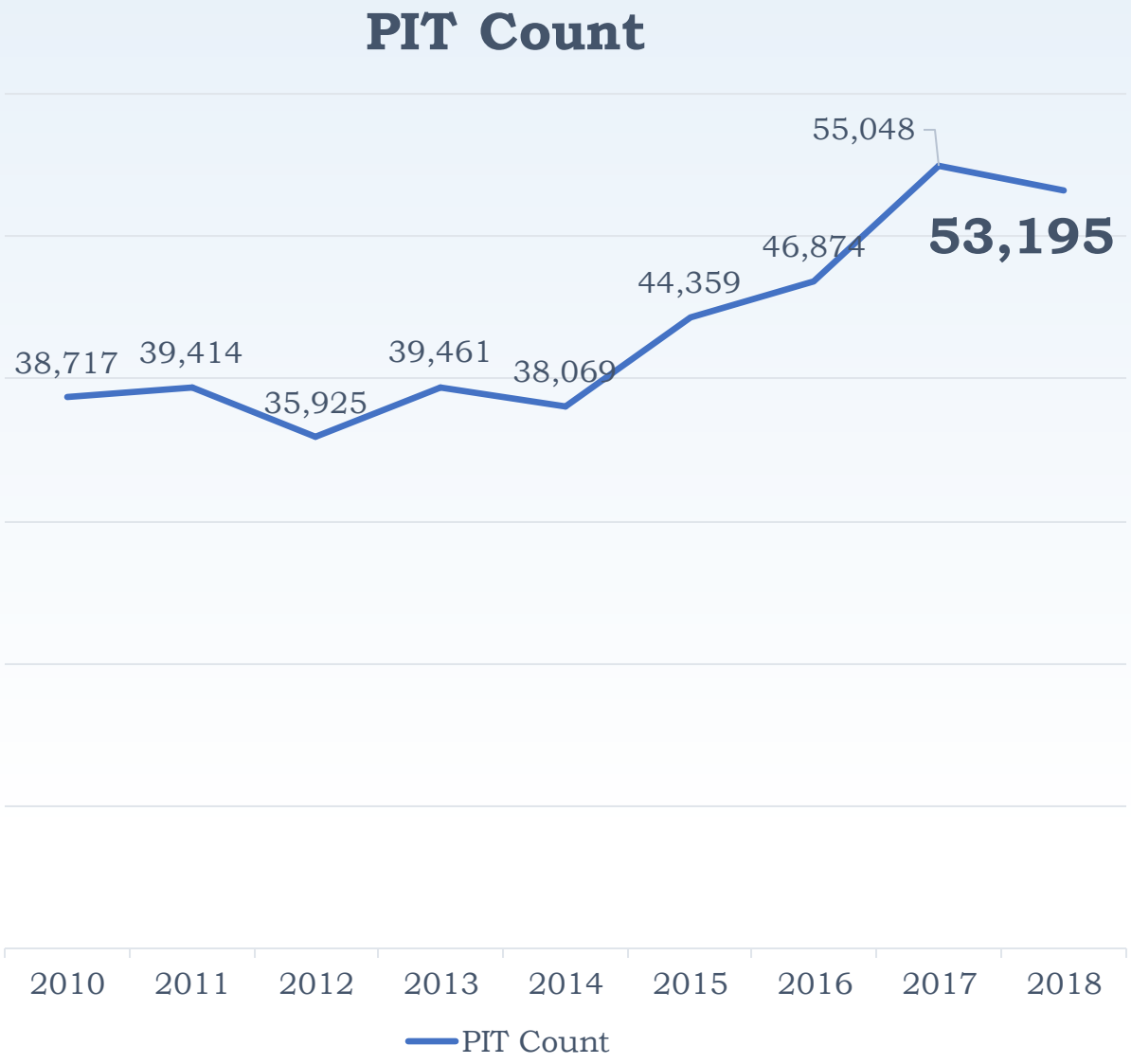
LOS ANGELES HOMELESS SERVICES AUTHORITY

Greater Los Angeles Homeless Count

Community Engagement & Reintegration Service (CERS)

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

People Experiencing Homelessness



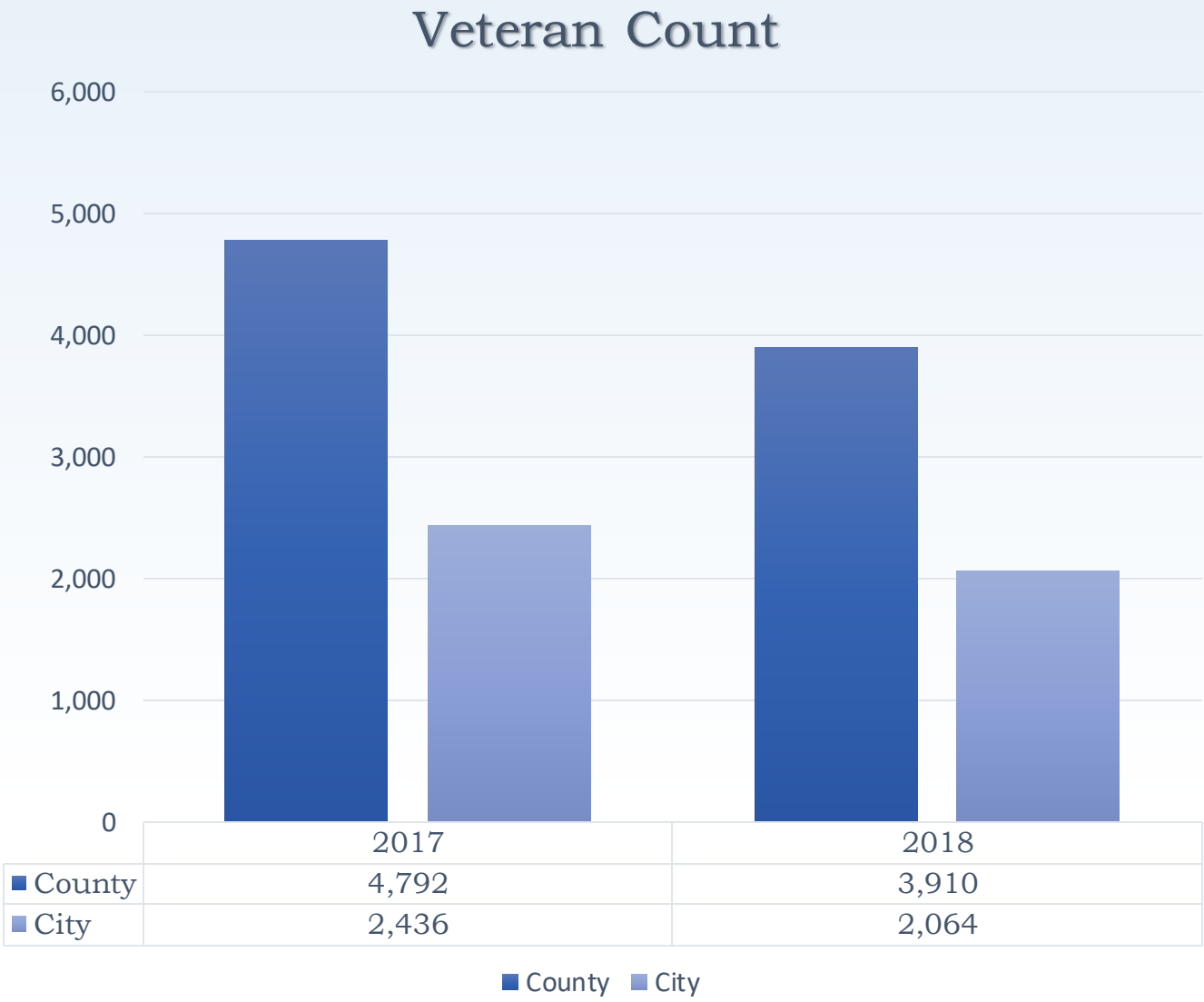
First Decrease in 4 Years

County of Los Angeles	City of Los Angeles
53, 195	31, 516
3% Decrease	5% Decrease

Community Engagement & Reintegration Service (CERS)

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

18% Decrease in Veteran Homelessness



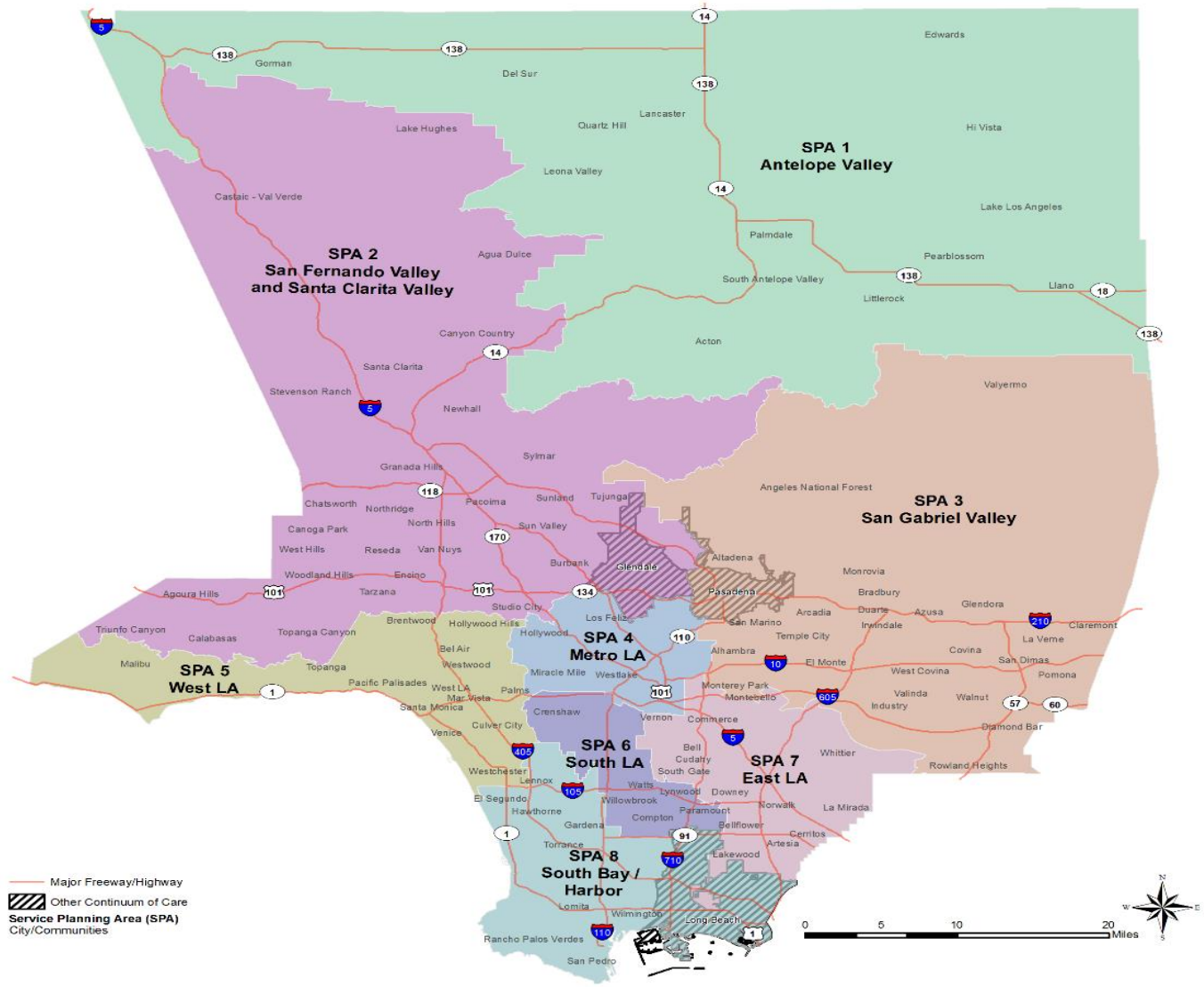
- Through programmatic redesign and implementation of targeting/outreach strategies, we are housing more vulnerable and chronically homeless Veterans than ever before.
- Focused efforts on reducing the number of Veterans who fall out of housing
- New leadership and VACO support that lead to data validation and system re-design. We can now use data better to inform policy and operational decisions about Veteran homelessness
- Increased collaboration with CES / BNL Case Conferencing
- Veteran specific PBV Units account for less than 5% of total PH Placements

