THE INDEPENDENT BUDGET

Veterans Agenda for the 116th Congress

Policy Recommendations for Congress and the Administation

One Critical Issue for the 116th Congress – Fully and Faithfully Implement the VA MISSION Act

Introduction

This VA MISSION Act is an historic law that contains a number of policy priorities that *The Independent Budget* veterans service organizations (IBVSOs) had been advocating for years. Most notably, the law reforms the Department of Veterans Affairs' (VA) health care services and provides an expansion of VA's Caregiver Support program.

Though enactment of the VA MISSION Act was the culmination of more than four years of debate over the future of the VA health care system, it also marks the beginning of a far more complex and critical phase: implementation. The VA MISSION Act was the result of a long and deliberative process that led to a broadly-supported, bipartisan consensus for expanding access to and improving the quality of care provided to veterans. Although there were and continue to be some who would prefer more far-reaching changes to VA, such as incremental outsourcing of services leading to wholesale privatization, the law is a carefully balanced compromise that must be faithfully implemented as intended. These reforms will require Congress and veteran stakeholders to aggressively oversee VA's implementation of the law and continually advocate for sufficient funding.

If VA and Congress implement this law fully, faithfully, and effectively, veterans' health care will enter a new era marked by expanded, timely access to high quality care for all enrolled veterans. However, if implementation deviates from the clear and widespread consensus reached by all key stakeholders, the VA health care system could enter a period of decline with devastating consequences for veterans who rely on VA for their care, and perhaps even threaten the viability of the VA health care system itself.

Given the stakes involved in getting implementation of the law right, the IBVSOs have determined that for the 116th Congress funding and implementation of the VA MISSION Act rises above every other policy priority for the next two years. As such, we have chosen to deviate from our longstanding practice of enumerating multiple critical issues for the year ahead, and instead we are designating One Critical Issue for the 116th Congress: Fully and Faithfully Implementing the VA MISSION Act.

Background

The origins of the VA MISSION Act can be traced back to the 113th Congress (2013-2014), when it became clear that too many veterans were waiting too long to receive care at VA facilities. Some veterans were kept on hidden VA waiting lists. Some veterans may have died due to preventable errors at VA facilities. To address these problems, on August 7, 2014, President Obama signed Public Law 113-146, the Veterans Access, Choice, and Accountability Act (VACAA) – commonly called the "Choice Act" – which provided veterans with a new way to access community care when VA care could not be scheduled within 30 days or if a veteran would be forced to travel more than 40 miles to a VA facility to receive needed care. However, the short and unrealistic implementation timeframe (90 days) hindered the program from the outset, creating almost as many new problems for its veteran patients and VA as it resolved.

The Veterans Choice Program was fully phased in during the 114th Congress (2015-2016). Persistent problems with the program led to enactment of Public Law 114–41 on July 31, 2015, which adjusted time and distance access standards, lengthened Choice authorizations for an episode of care to one year, authorized VA to transfer funding from Choice to other VA community care programs, and required VA to develop a plan to consolidate all non-VA care programs, including Choice, into a single new program. In September 2015, the Independent Assessment required by the Choice Act concluded that VA's access problems were primarily caused by inadequate funding to meet rising demand for health care, echoing what the IBVSOs had been saying for years. On October 30, 2015, VA issued its new plan calling for restructuring and integrating VA and non-VA health care programs into high-performing networks that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community. The IBVSOs welcomed the VA plan, which was very similar to the *IB Framework for VA Health Care Reform*, which was also released in the fall of 2015.

In June 2016, the congressionally-created Commission on Care released its final report and recommendations, calling for establishment of "high-performing, integrated community-based health care networks." Similar to the VA and *IB* plans, the Commission's preferred option maintained VA as the coordinator and primary provider of care to address cost and quality of care concerns, and viewed the use of community providers and the Choice program as a limited means to expand access when VA was unable to meet local demand for care. The Commission overwhelmingly rejected more radical alternatives, such as one known as the "Strawman Proposal," which advocated privatizing veterans' health care and completely eliminating all VA health care treatment facilities over the next 20 years. Ultimately, the Commission reached an overwhelming consensus to strengthen and reform the VA health care system.

