

## 4 Rebuild VA Infrastructure

The Department of Veterans Affairs (VA) health care system provides direct medical care to more than seven million veterans every year through an integrated system of over 1,750 access points, including medical centers, outpatient clinics, Vet Centers, and community living centers. VA's health care infrastructure includes more than 5,600 buildings and 34,000 acres, much of which was built more than 50 years ago. For more than two decades, funding for construction, repairs, and maintenance of VA's health care facilities has lagged even the most conservative estimates of the actual needs. A long list of seismic deficiencies remains a significant concern that VA has failed to address. Efforts to develop long-term plans have proven ineffective as parochial politics and fiscal challenges have proven insurmountable. The inclusion of the Asset and Infrastructure Review (AIR) process in the VA MISSION Act

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provides VA, the Administration, and Congress with an opportunity to establish and implement a comprehensive plan to rebuild and realign VA's infrastructure to better meet veterans' needs for accessible health care. Its success, however, will depend on fully and faithfully implementing the AIR process that has already begun in true partnership with veterans and veterans service organizations (VSO) stakeholders.

### Amend AIR for COVID Delays & Lessons Learned

Congress structured the VA MISSION Act so that VA would establish new community care networks (CCNs) and allow them to stabilize before beginning AIR. However, the slow transition from Choice third-party administrator (TPA) provider networks to the new MISSION Act TPA provider network was only recently completed. Furthermore, VA has yet to complete the market assessments or deliver the “Strategic Plan to Meet Health Care Demand” required by the MISSION Act. Moreover, even in markets that have transitioned, the year-long novel coronavirus (COVID-19) pandemic has interfered with veterans' normal health care utilization and reliance patterns. Without accurate and reliable data on how veterans are utilizing CCNs after full implementation and what their preferences are for receiving health care, it would be premature to make decisions about the number, size, and scope of facilities VA will require in the future.

Furthermore, COVID-19 forced VA to make significant health care delivery changes to protect veterans and health care personnel. VA must evaluate the impact on health outcomes due to pandemic changes in order to ensure VA has the best model of health care in the future. While we are amid the pandemic, it is also too early to assess the significant lessons about the safest and most effective ways to deliver health care, and how health care delivery may have been irreversibly altered.

### Revise the Market Assessment Process to Fully Engage Veterans & VSO Stakeholders

Although VA had begun market assessments in preparation for building a replacement for the Choice network before the MISSION Act was passed in June 2018, the law mandated two sets of VA market assessments: one to guide the development of new CCNs and one to guide AIR. After enactment, VA chose to combine them and conduct only one set of market assessments for both purposes. Now, more than two years after the MISSION Act was signed and over three years since VA began conducting these market assessments, neither VSOs nor

# Health Care Critical Issues

veterans have been adequately consulted about their preferences for receiving health care.

## **Develop a Joint Communications Plan for AIR**

Previous attempts by VA to realign its infrastructure, including the Capital Asset Realignment for Enhanced Services initiative, conducted more than a decade ago, failed due to public and congressional opposition. While VA has begun to consult with VSOs about certain aspects of the AIR process, there has been no outreach to collaborate with them on a joint communications strategy. With our combined memberships and social media reach, VSOs can play a critical role in educating veterans about the upcoming AIR process and its overall success.

## **Fix Scoring Problem with Building Leases**

As a result of decisions by the Office of Management and Budget (OMB) and interpretations by the Congressional Budget Office (CBO), current congressional Pay-As-You-Go (PAYGO) rules require Congress to offset the full 10-year lease cost of new or extended leases during the first year; thereby, scoring it the same as new construction. As a result, Congress has been severely challenged to overcome PAYGO requirements and VA has had tremendous difficulty leasing new or extending existing leases for health care facilities.

## **Increase VA's Internal Capacity to Maintain Existing Infrastructure & Build New Facilities**

VA's ability to manage a growing portfolio of construction projects is dependent on the number and capability of its construction management staff. To manage a larger, more complex project portfolio and the impending AIR process, VA must have sufficient personnel—both within the VA Central Office and onsite throughout the VA system. Further, there is a need for more rigorous and forward-looking training and certification programs to utilize construction funding effectively and efficiently.

## **Plan for Institutional Long-Term Care (LTC) Facilities**

VA supports institutional LTC for aging and severely disabled veterans by operating 131 Community Living



Centers (CLCs), providing grants and per diem support to 157 State Veterans Homes (SVHs), as well as providing per diem support for veterans in hundreds of community nursing facilities. While VA has developed strategic plans to increase and rebalance the use of noninstitutional services and support, there continues to be a growing number of aging veterans who require institutional care. VA currently supports approximately 30,000 LTC beds in skilled nursing and domiciliary facilities within the CLCs and SVHs, a tiny fraction of the overall number that aging veterans require today and will require in the future. There are also unique challenges maintaining adequate numbers of LTC facilities for veterans with spinal cord injuries and disorders (SCI/D) that must be addressed.

While VA must continue to expand its noninstitutional, home-based services and support, there will always remain a significant number of veterans who will require institutional care.

**NOTE:** Additional recommendations of long-term care programs are addressed in the next Critical Issue.

## Explore & Expand New Models of Shared Health Care Facilities

VA has explored many shared health care facility models over the years to supplement VA's normal construction programs, including the Public-Private Partnership and the Communities Helping Invest through Property and Improvements Needed for Veterans models. Both of these VA construction programs seek to match private investment with VA funding for new facilities. Given the high cost of constructing new facilities coupled with the increasing integration of non-VA providers into VA community care networks, VA should consider leveraging existing health care relationships with other federal agencies (the Department of Defense and the Indian Health Service), and academic affiliates, as well as sharing arrangements with private providers in VA's community care networks. ♦

### The IBVSOs Recommend:

- Congress extend the AIR timeline by at least one year to ensure that the delays and lessons learned from the COVID-19 pandemic can be fully incorporated into VA's infrastructure planning.
- VA fully engage with veterans and VSO stakeholders on a national and local level to ensure veterans' preferences are paramount both in designing local community care networks and during the implementation of the AIR process.
- VA partner with VSOs on a communications plan to educate veterans, the public, and the media about the upcoming AIR process before critical decisions are made.
- Congress modify PAYGO rules or enact legislation to change how VA leases are approved and scored to reflect the actual funding required annually.
- Congress increase VA's internal capacity and expertise to manage and expand infrastructure and lease facilities by hiring additional personnel, and implementing training curriculum and certification programming required by the VA MISSION Act.
- VA develop a new strategic plan that estimates the number of veterans who will require institutional LTC and the number of veterans that VA will support in LTC facilities. Additionally, it should develop a plan to build, maintain, and subsidize sufficient LTC facilities within the VA's nursing homes (CLCs), and SVHs.
- VA explore additional opportunities to expand partnering arrangements to supplement VA's health care infrastructure.