Community Engagement & Reintegration Service (CERS)

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

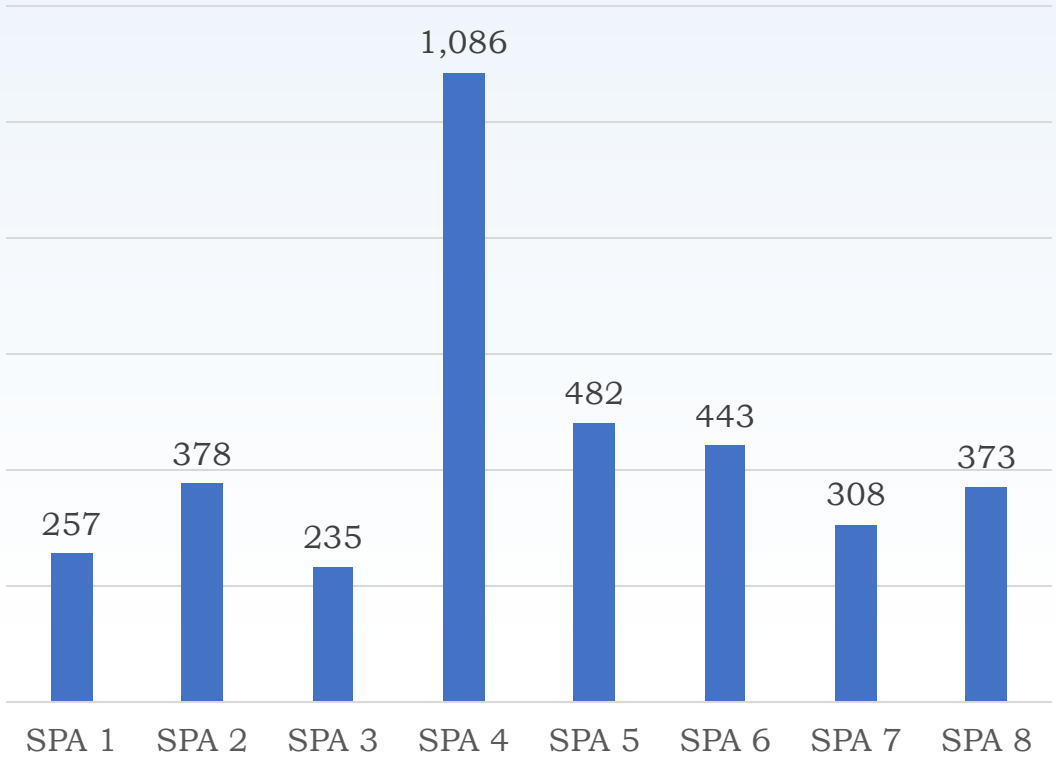
Veteran Homelessness by Service Planning Area (SPA)

SPA	Region	Count	Compared to 2017
1	Antelope Valley	257	-2%
2	San Fernando and Santa Clarita Valley	378	-5%
3	San Gabriel Valley	235	+10%
4	Metro Los Angeles	1,086	-25%
5	West Los Angeles	482	-53%
6	South Los Angeles	443	-29%
7	East Los Angeles County	308	+99%
8	South Bay	373	+17%

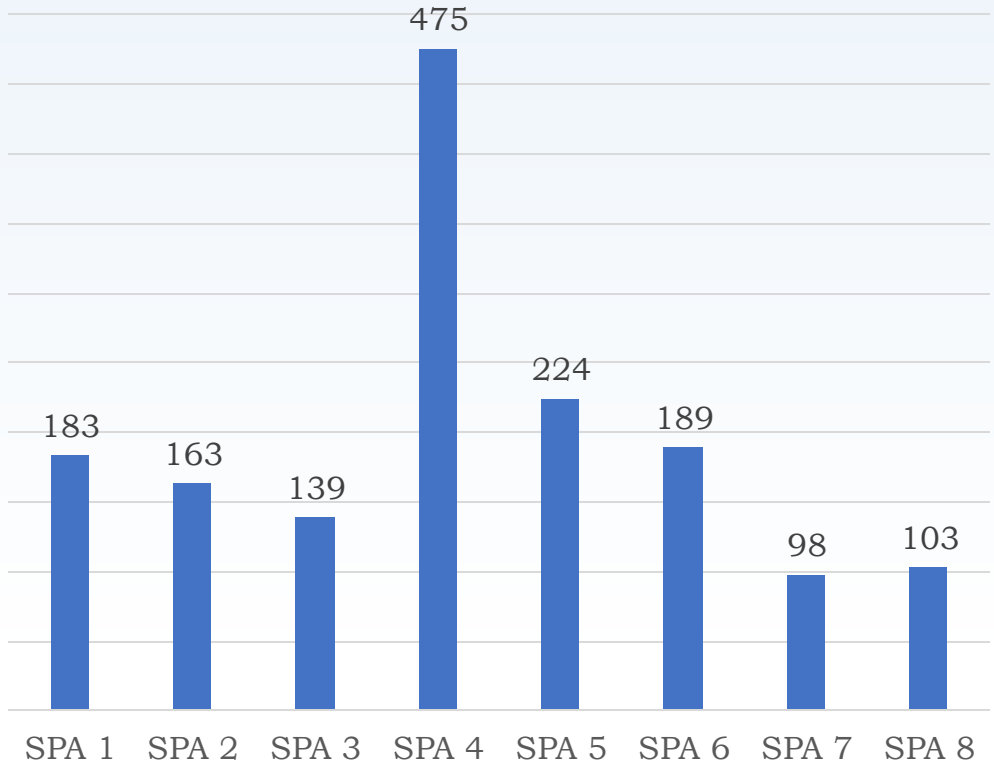


Veteran Homelessness by Service Planning Area (SPA)

Homeless Veterans

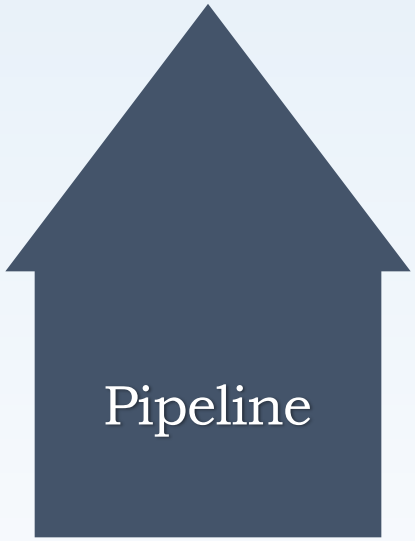


Chronically Homeless Veterans



Community Engagement & Reintegration Service (CERS)

Permanent Supported Housing



PHA	Unit Count *(Coming online by end of 2020)*
HACLA	626
HACOLA	114
Total	740
**Does not include units coming online through DMP*	

Strategies

- ❑ Expanded intake functions to Sepulveda and SPA 4 (Downtown)
- ❑ Contracted HUD VASH Case Managers imbedding into GPD Programs
- ❑ Expanded Peer Support Roles and Capabilities
- ❑ Maximize best practices (i.e. NYC CES Demo to LAHSA)

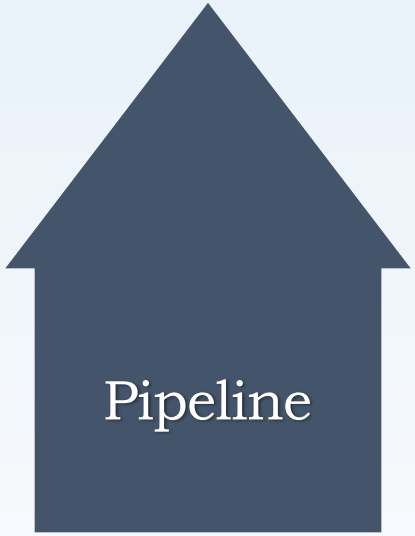
On The Horizon

- ❑ Housing Location Contract
- ❑ Training Contract for HUD VASH Case Management
- ❑ On-boarding three CES Coordinator Positions

Community Engagement & Reintegration Service (CERS)

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Permanent Supported Housing



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Community Engagement & Reintegration Service (CERS)