As the 114th Congress drew to a close in late 2016, the IBVSOs, most other veterans leaders, VA, the Commission on Care, and bipartisan leaders in Congress were all coalescing around a common approach to fixing the access problem and ending long wait times, while maintaining a high-quality, comprehensive, and veteran-focused health care system. All arrived at the same basic solution: create local integrated health care networks that combine the strength of the VA system with the best of community care, whenever and wherever gaps in coverage exist.

For much of the 115th Congress (2017-2018), the House and Senate Veterans' Affairs Committees developed and debated separate legislation to replace the Choice program. Ultimately, a broad, bipartisan consensus emerged, and with support from the IBVSOs and other veterans' leaders, a compromise agreement was reached and the VA MISSION Act was signed into law by President Trump on June 6, 2018.

Overview of the VA MISSION Act – Public Law 115-182

The VA MISSION Act makes significant changes in four areas:

- Consolidation and creation of a new community care program;
- VA health care capacity and program enhancements;
- VA asset and infrastructure review; and
- Caregiver support program expansion.

New Veterans Community Care Program (VCCP)

The law consolidates seven existing community care programs, including the current Veterans Choice Program, into a single Veterans Community Care Program (VCCP), using local integrated networks of community providers, particularly the Department of Defense (DOD) and academic affiliates. By June 6, 2019, VA must complete market area assessments, develop strategic plans to provide care to enrolled veterans in each market, and promulgate all regulations necessary to operate the VCCP. VA will remain the primary provider of care and be responsible for coordinating care, including scheduling.

The law requires VA to develop new access standards by regulation to replace current 30-day, 40-mile standards, as well as new quality standards, by March 6, 2019. Service lines in VA facilities that fail to meet quality standards will undergo remediation, though VA may not designate more than three lines in a single facility, or 36 total across VA. Enrolled veterans will be eligible to choose non-VA care providers within integrated networks if they are seeking a medical service that VA does not provide; if VA cannot meet its access standards; if the service line at the VA facility is in remediation for failure to meet quality standards; or if the veteran and their clinician agree that it is in the "best medical interest" of the veteran. The law also authorizes veterans to access "walk-in care" a limited number of times each year at clinics that VA has contracted with.

VA Health Care Capacity and Program Enhancements

The law appropriated $5.2 billion to continue the current Choice program, intended to last until the VCCP is up and running in July 2019. Additionally, the law strengthened, expanded, and created a number of programs to improve VA's ability to recruit, hire, and retain high-quality medical personnel. It also expands VA's ability to provide telehealth programs across state lines and strengthens health programs targeted at rural and underserved areas of the country.

Asset and Infrastructure Review (AIR Act)

The law creates a multi-year process to review VA's health care infrastructure and develop a long-term plan to realign and modernize it. The plan must be reviewed and approved by VA, an independent Commission, the president, and Congress. The Commission will consist of nine members chosen by the president, including three specifically representing major veterans service organizations (VSOs).

Caregiver Support Program Expansion

The law expands VA's Caregiver Support program to eligible veterans severely injured prior to September 11, 2001. VA must first ensure that it's administrative and IT capacity to manage an expanded caregiver program is ready, followed by a two-phase expansion: beginning as early as 2019 for WWII to Vietnam War era veterans, followed two years later for post-Vietnam War era to pre-9/11 veterans.

Veterans Community Care Program (VCCP)

Building and Operating Integrated Veterans Health Care Networks

Even before the VA MISSION Act became law, VA began developing a Request for Proposal (RFP) for provider networks that could be used with the existing Choice program and/or with its successor, now identified as VCCP. Additionally, VA had already begun to perform some market area assessments of capacity. In order to create the integrated networks of VA and community providers, VA must complete all market area assessments; finalize the strategic plans to meet increased veteran demand in each market; establish contracts and agreements with required community providers; and prepare VA, community providers, and veterans to operate and engage with the integrated networks. To comply with the VA MISSION Act's deadlines, all of this work must be completed no later than August 7, 2019.