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Progress Report

SafeParkingLA

Safe Parking - Live

- ❑ Utilize available parking spaces on VA's West LA Campus to provide Safe Parking to homeless Veterans living in their vehicles

Temporary Bridge Housing – In Progress

- ❑ Partnership between community, Federal, State, and Local Governments to address the immediate, emergent need

- ✓ Building # 209 opened the first **54** units of permanent supportive housing on the West LA Campus in June 2017
- ✓ VA anticipates opening Buildings # 205 & # 208 in Fall 2019, to provide an estimated **120** additional units of permanent supportive housing on the Campus
- ✓ For the remaining development on the Campus, VA must first complete its Environmental & Historic due diligence, which kicked-off May 2017; anticipated completion in late Summer 2019

Greater Los Angeles Homeless Count

2018 Greater Los Angeles Homeless Count - Data Summary

Skid Row

Population	Sheltered	Unsheltered	Total	Prevalence of Homeless Pop. (%)	Percent Change 2017 - 2018
All Persons					
All Persons	2,149	2,145	4,294	100%	-7%
Household Composition					
Individuals *(Those not in family units)*	1,713	2,103	3,816	89%	-18%
Adults (Over 24)	1,658	2,058	3,716	87%	-13%
Transition Age Youth (18-24)	55	45	100	2%	-15%
Chronically Homeless	274	929	1,203	28%	-8%
Veterans	113	233	346	8%	-22%
Unaccompanied Minors *(Under 18)*	0	0	0	0%	N/A*
Family Members *(Those in family units)*	436	42	478	11%	+111%
Adult Family Members (Over 24 Head of Household)	410	42	452	11%	+108%
Young Family Members (18-24 Head of Household)	26	0	26	1%	+160%
Children in Families (Under 18)	286	23	309	7%	+109%
Chronically Homeless	0	26	26	1%	N/A*
Veterans	0	3	3	0.1%	N/A*
Veterans					
All Veterans	113	236	349	8%	-22%
Chronically Homeless Veterans	31	108	139	3%	+34%
Gender					
Male	1,362	1,399	2,761	64%	-21%
Female	770	672	1,442	34%	+35%
Transgender	17	62	79	2%	+61%
Gender Non-Conforming	0	12	12	0.3%	+140%
Race/Ethnicity					
American Indian/ Alaska Native	18	25	43	1%	-22%
Asian	40	22	62	1%	+0%
Black/African American	1,291	1,539	2,830	66%	-1%
Hispanic/ Latino	409	333	742	17%	-24%
Native Hawaiian/ Other Pacific Islander	16	0	16	0.4%	+0%
White	375	146	521	12%	-10%
Multi-Racial/Other	0	80	80	2%	+4%
Age					
Under 18	286	23	309	7%	+109%
18 - 24	77	48	125	3%	+1%
25 - 54	1,286	1,288	2,574	60%	-12%
55 - 61	325	518	843	20%	-16%
62 and Over	175	268	443	10%	+5%
Chronically Homeless					
Individuals (Those not in family units)	274	929	1,203	28%	-8%
Family Members (Those in family units)	0	26	26	1%	N/A*
Total Chronically Homeless Persons	274	955	1,229	29%	-6%

Health and Disability					
Health/Disability Indicator[1]	Sheltered	Unsheltered	Total	Prevalence in 18 and Over Homeless Pop. (%)	Percent Change 2017 - 2018
Substance Use Disorder	67	523	590	15%	-21%
HIV/AIDS	91	31	122	3%	+2%
Serious Mental Illness	338	926	1,264	32%	-2%
Developmental Disability	208	179	387	10%	-15%
Physical Disability	221	561	782	20%	-2%

Domestic/Intimate Partner Violence					
Domestic/Intimate Partner Violence	Sheltered	Unsheltered	Total	Prevalence in 18 and Over Homeless Pop. (%)	Percent Change 2017 - 2018
Domestic/Intimate Partner Violence Experience	180	980	1,160	29%	+3%
Homeless Due to Fleeing Domestic/Intimate Partner	71	287	358	9%	N/A[2]

Notes:
1. Health/Disability indicators are not mutually exclusive (a person may report more than one). Numbers will not add up to 100%.2. Health/Disability indicators are not mutually exclusive (a person may report more than one). Numbers will not add up to 100%.
2. No data available to compare from 2017.
* The value for 2017 was zero.
Prepared by Los Angeles Homeless Services Authority (May 2018).

John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson
VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018
Public Law 115-182, Signed June 6, 2018

Overview: The VA MISSION Act of 2018 includes five titles containing more than 60 substantive provisions both amending existing law and creating new sections of law.

- Title I, the Caring for Our Veterans Act of 2018, contains 30 substantive provisions within three subtitles.
  - Subtitle A principally deals with VA's community care authorities and includes two dozen substantive provisions.
  - Subtitle B contains three provisions dealing with VA's telehealth authority, authority for a VA Center for Innovation for Care and Payment, and authority concerning treatment for live organ transplant donors.
  - Subtitle C contains three provisions that expand VA's family caregiver program authorities, create requirements concerning the family caregiver program's information technology (IT) system, and modify a reporting requirement related to the family caregiver program.
- Title II, the VA Asset and Infrastructure Review (AIR) Act of 2018, contains 11 substantive provisions in two subtitles.
  - Subtitle A contains eight substantive provisions that principally deal with the AIR Commission, its functions, and the process for reviewing and making decisions regarding VA's real property assets.
  - Subtitle B contains three substantive provisions dealing with improvement of training for construction personnel, the review of enhanced use leases, and an assessment of VA health care for Veterans who live in the Pacific territories.
- Title III contains six substantive provisions dealing with improvements to the recruitment of VA health care professionals.
- Title IV contains three substantive provisions regarding health care in underserved areas.
- Title V contains 12 substantive provisions dealing with other matters, including appropriation of $5.2 billion for the Veterans Choice Fund.

The following tables identify statutory timelines for action and reports. Please note these tables only include provisions for which the law itself clearly establishes a timeline for an action. Other provisions of law include requirements for action or reports that are relative (such as a report upon the completion of a pilot program). These are identified in the subsequent section providing a general description of the various provisions in the law. Page numbers refer to the page number of the enrolled bill version of the bill text.

Unless otherwise noted, references to sections of codified law refer to title 38, United States Code (U.S.C.).

Statutory Timelines for Action:

Deadline	Action Required	Section	Pg
July 8, 2018	Modify podiatrist and surgeon pay schedule	502(b)(2)	83
September 4, 2018 **(Quarterly)**	Post information online regarding VA personnel	505(a)(1)	85
October 1, 2018 [A]	Implement an IT system that fully supports PCAFC	162(a)	48
October 4, 2018	Provide first update to Congress on progress in developing regulations for the new community care program	101(c)(2)	11
October 4, 2018	Provide first update to Congress regarding creation of access standards	(104) § 1703B(d)(2)	17
October 4, 2018	Provide first update to Congress regarding creation of standards for quality	(104) § 1703C(a)(5)	19
December 3, 2018	Develop criteria to designate VA medical facilities as underserved facilities	401(a)	78
April 1, 2019 [B]	Conduct an assessment of PCAFC using data from the IT system developed for the program and other relevant data	162(b)	49
May 31, 2019	Carry out pilot program for peer specialists at not fewer than 15 medical centers	506(b)(1)	85
June 6, 2019	Publish regulations and begin operating the new Veterans Community Care program	(101(b)-(c)) § 1703	11
June 6, 2019	Publish regulations and begin operating the walk-in care program	(105) § 1725A(g)	21
June 6, 2019	Deny or revoke the eligibility of certain community health care providers to furnish care to Veterans; may deny, revoke, or suspend in certain cases	108(a)-(b)	24
June 6, 2019 [C]	Establish competency standards and requirements for community providers	133	35
June 6, 2019	End the Veterans Choice Program	143	37
June 6, 2019 **(Annual)**	Make determinations regarding staffing needs for physicians in medical specialties	(303(c)) § 7692	72, 75
June 6, 2019 **(Annual)**	Secretary to provide informational material to appropriate educational institutions about designated scholarship program	(301(a)) § 7612(b)(6)(E)	71
September 30, 2019	Implement covered training curriculum for construction personnel	(211) § 8103(g)(1)	68-69
December 3, 2019 **(Annual)**	VISN Directors must perform an analysis to determine which facilities within that VISN qualify as underserved facilities	401(c)	78
December 6, 2019	Submit first proposal for pilot program for VA Center for Innovation for Care and Payment	(152) § 1703E(g)(3)	44
May 31, 2020	Carry out pilot program for peer specialists at not fewer than 30 medical centers	506(b)(2)	86
June 6, 2020	End of eligibility for certain Veterans grandfathered under the 40-mile provision	(101) § 1703(d)(1)(C)	4
June 6, 2020 [D]	Publish quality rating of VA medical facilities through Hospital Compare website	(104) § 1703C(b)(1)	19

September 30, 2020	Majority of construction employees subject to the covered certification program must have achieved certification or the appropriate level of certification	(211) § 8103(g)(5)	69
February 1, 2021	Publish in the Federal Register and transmit to Congress the criteria proposed to be used by VA in assessing and making recommendations to the AIR Commission	203(a)(1)	54
May 31, 2021	President submits nominations for the AIR Commission	202(c)(1)	51
May 31, 2021	Publish in the Federal Register the final criteria to be used by VA in making recommendations to the AIR Commission	203(a)(3)	54
June 6, 2021 [D]	Consider and solicit public comment on potential changes to standards for quality	(104) § 1703C(b)(2)	19
January 31, 2022	Publish in the Federal Register and submit to Congress and the AIR Commission a report detailing the recommendations regarding the modernization or realignment of VHA facilities	203(b)(1)	54
June 6, 2022 **(Quadrennial)**	Perform market area assessments regarding VA and VA-furnished health care services	(106) § 7330C(a)(1)	21
January 31, 2023	AIR Commission shall transmit a report to the President containing the Commission's findings and conclusions	203(c)(2)	57
February 15, 2023	President transmits to AIR Commission and Congress a report containing approval or disapproval of Commission's recommendations	203(d)(1)	58
March 1, 2023	President transmits to AIR Commission and Congress a report providing the reasons for any disapproval of the Commission's recommendations	203(d)(3)	58
March 15, 2023	AIR Commission shall transmit to the President a report containing its findings regarding the President's reasons for disapproving the Commission's recommendations	203(d)(3)	58
March 30, 2023	Process for modernizing or realigning facilities under the AIR Act terminate if the President does not transmit to Congress an approval and certification in certain cases	203(d)(5)	58
December 31, 2023	Termination of AIR Commission	202(j)	53
August 7, 2024	Medical residency pilot program ends	403(d)	82
March 2026	VA must begin to implement the recommended modernizations and realignments in the President's report within 3 years of submission	204(a)	58
September 30, 2028	Authority to collect home loan fees expires	(508) § 3729(b)(2)	88
September 30, 2028	Authority to reduce the amount of pension for certain Veterans covered by Medicaid plans	(509) § 5503(d)(7)	88
December 31, 2033	Authority to operate VA's Health Professionals Scholarship Program expires	(301(c)) § 7619	71