Recommendations

- **VA's process for developing market area assessments and strategic plans must be fully open and transparent, actively engage VSO stakeholders, and maintain robust VA capacity and expertise wherever feasible.**

  The VCCP will be judged on how well the integrated networks meet the needs and preferences of veterans. To win veterans' approval, it is essential that veterans, their representatives, and leaders are fully engaged from the outset, as VA is developing market area assessments and strategic plans. Unless veterans and other stakeholders have confidence in this process, it is unlikely to be successful in the long run. Therefore, VA must develop their assessments and plans in a fully open, transparent process with opportunities for meaningful participation from veterans at key decision points. Finally, as VA makes critical decisions about how best to deliver medical care to veterans in

each market, there must be a fundamental understanding that VA is more likely to produce better health care outcomes for veterans than community providers, even those selected for integrated networks. For this reason, preference must be given to maintaining a full continuum of care within VA health care facilities, whenever and wherever feasible.

- **Foundational services should include the widest array of services practicable in each market area, and VA must only grant exceptions in locations or facilities where there will be a clear benefit to veterans' health care outcomes.**

  While there may sometimes be unique circumstances or justifiable exceptions, VA must seek to maintain all foundational services in all locations to assure its long-term viability to provide care for veterans. This requires a robust VA health care system. Cost should never be the sole determinant for dropping a foundational service in a market area unless there is a very high degree of certainty that the foundational service can be provided with at least the same level of quality and veteran-centric expertise that VA is capable of providing.

- **Competency standards for non-VA community providers should be equivalent to standards expected of VA providers, and non-VA providers must meet continuing education requirements to fill gaps in knowledge about veteran-specific conditions and military culture.**

  The success of VA's new Community Care program should be judged on how it improves health outcomes for veterans, not how many veterans use non-VA providers or how many "choices" veterans are provided. Non-VA providers who wish to be part of the integrated networks must demonstrate a high level of expertise in veteran and military medicine, significant cultural competency about the veteran and military experience, and a commitment to improving and maintaining their skills and expertise.

- **VA should use its authority to create a tiered provider network when building integrated networks, with VA providers in the first tier, and DOD, other federal partners, and academic affiliates occupying the second tier when VA is not feasibly accessible.**

  The VA MISSION Act authorizes, but does not mandate, that VA develop a tiered provider network. However, VA should have a strong preference for providers with a demonstrated history of providing high quality care to veterans and military members, which includes DOD, Indian Health Services (IHS), and academic affiliates that regularly treat veterans and with whom VA already has ongoing partnerships. Additional tiers of providers may be necessary for locations and situations where there are an insufficient number of VA, DOD, IHS, or academic affiliate providers available to meet specific veterans' needs. As the integrated networks are built and operated, VA should seek to educate and guide veterans to those providers who work closely with the VA and whose care will most likely result in better health outcomes for veterans. Specifically, these providers would have the most experience, expertise, and cultural competency working with veterans - specifically DOD, IHS, and academic affiliates.

- **The VCCP training program for VA employees and contractors must ensure that VA maintains responsibility for tightly managing the networks and coordinating the care of veterans.**

  The law requires VA to develop a training program for VA employees and contractors on operation of the new VCCP. The curriculum developed to accomplish this training must include clear instruction that VA retains the primary responsibility for managing the network to ensure the highest levels of quality, access, and cost-effectiveness. The training must also make clear that VA remains responsible for the seamless coordination of care, as well as scheduling and payments by veterans and to providers.

- **VA must have sufficient resources, personnel, and IT capacity to handle scheduling and develop effective self-scheduling options for veterans.**

In order to create an efficient and veteran-centric process for scheduling appointments within the integrated networks, VA must be provided sufficient resources to develop new scheduling systems, including self-scheduling options that veterans can easily access and utilize. To be successful, VA must be provided sufficient funding, personnel, and IT support to develop these new systems on time. As VA begins implementation of its new COTS software for electronic patient records, which should ultimately lead to better communications between VA and its provider networks on all aspects of patient care and management, every effort must be made to keep this vital project appropriately resourced and on schedule.