[A] The statute provides that VA has to implement an IT system that fully supports the Program of Comprehensive Assistance to Family Caregivers (the Program) and allows for data assessment and

comprehensive monitoring of the Program by October 1, 2018. VA is required to certify by October 1, 2019 that VA has implemented this IT system, and such certification is the triggering action for the first phase of expansion of the Program to pre-9/11 Veterans. While the October 1, 2018 deadline is for implementation of the IT system, the certification is required no later than October 1, 2019. Additionally, the language in section 161(a)(1)(A) of the bill and codified at 38 U.S.C. 1720G(a)(2)(B)(ii) focuses on when VA submits a "certification" that it has "fully" implemented the IT system, so VA has some discretion as to when to submit the certification and thus when the expansion to pre-9/11 Veterans begins.

[B] This date is based off the requirement in the statute that VA conduct an assessment "…180 days after implementing the [IT] system…" To the extent VA has not implemented the IT system by October 1, 2018, this due date will also move. As discussed in the prior note, this implementation does not necessarily require full implementation or certification that the IT system is fully implemented.

[C] This requirement does not take effect until 1 year after enactment for providers currently furnishing care and services to Veterans. For providers who enter into an agreement after this effective date, those providers have six months to meet these standards.

[D] Requirement is one year (for (b)(1)) or two years (for (b)(2)) after establishing standards for quality, which will likely occur one year after enactment and concurrent with publication of regulations for the Veterans Community Care program under 38 USC 1703, as amended by section 101.

Reporting Requirements:

Deadline	Reporting Requirement	Section	Pg
Upon enactment [A]	Submit market area assessments completed by the date of enactment	(106) § 7330C(a)(3)	22
September 4, 2018	Report on the feasibility and advisability of adopting a pass through funding mechanism	(111) § 1703D(h)	28
September 4, 2018	Report to Congress and GAO on the status of the planning, development, and deployment of the IT system for the Family Caregiver Program, including any changes in the timeline for the implementation, and an assessment of the needs of family caregivers of pre-9/11 Veterans, the resources needs for the inclusion of such family caregivers in PCAFC, and such changes to PCAFC as VA considers necessary to ensure successful expansion	162(d)(1)	49
September 4, 2018	Report to Congress on the East Bay CBOC and related construction projects	504(c)	84
December 3, 2018	Report to Congress regarding health care furnished by VA to Veterans who live in the Pacific territories	213(a)	70
December 3, 2018 **(Every 180 days)** [B]	Report to Congress on the peer specialist pilot program	506(f)(1)	86
January 8, 2019 **(Annual)**	Report to Congress a description of all performance awards or bonuses to VISN, VAMC, and VARO Directors, and Senior VA Executives	(501) § 726(a)	82
February 2019 **(Annual)**	Submit as part of the annual budget request information on the VA AIR Account	206(d)(2)	64
March 3, 2019	Report to Congress detailing the access standards developed by VA	(104) § 1703B(d)(1)	17
March 3, 2019	Report to Congress detailing the standards for quality developed by VA	(104) § 1703C(a)(5)	19
June 6, 2019	Report on the effectiveness of the use of telemedicine	151(c)	39

June 6, 2019	Report to Congress on the study on the demand for education debt reduction	302(b)(1)	71
June 6, 2019	Report on the number of participants in VA's Education Debt Reduction Program who work at Vet Centers	306(b)	78
June 6, 2019	Progress report on implementation of pilot program to furnish mobile deployment teams to underserved facilities	402(d)(1)	79
June 6, 2019 **(Annual)**	Report on the payment of overdue claims	(111) § 1703D(d)(3)	27
June 6, 2019 **(Annual)**	Report on the effectiveness of the education program on health care options developed by VA for Veterans	121(d)	32
June 6, 2019 **(Annual)**	Report on the effectiveness of the education program on training program for VA and non-VA personnel regarding community care programs	122(b)	32
June 6, 2019 **(Annual)**	Report on the utilization and effectiveness of the education program on health care options developed by VA for Veterans	123(c)(6)	33
June 6, 2019 **(Annual)**	Report evaluating the compliance of covered health care providers with the requirements regarding opioid prescriptions	131(c)(3)	34
June 6, 2019 **(Annual)**	Submit a plan to address the problem of underserved VA facilities	401(d)	78
June 6, 2019 **(Annual)** [C]	Report to Congress on the implementation of the pilot program on graduate medical education and residency	403(c)(1)	81
June 6, 2019 **(Annual)**	Report to Congress on VA's steps to achieve full-staffing capacity	505(b)	85
June 6, 2019 **(Quadrennial)**	Submit a strategic plan that specifies a four-year forecast of demand for care and capacity to furnish care in VA and in the community	(106) § 7330C(b)(1)	22
October 1, 2019 [D]	Submit a final report that certifies that the IT system for PCAFC has been implemented	162(d)(3)	50
November 28, 2019	Report to Congress detailing the implementation and compliance by VA and community providers with access standards	(104) § 1703B(d)(3)	18
November 28, 2019 **(Annual)**	Submit a review of the types and frequency of care sought under 38 USC 1703(d), as amended by section 101	(101) § 1703(m)(1)	10
November 28, 2019 **(Annual)**	Report to Congress on the monitoring of care and services furnished under 38 USC 1703, as amended by section 101	(101) § 1703(m)(3)	10
June 6, 2020 **(Annual)**	Report to Congress an analysis of the remediation actions taken by VA with respect to each medical service line VA determined was not complying with the standards for quality and timeliness	(109) § 1706A(d)(1)	26
November 27, 2020 [E]	Submit final report with recommendations on the peer specialist pilot program	506(f)(2)	86
December 31, 2020 **(Annual)**	Report to Congress on the "Veterans Healing Veterans" medical access and scholarship pilot program	304(f)	77

February 1, 2021	Report to Congress and publish in the Federal Register the criteria proposed to be used by VA in assessing and making recommendations to the AIR Commission	203(a)(1)	54
May 31, 2021	Report to Congress on the final criteria to be used by VA in making recommendations to the AIR Commission	203(a)(3)	54
June 6, 2021	Submit a final report to Congress on implementation of mobile deployment team pilot program	402(d)(2)	79
January 31, 2022	Report to Congress and publish in the Federal Register the recommendations regarding the modernization or realignment of VHA facilities for the AIR Commission	203(b)(1)	54
February 7, 2022	Report to Congress a summary of the selection process that resulted in VA's recommendations for the AIR Commission	203(b)(4)	56
June 6, 2022 [F] **(Triennial)**	Report on VA's review of the access standards and any modifications to such standards	(104) § 1703B(e)	18
June 6, 2022 **(Quadrennial)**	Submit market area assessments to Congress	(106) § 7330C(a)(3)	22
January 31, 2023	AIR Commission shall report to Congress with an explanation and justification of any recommendation of the Commission that differs from VA's recommendations	203(c)(3)	57
February 15, 2023	President transmits to Congress a report containing approval or disapproval of Commission's recommendations	203(d)(1)	58
March 1, 2023	President transmits to Congress a report providing the reasons for any disapproval of the Commission's recommendations	203(d)(3)	58

[A] Requirement is to submit 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". Any assessments that were already completed should be submitted as soon as possible. Any assessments still being performed should be submitted as soon as possible after their completion.
[B] Requirement is to continue this report every 180 days until the pilot program is being carried out at the last location, which must occur by May 31, 2020.
[C] Requirement is to continue this report annually until the expiration of the pilot program in 2024.
[D] VA is required to certify, by October 1, 2019, that VA has implemented this IT system, and such certification is the triggering action for the first phase of expansion of the program to pre-9/11 Veterans. While the October 1, 2018 deadline is for implementation of the IT system, the certification is required no later than October 1, 2019. Additionally, the language in section 161(a)(1)(A) of the bill and codified at 38 U.S.C. 1720G(a)(2)(B)(ii) focuses on when VA submits a "certification" that it has "fully" implemented the IT system; VA has some discretion as to when to submit the certification and thus when the expansion to pre-9/11 Veterans begins.
[E] Requirement is to submit this report 180 days after the last site is active in the pilot program, which must occur by May 31, 2020.
[F] Requirement is three years after establishing access standards, which will likely occur one year after enactment and concurrent with publication of regulations for the Veterans Community Care program under 38 USC 1703, as amended by section 101.

Summary of Other Requirements:

The following descriptions are intended as general summaries and are not exhaustive. Information presented in one of the preceding tables is generally omitted.

Title I: Caring for Our Veterans Act of 2018

- Sec. 101: Amends 38 U.S.C. § 1703 to create a new community care program. Covered Veterans may only receive care or services under this section upon VA's authorization. VA would have to furnish care through community providers using five eligibility criteria: (1) VA does not offer the care or service required; (2) VA does not operate a full-service medical facility in the State in which the Veteran resides; (3) the Veteran meets certain conditions related to eligibility under the "40 mile" criterion in the Veterans Choice Act; (4) VA is not able to furnish care or services in a manner that complies with designated access standards developed by the Secretary; or (5) the Veteran and the Veteran's referring clinician agree that furnishing care and services through a community entity or provider is in the best medical interest of the Veteran based upon criteria developed by VA. Covered Veterans could receive care if VA determined a medical services line was not meeting VA's standards for quality, with certain limitations. In implementing the new community care program, VA is generally responsible for:
    - coordinating the furnishing of care and services, including at a minimum scheduling appointments in a timely manner;
    - establishing a mechanism to receive medical records from community providers;
    - ensuring continuity of care and services;
    - ensuring coordination among regional networks;
    - ensuring that Veterans do not experience a lapse in care resulting from errors or delays by VA or its contractors;
    - establishing criteria to determine when it is in a Veteran's best medical interest to receive community care;
    - making determinations regarding eligibility for community care;
    - designating certain access standards as eligibility criteria for community care;
    - entering into consolidated, competitively bid contracts to establish networks of community providers to furnish care and services;
    - ensuring, to the extent practicable, that Veterans could make their own appointments using advanced technology, while also, to the extent practicable, being responsible for scheduling appointments;
    - reporting to Congress whenever VA submits a cure notice to a contractor;
    - instructing each contractor to recognize and accept, on an interim basis, the credentials and qualifications of providers currently authorized to provide community care;
    - establishing a system or systems for monitoring the quality of care furnished through network providers;
    - paying no more than the rate the United States pays under the Medicare program, with certain exceptions;
    - seeking to recover or collect reasonable charges from a Veteran's health care plan in accordance with § 1729 of title 38; and

    - continuing all contracts, memorandums of understanding (MOU), and memorandums of agreement (MOA) that were previously in effect between VA and the American Indian and Alaska Native health care systems established under a 2010 MOU and other agreements with Native Hawaiian Health Care Systems.
- Sec. 102: Creates a new § 1703A authorizing VA to enter into Veterans Care Agreements (VCA). VCA's generally are not subject to Federal contracting laws. VA can furnish care through VCAs when such care and services are not feasibly available through a contract or sharing agreement based on a Veteran's medical condition, the travel involved, the nature of the care or services required, or a combination of these factors. At least every 2 years, VA must review VCAs of material size.
- Sec. 103: Amends § 1745 to exempt from competitive procurement procedures agreements with State Veterans Homes.
- Sec. 104: Creates a new § 1703B and § 1703C regarding access standards and standards for quality, respectively.
    - For § 1703B (access standards), VA must:
        - ensure access standards cover all care and services within the medical benefits package;
        - consult with pertinent Federal and non-Federal entities in establishing the access standards;
        - ensure community care providers are able to comply with applicable access standards;
        - publish in the Federal Register and on VA's website the designated access standards for purposes of community care eligibility; and
        - establish a process for receiving requests from Veterans for determinations regarding whether care can be furnished within designated access standards.
    - For § 1703C (standards for quality), VA must:
        - establish standards for quality after considering existing quality measures applied to public and private health care systems;
        - collect and consider data for purposes of establishing standards for quality; and
        - consult with pertinent Federal and non-Federal entities in establishing the access standards;
- Sec. 105: Creates a new § 1725A requiring VA to develop procedures to ensure eligible Veterans are able to access walk-in care from certain community providers. To qualify, Veterans must be enrolled in VA health care and have received care within the 24-month period preceding the furnishing of walk-in care. VA must enter into a contract or other agreement with an entity or provider to furnish walk-in care. VA must ensure continuity of care, including by establishing a mechanism to provide to and receive from community providers relevant medical records. VA may require certain Veterans to pay a copayment and must require a higher copayment from these Veterans if they use this service more than twice in a calendar year. VA could adjust the copayment amounts after the first two visits based upon several factors. VA also could charge a

higher copayment rate than the copayment that would be applicable if the Veteran received the care directly from VA. VA must define what walk-in care means through regulations.

- Sec. 106: Creates a new § 7330C regarding a Quadrennial Veterans Health Administration (VHA) review. VA must conduct market area assessments at least once every 4 years. The assessments must determine demand for VA health care in different areas, VA's internal capacity, an assessment of VA's community provider network, and other factors. VA must submit these assessments to Congress and use these assessments in determining the capacity of VA's community care network, in forming the budget, and in determining the appropriateness of the access standards and standards for quality under §§ 1703B and 1703C. VA must submit information reflecting the most recent market area assessments as part of its budget submission each year. The Secretary is responsible for overseeing the transformation and organizational change across VA to achieve a high performing integrated health care network, developing the capital infrastructure planning and procurement processes, and developing a multi-year budget process capable of forecasting future year budget requirements.
- Sec. 107: Applies the Office of Federal Contract Compliance Programs (OFCCP) TRICARE moratorium to VA's authority to enter into agreements under § 1703A and § 1745, as amended by sections 102 and 103 of this Act, effective until May 7, 2019.
- Sec. 108: VA must suspend the eligibility of a provider to furnish community care if the provider is suspended from serving as a VA health care provider. The Comptroller General must submit a report to Congress on VA's implementation of this authority within 2 years of enactment.
- Sec. 109: Creates a new § 1706A concerning remediation of medical service lines. VA must, within 30 days of determining that a medical service line is not complying with VA's standards for quality under § 1703(e), submit to Congress an assessment of underperforming medical service lines and to develop a plan for remediation of such service lines. VA could take various actions, such as increasing personnel or temporary personnel assistance, use of special hiring incentives, using direct hiring authority, providing improved training opportunities, acquiring improved equipment, making structural modifications, and other actions considered appropriate. VA must identify the individuals in Central Office, the facility, and the Veterans Integrated Service Network (VISN) who are responsible for overseeing the progress of the medical service line. VA must report within 180 days and annually on remediation efforts taken under this section and progress made.
- Sec. 111: Creates a new § 1703D regarding prompt payment standards. In general, VA must pay entities or providers within 30 days of receipt of a clean electronic claim or 45 days for a clean paper claim. Providers must submit claims within 180 days for payment. If a claim is denied, VA must notify the provider within 30 days for an electronic claim and 45 days for a paper claim and identify the deficiencies. Overdue claims are subject to interest payments. VA must provide to all entities and providers a list of information and documentation

required for a clean claim and must consult with public and private sector industries in developing this list. VA may process claims through a third-party and must seek to enter into a contract to review the feasibility and advisability of using a non-Department entity to process claims for community care under § 1703.

- Sec. 112: Creates a new § 8159 authorizing VA to compensate a provider who furnishes authorized care when VA does not have a contract, agreement, or other arrangement with that provider. VA must take reasonable efforts to enter into a contract, agreement, or other arrangement with such a provider for purposes of future care and services.
- Sec. 113: Amends § 1729 to improve VA's authority to recover the cost of services furnished for non-service-connected disabilities. The provision authorizes VA to collect for care furnished to non-Veterans by referring to "individuals" instead of "veterans". The provision further clarifies that VA may seek collections in the event that VA pays for care, rather than just furnishes it. Finally, this provision authorizes VA to recover for the cost of care for a non-service connected disability that is incurred by an individual who is entitled to care, or payment for the expenses of care, under a health-plan contract.
- Sec. 114: Authorizes VA to enter into an agreement with a third-party to process, through an electronic interface, claims for reimbursement for health care furnished for VA.
- Sec. 121: Requires VA to develop and administer an education program that teaches Veterans about their health care options through VA. This education program must include information in a format accessible to Veterans without access to the Internet.
- Sec. 122: Requires VA to develop and implement a training program for employees and contractors on how to administer non-Department health care programs. The training program must include education about reimbursement for non-Department emergency room care, the community care program under § 1703, and management of opioid prescriptions under section 131.
- Sec. 123: Requires VA to establish a program to provide no cost continuing medical education material to non-Department medical professionals that includes education on identifying and treating common mental and physical conditions of Veterans and their families, the VA health care system, and other matters as appropriate. This material must be the same material furnished to VA providers. VA must administer this program through the Internet, with the Secretary determining the curriculum of the program and the number of hours of credit to provide to participating medical professionals. VA must ensure that the program is accredited in as many States as practicable and must ensure the program is consistent with the rules and regulations of the medical licensing agency of each State in which the program is accredited and such medical credentialing organizations as the Secretary considers appropriate.
- Sec. 131: Requires VA to ensure that all community providers are furnished a copy of and certify that they have reviewed the evidence-based guidelines for prescribing opioids set forth by VA's Opioid Safety Initiative. Requires VA to implement a process to ensure that VA submits to community providers the

available and relevant medical history of the Veteran and a list of all medications prescribed to the Veteran as known by the Department. Community providers must submit medical records, including records of any opioid prescriptions to VA in the timeframe and format specified by VA. If VA determines that the opioid prescribing practices of a community provider, when treating covered Veterans, meet certain conditions, VA must take appropriate action to ensure the safety of all Veterans receiving care from the provider. VA must ensure any network contracts include language authorizing the contractors to take similarly appropriate action.

- Sec. 132: Amends § 7332 to allow VA to share patient information that would otherwise be protected for the purpose of providing health care to patients or performing other health care-related activities or functions; it also allows for disclosing this information for purposes of recovering or collecting reasonable charges for care furnished to, or paid on behalf of, a patient in connection with a non-service connected disability under § 1729.
- Sec. 133: Requires VA to establish standards and requirements for the provision of care by community providers in clinical areas in which VA has special expertise, including posttraumatic stress disorder (PTSD), military sexual trauma (MST)-related conditions, and traumatic brain injuries (TBI). Each community provider is required, to the extent practicable, to meet the standards and requirements established under this section before furnishing care through a contract, agreement or other arrangement. Community providers are required, to the extent practicable, to fulfill training requirements established by VA within defined timeframes on how to deliver evidence-based treatments in the clinical areas in which VA has special expertise.
- Sec. 134: Creates a new § 1730B regarding access to State prescription drug monitoring programs. Requires VA licensed health care providers or their delegates to query the national network of State-based prescription drug monitoring programs; it provides that any VA licensed health care provider or delegate is considered an authorized recipient or user, and that no State law, rule, or regulation restricting access would apply to such providers or delegates. States may not deny or revoke the license of a VA licensed health care provider or delegate who otherwise meets the requirements for holding a license, registration, or certification, solely based on the provider or delegate's querying, or attempting to query, such a database.
- Sec. 141: Requires VA to submit a justification for any supplemental appropriation request it submits to Congress, including a plan for how VA intends to use the requested appropriation, how long the requested appropriation is expected to meet the needs of VA, and certification that the request was made using an updated and sound actuarial analysis. Such request must be submitted 45 days prior to a program or service being affected by the budgetary issue.
- Sec. 142: Amends section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 38 U.S.C. § 1701 note) to allow for use, beginning on March 1, 2019, of amounts in the Veterans Choice Fund to furnish community care under other authorities.