Providing Access to Timely, Quality Care for All Enrolled Veterans

Among the most crucial provisions of the VA MISSION Act are those involving new standards and practices which will act as triggers for veterans to make decisions about accessing community providers within the integrated community networks. Under the Choice program, access was primarily defined by arbitrary time and distance standards, generally 30 days or 40 miles. Under the new Veterans Community Care Program (VCCP), there will be new access and quality standards designated that will have greater detail and specificity to account for the variety of conditions and circumstances of the enrolled veterans population. The law requires VA to finalize these standards by March 7, 2019, so most of the decisions will have already been made by the time this document is published. The law also requires that access and quality standards be regularly reviewed and adjusted to ensure veterans are not forced to wait too long or travel too far, or because a shift from VA-provided care to community care is financially unsustainable or threatens the viability of the VA system of one or some of its VA facilities.

The law also provides access to community care when a clinician and veteran patient determine it is in the "best medical interest" of the veteran, even if VA care is readily available. Veterans may also elect to access community providers in the network when a service line of a VA facility is under remediation. In addition, the law provides veterans limited access to "walk-in care."

Recommendations

- **Access standards for timeliness, distance, and other factors that impact veterans' ability to receive care at VA facilities must balance the need to be objective and specific for different types of care with the need for standards that are simple, understandable, and usable by veterans, VA employees, and VCCP providers.**

It is important for VA to establish access standards that define objective criteria for when veterans have the option to use non-VA network providers. Unless these standards are realistically achievable and clinically appropriate, either veterans or the VA system will suffer negative consequences. VA must establish standards that are realistic in relation to VA's capacity, and comparable to measures of local private sector access. Given the critical role these standards will play in the new VCCP, both VA and Congress must be willing to revisit them regularly and as necessary.

- **VA quality standards must be applied equally to VA and non-VA providers to ensure the highest level of care practicable, carefully balancing the need to align VA quality standards with private sector standards, against the need to maintain veteran-specific standards that make VA the leader in veteran medicine.**

As with access standards, quality standards must balance the need to be simple and objective with the need to maintain the unique features of the VA health care system that effectively serve veterans, but are different than those in the private sector.

- **VA must develop clear and understandable criteria for determining when veterans and their referring clinicians agree that it is in the veterans "best medical interest" to use non-VA providers, and there must be a rapid and transparent appeal process for veterans when there is disagreement.**

  As with access and quality standards, the criteria guiding "best medical interest" determinations must be a balance: in this case - between the need to be clear and objective with the need to address each veteran's individual health care circumstances. The guidelines for using "best medical interest" to access community providers when VA has sufficient capacity must be clinically based, but must also take into account how their implementation will affect VA's ability to manage and sustain a robust health care system to meet the needs of all enrolled veterans.

- **VA must develop a clear and consistent methodology for selecting service lines in VA facilities that are not meeting quality standards and will undergo remediation.**

  While subpar quality is the principle determining factor, VA must also determine whether there is sufficient high-quality care locally in the private sector before offering veterans the option to utilize non-VA care.

- **VA must receive and properly allocate sufficient funding, personnel, and other resources to improve the quality of care in service lines of VA facilities under remediation.**

  In order to improve quality and expand capacity to deliver care, VA must devote adequate resources and focus to resolve problems causing any decline in quality in service lines under remediation.

- V**A should implement the new "walk-in care" benefit without requiring copayments by service-connected veterans, and VA and Congress should develop a new plan to expand from "walk-in care" to a full "urgent care" benefit for enrolled veterans.**

  While the IBVSOs support the "walk-in care" benefit, we view it as a first step towards developing and implementing a more comprehensive "urgent care" benefit for enrolled veterans, a benefit that is standard in most health care plans and has proven to be cost effective when coupled with a toll-free nurse triage line.

- **In close consultation with VSO stakeholders, VA must develop and implement an education program for veterans about the new VCCP, with tiered providers such as DOD, IHS, and academic affiliates, and with a focus on the demonstrated advantages of VA's comprehensive, holistic health care program.**

  In addition to making veterans aware of how the new VCCP operates and their options for care within the integrated networks, it is essential that veterans are provided evidence-based information about the relative advantages of VA's holistic model of care and benefits in order to make informed decisions.