- Sec. 143: Establishes a firm sunset date for the Veterans Choice Program on the date that is 1 year after the date of the enactment of this Act.
- Sec. 144: Makes conforming amendments to various provisions of law to reflect the new community care program.
- Sec. 151: Creates a new § 1730C that authorizes VA health care providers to practice, regardless of their location in any State, their health care profession through the practice of telemedicine. This authority extends to situations where the provider is not located on Federal property. States are prohibited from taking licensure action against a VA employee to the extent the employee's conduct was authorized by this provision.
- Sec. 152: Creates a new § 1703E in title 38 establishing a Center for Innovation for Care and Payment. The Center is authorized to carry out such pilot programs as appropriate to develop new, innovative approaches to testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished by VA. VA is required to test payment and service delivery models to determine whether such models improve the access to and quality, timeliness, and patient satisfaction of such care and services, as well create cost savings. Pilot programs can last no longer than five years. VA must publish information about such pilot programs in the Federal Register and take reasonable actions to provide direct notice to Veterans eligible to participate in a pilot program, to ensure Veterans have information about such pilot programs.
    - The models tested under this program cannot be designed in such a way as to allow the United States to recover or collect reasonable charges from a Federal health care program (including Medicare, Medicaid, and TRICARE) for care or services furnished by VA to Veterans. VA also cannot conduct more than 10 pilot programs concurrently, and may not expend more than $50 million in any fiscal year, with limited exceptions.
    - In implementing the pilot programs under this section, the Secretary may waive such requirements in subchapters I, II, and III of chapter 17 of title 38, United States Code, as may be necessary solely for the purpose of carrying out this section with respect to testing models under this program. Before the Secretary can waive any of these authorities, the Secretary must submit a report to Congress explaining the authorities to be waived and the reasons for such waivers, along with other information. If Congress enacts a joint resolution approving the requested waiver in its entirety, the Secretary would be allowed to act upon that waiver.
    - If the Secretary determines that a pilot program is not improving the quality of care or producing cost savings, VA must propose a modification to the pilot program or terminate the program within 30 days of submitting an interim report to Congress. VA must conduct an evaluation of each model tested, including an analysis of the quality of care furnished and the changes in spending by reason of that model. VA must make each evaluation available to the public in a timely fashion.
    - VA is required to obtain advice from the Special Medical Advisory Group in the development and implementation of any pilot program operated

under this section. VA also must consult with Federal agencies and clinical and analytical experts in medicine and health care management.
    - VA may expand, through rulemaking, the duration and scope of successful pilot programs to the extent the Secretary determines that such expansion is expected to reduce spending without reducing the quality of care or improve the quality of care without increasing spending; the Secretary also must determine that such expansion would not deny or limit the coverage or provision of benefits for applicable individuals.
- Sec. 153: Creates a new § 1788 authorizing VA to provide for an operation on a live donor to carry out a transplant procedure for an eligible Veteran, notwithstanding that the live donor may not be eligible for VA health care. VA is required to provide to a live donor any care or services before and after conducting the transplant procedure that may be required in connection with the transplant. VA is authorized to provide the operation and services at non-Department facilities pursuant to agreements entered into under chapter 17, title 38.
- Sec. 161: Expands eligibility for VA's Program of Comprehensive Assistance for Family Caregivers under § 1720G(a), expands benefits available to participants under such program, and makes other changes affecting program eligibility and VA's evaluation of applications.
    - Expands the population of eligible Veterans, upon the certification by the Secretary that VA has fully implemented the IT system required by section 162, to those who have a serious injury incurred or aggravated in the line of duty on or before May 7, 1975. Two (2) years after the date of the certification, eligibility is expanded to include all Veterans who have a serious injury incurred or aggravated in the line of duty, regardless of when such injury occurred Within 30 days of submitting the certification to Congress, VA is required to publish the certification and expansion date in the Federal Register.
    - Expands the eligibility criteria to include an additional basis upon which an eligible Veteran can be deemed in need of personal care services to include those who have 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.
    - Expands the benefits available to primary family caregivers to include financial planning services and legal services; such services must be provided through contracts with or grants to public or private entities.
    - States that in calculating stipend payments for Veterans who qualify based on a need for supervision or protection or regular instruction or supervision, VA must take into account the assessment of the family caregiver of the needs and limitations of the Veteran, the extent to which the Veteran can function safely and independently, and the amount of time required for the family caregiver to provide such supervision, protection, or instruction to the Veteran.

- Requires VA to evaluate periodically the needs of eligible Veterans and the skills of family caregivers to determine if additional instruction, preparation, training, or technical support is needed.
- Requires that joint applications be evaluated in collaboration with the eligible Veteran's primary care team to the maximum extent practicable.
- Authorizes the provision of assistance through contracts, provider agreements, and memoranda of understanding with Federal agencies, States, and private entities, but only if such assistance is reasonably accessible to the family caregiver and is substantially equivalent or better in quality to similar services provided by VA. VA could provide fair compensation to such entities for assistance under this provision.
- Modifies the definition of "personal care services" to generally reference the three bases upon which an eligible Veteran can be deemed in need of personal care services under § 1720G(a)(2)(C)(i)-(iii) in addition to "[a]ny other non-institutional extended care (as such term is used in section 1701(6)(E))".

- Sec. 162: Requires that, by October 1, 2018, VA implement an IT system that fully supports the Program of Comprehensive Assistance for Family Caregivers (PCAFC) and allows for data assessment and comprehensive monitoring of the program. The IT system must include certain specified capabilities, including managing data for a number of caregivers beyond the expected number of applicants. VA must use the system to monitor and assess the workload of the program, and based upon such efforts, identify and implement such modifications as necessary to ensure the program is functioning as intended and providing timely services to Veteran and caregiver participants. The Comptroller General must review VA's initial report (due within 90 days after the date of the enactment of this Act) and notify Congress with respect to VA's progress in fully implementing the required IT system and implementing a process for using such system to monitor, assess, and modify (as necessary) PCAFC. VA must submit to Congress by October 1, 2019, a final report that certifies the IT system for PCAFC has been implemented; it also must include a description of how VA has implemented the IT system, any modifications to PCAFC that were identified and implemented, and how VA is using the IT system to monitor PCAFC workload.
- Sec. 163: Makes amendments to the requirement for an existing annual report on the Caregiver Support Program by requiring VA to identify any barriers to accessing and receiving care and services and by evaluating the sufficiency and consistency of training provided to family caregivers under PCAFC.

Title II: VA Asset and Infrastructure Review

- Sec. 201: Titles this subtitle the "VA Asset and Infrastructure Review Act of 2018".
- Sec. 202: Establishes an independent nine member Asset and Infrastructure Review Commission (the "AIR Commission") consisting of Commissioners nominated by the President and confirmed by the Senate. In making nominations, the President must consult with the Speaker of the House of Representatives, the minority leader of the House of Representatives, and the

majority and minority leaders of the Senate. Additionally, the President must consult with Congressionally-chartered, membership-based Veterans Service Organizations (VSO) specifically concerning the appointment of three (3) members. Certain nominees must meet certain conditions to be appointed. The AIR Commission may meet only during calendar years 2022 and 2023. Each meeting of the AIR Commission must be open to the public, and all proceedings, information, and deliberations of the AIR Commission must be available for review by the public. Commissioners will serve without pay, and each member of the AIR Commission who is an officer/employee of the United States may only receive compensation for their services as an officer/employee of the United States. However, AIR Commissioners may receive travel expenses, including per diem. Section 202 includes provisions concerning staffing and personnel matters as well. The AIR Commission terminates on December 31, 2023.

- Sec. 203: Requires VA to develop criteria and solicit public feedback on such criteria regarding the closure, modernization, or realignment of VHA facilities. Section 203 details the procedural and substantive requirements of such criteria.
    - VA must conduct Capacity and Commercial Market Assessments in consultation with VSOs and Veterans. VA must submit the assessments to Congress and make such assessments publicly available. In addition to providing recommendations for each VHA facility concerning modernization or realignment, VA must include a summary of the selection process and a justification for each recommendation and submit such summary and justification to Congress within 7 days of transmitting the report detailing VA's recommendations regarding the modernization or realignment of VHA facilities.
    - VA must consider all facilities equally, and all information used by VA to prepare a recommendation must be made available to Congress, the AIR Commission and the Comptroller General.
    - Each VA Under Secretary, VISN director, medical center director, program office director, and each person who is in a position the duties of which include personal and substantial involvement in the preparation and submission of information and recommendations concerning the modernization or realignment of VHA facilities, must certify that information submitted to VA or to the AIR Commission concerning the modernization or realignment of VHA facilities is accurate and complete to the best of that person's knowledge and belief.
    - The AIR Commission must conduct public hearings on the Secretary's recommendations regarding the modernization or realignment of VHA facilities, to include required public hearings in regions affected by a VA recommendation for the closure of a facility and, to the greatest extent practicable, public hearings in regions affected by a recommendation for another (non-closure) action by VA. Each AIR Commission public hearing must include, at a minimum, a local Veteran who is enrolled in the VA health care system and is identified by a local VSO as well as a local elected official.

- The AIR Commission must transmit to the President a report containing a review and analysis of the recommendations made by VA, together with the AIR Commission's recommendations for the modernization and realignment of VHA facilities. The AIR Commission may change any recommendation made by VA if certain conditions are met. The AIR Commission must explain and justify any recommendation made by the AIR Commission that differ from VA's recommendations. The President is required to transmit to the AIR Commission and to Congress a report containing the President's approval or disapproval of the AIR Commission's recommendations.