Sustaining and Improving the VA Health Care System

During and after the establishment of VA's new Veterans Community Care Program (VCCP), it will be essential that VA, Congress, and veteran stakeholders continue advocating for funding and policies that will sustain and improve veterans' health care services. The most critical factor will be ensuring VA has sufficient funding and resources to meet the full demand for care by enrolled veterans. As history has repeatedly proven, when demand rises faster than available resources, veterans end up waiting for necessary care, resulting in worse health outcomes, lower quality of care, and a weaker VA health care system.

The law also authorizes the creation of a Center for Innovation for Care and Payment within VA, which is intended to test new care and payment models in order to reduce costs while maintaining or enhancing quality of care. Congress must specifically authorize any legal or regulatory waivers VA requires to move forward with pilot programs proposed through the Center.

Recommendations

- **VA must request, and Congress must provide, sufficient and timely funding to meet the full demand for care by enrolled veterans within VA facilities and through non-VA providers in the integrated networks, including full demand funding of advance appropriations for VA's medical care accounts.**

  As both the Independent Assessment and the Commission on Care concluded, the primary reason for the access crisis that led to the Choice program was insufficient funding provided to VA to meet the rising demand for care by enrolled veterans. The Choice program has further proven that when access to care is improved, more veterans enroll in VA and overall utilization rises, both requiring additional resources. It is imperative that Congress fund the full demand for care that will be generated by increased access through integrated networks. Additionally, VA must request, and Congress must provide, sufficient advance appropriations for medical care to meet all projected demand, rather than appropriating a "base" level of funding for the second year, and then providing the balance the following year, an approach often referred to as a "second bite of the apple" approach.

- **Congress should make adjustments to existing and future budget caps, and consider changes to budget and appropriations statutes, to accommodate increased funding needs of VA due to the increased demand for, and higher utilization of, health care resulting from the new VCCP.**

  As Congress and the Administration continue to negotiate and adhere to overall budget caps for domestic discretionary spending, demand for VA health care services is expected to rise significantly and often unpredictably - particularly in the first few years as the new VCCP and integrated networks are being optimized. In order to help ensure that VA is provided sufficient medical care funding, without cutting any other essential veterans benefits or services, Congress should temporarily or permanently exempt VA from budget caps, sequestration, and other budget cutting strategies.

- **VA must not use the new Innovation Center to propose pilot programs based on proposals that were previously rejected by the Commission on Care, VA, or Congress, or that contradict the underlying consensus upon which the VA MISSION Act was approved.**

  Innovation has been critical to VA's success as a health care system, and the Innovation Center has the potential to help VA as they undergo a generational transition to a new model of integrated and seamless networks of care. However, the Innovation Center must not become a backdoor for ideas and proposals that have already been rejected during the development and approval of the VA MISSION Act, such as proposals to change the governance of VA health care or make VA primarily an insurer rather than a provider of care.

Veterans Community Care Program (VCCP) - Key Implementation Dates	
Date	**Deadline or Milestone Explanation**
March 6, 2019	VA Must Finalize Access and Quality Standards for Health Care
June 6, 2019	Promulgate All Regulations Necessary to Implement VA MISSION Act
June 6, 2019	Finalize Competency Standards for Non-VA Providers in Networks
June 6, 2019	Disqualify Non-VA Providers Who Fail to Meet VA Standards
June 6, 2019	Complete Strategic Plan to Meet Demand for Care within Market Areas
July 6, 2019	Effective Date for New Veterans Community Care Plan
March 6, 2020	Begin Designating Substandard Service Lines for Remediation
June 6, 2020	GAO to Issue Report on Disqualified Non-VA Providers
December 6, 2020	Report on Implementation and Compliance of Access Standards Due
March 6, 2021	Solicit Public Comment and Consider Changes to Quality Standards
March 6, 2022	Review and Update Access Standards for VA Health Care
June 1, 2023	New Strategic Plan to Meet Demand for Care Due
June 6, 2023	Updated Market Areas Assessments Due