- Sec. 204: Requires VA to begin to implement the recommended modernizations and realignments as stated within the AIR Commission's report that was transmitted to Congress by the President no later than 3 years after the date on which the President transmitted such report. Prohibits VA from carrying out any action recommended by the AIR Commission in the report transmitted to Congress by the President if a joint resolution is enacted in accordance with section 207 before the earlier of the end of the 45 day period beginning on the date in which the President transmits such report or the adjournment of Congress sine die for the session during which the report is transmitted.
- Sec. 205: Authorizes VA in modernizing or realigning any VHA facility to: (a) take such action as may be necessary to modernize or realign any VHA facility; (b) carry out such activities for the purposes of environmental abatement, restoration, or mitigation at any VHA facilities and use funds in the Account for such purposes; (c) reimburse other Federal agencies for actions performed at VA's request with respect to such closure or realignment and use for such purposes funds in the Account established by section 206 of the Act or otherwise appropriated to VA and available; and (d) exercise VA's authority under subchapter V of chapter 81 of title 38, United States Code, concerning enhanced use leases. It also requires VA, to the extent responsible, to carry out environmental abatement, mitigation, or restoration and comply with historical preservation requirements with regard to any property made excess to VA's needs as a result of modernization or realignment.
    - Authorizes VA to utilize any existing transfer or disposal authority under chapter 81 of title 38 U.S.C. as well as any authority delegated by the Administrator of GSA. Before taking any action with respect to disposal of any surplus real property or infrastructure to be closed or realigned under this Title, VA must consult with the Governor of the applicable State and the heads of local governments in which the disposal action is to occur for the purposes of considering any plan for the use of such property by the local community. VA could utilize its authority in § 8108 in regard to closures or realignment of VHA facilities that include roadways used for public access through, into, or around the VHA facility and would require similar consultation for such activities.
    - This section also authorizes VA to transfer the title to a VHA facility approved for closure or realignment, including property at a facility that will be retained by VA or another Federal agency, to a redevelopment

authority who agrees to lease, directly upon transfer and without requiring rental payments, one or more portions of the transferred property to VA or the head of another Federal department or agency for a term not to exceed 50 years (but which may provide options for renewal or extension). Additionally, the lease would have to include a provision specifying that, if the concerned entity ceases requiring the use of the leased property before the expiration of the lease, the remainder of the lease term may be satisfied by the same or a different Federal department or agency for a similar use in consultation with the redevelopment authority. Further, if the lease to the Federal department or agency involves a substantial portion of the facility, the Federal department or agency is authorized to obtain facility services for the leased property and common area maintenance from the redevelopment authority or assignee at a rate no higher than the rate charged to a non-Federal tenant and to exclude those services that the State or local government is required by law to provide without direct charge as well as firefighting and security guard services.

- The Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA) applies to any real property transfer and authorizes any additional terms and conditions as VA considers appropriate to protect the interests of the United States. Further, nothing in this title limits or otherwise affects the application of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11301 et. seq.) to VHA facilities closed under this section. The National Environmental Policy Act of 1969 (NEPA) does not apply to the actions of the President, the AIR Commission, or VA in carrying out this title with the exception of actions taken by VA during the process of property disposal and during the relocation process. However, in applying NEPA, VA will not need to consider the need for closing or realigning a facility as recommended by the AIR Commission, the need for transferring functions to the receiving facility, or for any VHA facility alternative to those recommended or selected.
- VA is authorized to close or realign VHA facilities under this title without regard to any provision of law restricting the use of funds for such actions included in any appropriations or authorization Act. Further, VA may close or realign VHA facilities without regard to § 8110. VA may enter into an agreement to transfer by deed a VHA facility with any person who agrees to perform all environmental restoration, waste management, and environmental compliance activities that are required under Federal and State laws, administrative decisions, agreements, and concurrences and to require additional terms and agreements as appropriate to protect the interests of the United States. Such transfer may be made only if VA certifies to Congress that all costs otherwise paid by VA with respect to that facility were equal to or greater than the fair market value of the property of facility to be transferred or, if such costs are lower, the recipient of such transfer agrees to pay the difference and authorizes VA to pay the recipient an amount equal to the lesser of the two such

amounts. It also requires VA to disclose information regarding environmental restoration, waste management, and environmental compliance activities before entering into a deed transfer.

- Sec. 206: Establishes an Asset and Infrastructure Review Account (the "Account") to be administered by VA. This section credits the following to the Account: (a) funds authorized and appropriated to the Account, and (b) proceeds received from the lease, transfer, or disposal of any property at a VHA facility closed or realigned under this title. It authorizes VA to use the Account to: (a) carry out the VA Asset and Infrastructure Review (AIR) Act; (b) cover property management and disposal costs incurred at VHA facilities; (c) cover costs associated with the supervision, inspection, overhead, engineering, and design of construction projects undertaken under the AIR Act and subsequent claims related to such activities; and (d) fulfill other purposes VA determines support its mission and operations. VA must establish and include in the budget submission a consolidated budget justification display in support of the Account for each fiscal year that details the amount and nature of credits to and expenditures from the Account during the preceding fiscal year, separately detailing the environmental remediation costs associated with the VHA facility for which a budget request is made, specifies the transfers into the Account and the purposes for which those transferred funds would be further obligated (to include caretaker and environmental remediation costs), and details any intra-budget activity transfers with the Account that exceeded $1 million. The Account must be closed at the time and in the manner provided under section 1555 of title 31, U.S.C., and unobligated funds are to be held by the Treasury until transferred to VA. Finally, VA must transmit to Congress a report, within 60 days of closing the Account, containing an accounting of all the funds credited to and expended from the Account or otherwise expended and any funds remaining in the Account.
- Sec. 207: Defines the terms and conditions Congress must follow in considering recommendations of the Commission.
- Sec. 208: Requires VA to publish any information transmitted or received by VA, the AIR Commission, or the President regarding the AIR Act online within 24 hours. It also prohibits VA from stopping VHA construction and leasing activities, any long-term planning regarding VHA infrastructure and assets, or VHA budgetary processes as a result of the AIR Act. Finally, it authorizes VA, after consulting with VSOs, to include a recommendation for a future AIR Commission or other capital asset realignment and management process in a budget submission.
- Sec. 209: Defines various terms for purposes of the AIR Act.
- Sec. 211: Amends subsection (g) of § 8103 to require VA to implement a training and certification program for construction and facilities management personnel no later than September 30 of the fiscal year following the fiscal year of the enactment of the AIR Act. This language also amends and strengthens the existing requirement of § 8123(g). The Secretary would have to use as a model for the training and certification program the existing Defense Acquisition Workforce Improvement Act program. The certification may consist of one or multiple levels. The training may be provided in person, over the internet, by

another Federal agency, or a combination of the foregoing. The language also expands the existing statute to apply to all VA employees who are members of occupational series relating to construction or facilities management or VA employees who award or administer contracts for major construction, minor construction, or non-recurring maintenance (including contract specialists or contracting officers' representatives) and add that such training must be taken to complete a formal certification program. It also defines two terms for purposes of this section.

- Sec. 212: Amends § 8162(b)(6) to require the Office of Management and Budget to review each enhanced use lease prior to its execution to ensure compliance with 38 U.S.C. § 8162(b)(5), which prohibits such a lease from providing 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.
- Sec. 213: Requires VA, within 180 days of the date of the enactment of this Act, to submit a report to Congress on health care furnished by VA to Veterans who live in the Pacific territories.

Title III: Improvements to Recruitment of Health Care Professionals

- Sec. 301: Amends § 7612(b) to require the Secretary to award for a period of time no fewer than 50 scholarships each year to individuals who are accepted for enrollment or enrolled in a program of education or training leading to employment as a physician or dentist. After the period of time has elapsed, the Secretary could award no fewer than the number of scholarships equal to 10 percent of the staffing shortage of physicians and dentists in VA. Scholarship recipients must agree to perform a period of obligated service to VA. VA could provide preference to individuals who are Veterans and would have to provide information annually to appropriate educational institutions about this scholarship program. Individuals who fail to successfully complete post-graduate training leading to eligibility for board certification in a specialty will be considered in breach of the agreement and subject to the conditions imposed in § 7617. This provision also extends VA's Health Professionals Scholarship Program until December 31, 2033.
- Sec. 302: Increases the amount of assistance VA can provide through the Education Debt Reduction Program (EDRP) overall to $200,000 and annually to $40,000.
- Sec. 303: Creates a new subchapter to chapter 76 to establish a specialty education loan repayment program.
    - Section 7691 authorizes the Secretary, as part of the Educational Assistance Program, to carry out a student loan repayment program under § 5379 of title 5. The program is known as the Department of Veterans Affairs Specialty Education Loan Repayment Program, or the Specialty Education Loan Repayment Program.
    - Section 7692 states the purpose of this Program is to assist in meeting VHA's staffing needs for physicians in medical specialties for which VA has determined it faces recruitment or retention difficulties.

- Section 7693 defines who is eligible for the Program, namely individuals: (1) hired under § 7401 to work in an occupation described in § 7692; (2) who owe any amount of principal or interest under a loan used to pay costs relating to a course of education or training (defined broadly to include tuition expenses, other reasonable educational expenses, and reasonable living expenses) that led to a degree that qualified the individual for appointment under § 7401; and (3) who recently graduated from an accredited medical or osteopathic school and matched to an accredited residency program in a medical specialty described in § 7692 or who are physicians in training in a medical specialty described in § 7692 with more than 2 years remaining in such training. VA can provide preference to individuals who are Veterans in operating the Program, as well as those who are, or will be participating in certain residency programs.
- Section 7694 clarifies that payments under the Program will be for the principal and interest on loans described in § 7682(a)(2) for participating individuals. The Secretary must establish a schedule for making payments and cannot make more than $160,000 in payments over a total of 4 years or more than $40,000 per year of participation in the program. VA may, however, waive these limitations in the case of a participant who VA 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.
- Section 7695 allows participants to select, from a list of facilities developed by VA, where the participant will work.
- Section 7696 imposes a service obligation of at least two years (and 12 months for every $40,000 in benefits received) and other requirements for employment. Participants who receive an accredited fellowship in a designated medical specialty may have their service obligation delayed until the completion of the fellowship, but the participant must begin work within 60 days of completing the fellowship. Participants who fail to complete their service obligation will be subject to a repayment penalty.
- Section 7697 allows for assistance under the Program to be provided in addition to other assistance available to individuals under the Educational Assistance Program.
- Section 303(b) of the Act makes various conforming amendments to reflect this new Program.
- Section 303(c) of the Act requires VA, in making determinations about medical specialties under proposed § 7692, to consider the anticipated needs of VA during the period two to six years in the future.
- Section 303(d) of the Act requires VA, in granting preference under § 7693, to determine whether a facility is underserved based on the criteria developed under section 401 of this Act.
- Section 303(e) of the Act requires VA, in the case of a participant who applied for the Program before receiving a residency match, to offer

participation not later than 28 days after the applicant matches with a residency in a designated medical specialty and such match is published.
    - Section 303(f) of the Act requires VA to take such steps as appropriate to publicize this Program.
- Sec. 304: Section 304 requires the Office of Academic Affiliations to carry out a pilot program under which VA provides funding for the medical education of 18 eligible Veterans. Funding will be provided for two Veterans enrolled in each covered medical school.
    - To be an eligible Veteran, a person must have been discharged from the Armed Forces within the prior 10 years, not be entitled to educational assistance under chapters 30-35 of title 38 or chapters 1606 or 1607 of title 10, apply for admission to a covered medical school for the entering class of 2019, indicate on the application for admission the Veteran would like to be considered for an award under this section, meet the minimum admissions criteria for the covered medical school, and enter into an agreement described in subsection (e) (which we believe should be subsection (d)).
    - Section 304(c) provides that each covered medical school that opts to participate in the program required by this section must reserve two seats in the entering class of 2019 for eligible Veterans; funding will be provided for the two eligible Veterans with the highest admissions rankings for such class at such school. Eligible Veterans will receive an amount under this program equal to the actual cost of tuition at the covered medical school for four years; books, fees, and technical equipment; fees associated with the National Residency Match Program; two away rotations performed during the fourth year at a VA medical facility; and a monthly stipend, in an amount determined by VA, for the four-year period during which the Veteran is enrolled in medical school.
    - Section 304(d) requires each eligible Veteran who accepts funding for medical education to enter into an agreement with VA to maintain enrollment and attendance in the medical school, to maintain an acceptable level of academic standing (as determined by the medical school under regulations prescribed by VA), to complete post-graduate training leading to eligibility for board certification in a specialty applicable to VA, to obtain a license to practice medicine in a State, and to serve as a full-time clinical practice employee in VA for a period of four years. In the event of a breach of the agreement, the United States is entitled to recover damages in an amount equal to the total amount of such funding received by the Veteran.
    - Section 304(e) provides that nothing in this section may be construed to prevent any covered medical school from accepting more than two eligible Veterans for the entering class of 2019.
    - Section 304(f) requires VA, by December 31, 2020, and annually thereafter for the next three years, to submit to Congress a report on the program operated under this section.

    - Section 304(g) provides a list of nine covered medical schools, namely: Texas A&M College of Medicine; Quillen College of Medicine at East Tennessee State University; Boonshoft School of Medicine at Wright State University; Joan C. Edwards School of Medicine at Marshall University; University of South Carolina School of Medicine; Charles R. Drew University of Medicine and Science; Howard University College of Medicine; Meharry Medical College; and Morehouse School of Medicine.
- Sec. 305: Amends section 705(a) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 38 U.S.C. § 703 note) to raise the limitations on bonuses for recruitment, relocation, and retention from $230 million for fiscal year (FY) 2017 and FY 2018 to $250 million, and from $225 million to $290 million for FY 2019 through FY 2021. For each period, not less than $20 million shall be for recruitment, relocation, and retention bonuses.
- Sec. 306: Requires VA ensure that clinical staff working at Vet Centers are eligible to participate in VA's EDRP.

Title IV: Health Care in Underserved Areas

- Sec. 401: Requires VA to develop criteria to designate medical centers, ambulatory care facilities, and community-based outpatient clinics (CBOC) as underserved facilities. In developing these criteria, VA must consider various factors, including the ratio of Veterans to VA health care providers in an area, the range of clinical specialties offered, whether the local community is medically underserved, data on open consults, whether the facility is meeting the wait-time goals of the Department, and such other factors that the Secretary considers important in determining which facilities are not adequately serving area Veterans.
- Sec. 402: Requires VA to establish a three-year pilot program to furnish mobile deployment teams of medical personnel to underserved facilities.
- Sec. 403: Requires VA to establish a pilot program to establish graduate medical residency positions authorized under section 301(b)(2) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 38 U.S.C. 7302 note) at covered facilities. VA may enter into agreements with entities that operate covered facilities in which the Secretary places residents. VA is authorized to pay stipends and benefits for residents appointed under this authority, regardless of whether they have been assigned in a VA facility. VA must consider the extent to which there is a clinical need for providers at different locations based upon four identified criteria and must consider various factors in determining which specialties would be included. VA must place no fewer than 100 residents in covered facilities operated by the Indian Health Service, operated by an Indian tribe, operated by a tribal organization, or located in underserved communities as designated by the Secretary under section 401 of this Act. VA must reimburse covered facilities the costs of curriculum development, recruitment and retention of faculty, accreditation of the program by the Accreditation Council for Graduate Medical Education, the portion of faculty salaries attributable to duties under the agreement with VA, and expenses relating to educating a resident under the pilot program.

Title V: Other Matters

- Sec. 501: Creates a new § 726 requiring VA to report to Congress, within 100 days of the end of a fiscal year, on the performance awards and bonuses awarded to Regional Office Directors, VAMC Directors, VISN Directors, and senior executives of the Department.
- Sec. 502: Creates a new § 7413 making VHA podiatrists eligible for any supervisory position to the same degree that a physician would be. It also requires VA to establish standards to ensure that specialists appointed to supervisory positions in VHA do not provide direct clinical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties and amends pay schedule in § 7404(b) to podiatric surgeons with physicians. VA must treat podiatrists in a similar fashion to VA physicians for the purposes of pay, recruitment, and retention.
- Sec. 503: Amends § 8104(a)(3) to increase the dollar threshold for a "major medical facility project" from $10 million to $20 million and exclude from that term acquisitions for exchange, non-recurring maintenance projects, or shared medical facilities with other Federal agencies, where the Department's share of the project costs does not exceed $20 million. The definition of "medical facility" in section 8101(3) is expanded to include any facility or part thereof which is, or will be, under the jurisdiction of the Secretary, or as otherwise authorized by law, for the provision of health-care services.
- Sec. 504: Authorizes VA to carry out a major medical facility construction project to construct a new East Bay CBOC and associated site work, utilities, parking, and landscaping; construction of a Central Valley Engineering and Logistics support facility; and enhanced flood plain mitigation at the Central Valley and East Bay CBOCs as part of the realignment of medical facilities in Livermore, California, in an amount not to exceed $117,300,000, and authorizes such amount to be appropriated in FY 2018, or the year that funds are appropriated for VA's major construction account.
- Sec. 505: Requires VA within 90 days of enactment and quarterly thereafter to make publicly available online for each VA component and medical facility various data on personnel and staffing. VA may withhold from publication information relating to law enforcement, information security, or other positions the Secretary determines to be sensitive. Any positions filled by a contractor may not be counted as being Department positions for purposes of this section. On a semi-annual basis, the Inspector General must review administration of VA's website required under this provision and make recommendations relating to improving its administration of this website.
- Sec. 506: Requires VA to carry out a program to establish not fewer than two peer specialists in PACTs at 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. At least five of the medical centers at which the program is initiated must be medical centers designated by the Secretary as polytrauma centers, and at least 10 medical centers would have to be medical centers not designated as polytrauma centers. In selecting locations, VA must

consider the feasibility and advisability of selecting medical centers in rural and underserved areas, areas that are not close to an active duty military installation, and areas representing different geographic locations. VA must ensure that the needs of female Veterans are specifically considered and addressed and that female peer specialists are made available to female Veterans who are treated at each location. VA must consider ways in which peer specialists could conduct outreach to community providers to engage these providers and the Veterans they serve.

- Sec. 507: Requires VA to carry out a two-year pilot program under which VA will increase the use of medical scribes at VAMCs. The pilot program must be carried out at 10 VAMCs, with at least four located in rural areas, at least four in urban areas, and two located in areas with need for increased access or efficiency. Under the pilot program, VA must hire 20 new medical scribes and seek to enter into contracts with appropriate entities for the employment of 20 additional medical scribes. Four scribes must be assigned to each of the 10 medical centers. Two scribes shall be assigned to each of two physicians, 30 percent of the scribes shall be employed in the provision of emergency care, and the rest in the provision of specialty care in specialties with the longest patient wait times or lowest efficiency ratings. No additional funding is authorized to be appropriated to carry out the program.
- Sec. 508: Amends § 3729 to extend by one year, until September 30, 2028, VA's authority to continue collecting home loan fees at their current rates.
- Sec. 509: Amends § 5503(d)(7) to extend by one year until September 30, 2028, VA's authority to reduce the amount of pension furnished by VA for certain Veterans covered by Medicaid plans for services furnished by nursing facilities.
- Sec. 510: Authorizes to be appropriated to the Veterans Choice Fund $5.2 billion in mandatory funds to be available without fiscal year limitation.
- Sec. 511: Makes a technical correction to redesignate § 1712I as § 1720I.
- Sec. 512: Contains prohibitions regarding PAYGO scoring of the bill.

Background Information:

Enrolled Bill Text: https://www.congress.gov/115/bills/s2372/BILLS-115s2372enr.pdf

Statement of Administration Policy:
https://vaww.ogc.vaco.portal.va.gov/offices/HCLG/SitePages/38USC7330C.aspx

President's Remarks on Enactment:
https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-va-mission-act-2018/

White House Statement on Enactment:
https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-signs-s-2372-law/

White House Fact Sheet on Enactment:

https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-provides-resources-veterans-get-care-deserve-doctors-want/

White House Signing Statement:
https://www.whitehouse.gov/briefings-statements/statement-by-the-president-3/

Enrolled Bill Letter:

Final Enrolled Bill Letter - 052118 - Cor

House Report to H.R. 5674: https://www.congress.gov/115/crpt/hrpt671/CRPT-115hrpt671-pt1.pdf

House Report to H.R. 4242: https://www.congress.gov/115/crpt/hrpt585/CRPT-115hrpt585.pdf

Senate Report to S. 2193: https://www.congress.gov/115/crpt/srpt212/CRPT-115srpt212.pdf

Section by Section Summary from HVAC:
https://veterans.house.gov/uploadedfiles/va_mission_act_summary.pdf

Section by Section Summary from SVAC:
https://www.veterans.senate.gov/imo/media/doc/VA%20Mission%20Act%20Section%20by%20Section.pdf

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