Tracking Transformation: VA MISSION Act Implementation

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With Respect To

"Tracking Transformation: VA MISSION Act Implementation"

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After four years of tireless work and development, the *VA MISSION Act of 2018* was signed into law on June 6, 2018. The main prerogative of the *VA MISSION Act of 2018* is perfectly stated as Title I –– *Caring for Our Veterans*. The Veterans of Foreign Wars of the United States (VFW) believes that to successfully implement this multifaceted portion of the law, the Department of Veterans Affairs (VA), Congress, and veterans service organizations (VSOs) must collaboratively work together, while maintaining its implementation as the top priority of the 116th Congress. The VFW thanks the committees for the continued oversight of this important law and leadership in ensuring VA has the resources to properly implement it.

If the law is effectively implemented, veterans' health care will enter a new era of timely access to high-quality care. However, if implementation strays from the overwhelming consensus reached by stakeholders involved in development of the law, VA health care could decline, resulting in negative consequences for the millions of veterans who rely on VA for their health care, and threaten the viability of VA's teaching, world-class research, and

emergency response missions. While there are groups that believe VA facilities should be downsized and that veterans should receive more care through private sector doctors, the VFW's numerous surveys show veterans want VA to hire more doctors and increase internal capacity. In fact, our latest VA health care survey indicates nearly 60 percent of veterans who were offered community care elected to stay with VA. The main reason veterans prefer VA is they like the quality of care they receive, which a recently published peer-reviewed study entitled *Veterans Health Administration Hospitals Outperform Non-Veterans Health Administration Hospitals in Most Health Care Markets* found is better than the private sector.

The law requires VA to develop regulations for new access and quality standards to replace the current arbitrary rule of a 30-day wait and 40-mile distance standards, by March 6, 2019. This will be done by consolidating seven current community care programs, including the Veterans Choice Program, into one. This program will be the Veterans Community Care Program (VCCP), and will use local health care networks and academic affiliates to provide care to all eligible veterans. The VFW has serious concerns about the lack of collaboration and working communication from VA with VSOs to establish these new regulations. While VA has held consistent meetings between VSOs and the Office of Community Care, the majority of such meetings have been one-sided conversations. Without proper stakeholder input, VA will fail. For example, VA is considering up to 20 different access standard models, none of which have been shared with VSOs. The VFW understands Congress intended for VSOs to receive specific data and to work in cooperation with VA to develop these future regulations that will affect the lives of millions of veterans. The VFW also has concerns with the lack of participation at Office of Community Care meetings from VA's Executive Steering Committee, which will ultimately assist the Secretary in choosing access standard models and how the law is implemented. The VFW is encouraged by this past week's decision to include VSOs in VA MISSION Act workgroup meetings with VA leadership. We hope such meetings will be more productive, and look forward to working with VA to ensure this important bill is implemented in the best interest of the veterans VA was created to serve.

The VFW has made clear time and time again that VA must back away from setting arbitrary standards for when patients using VA are given the option to use community care. VFW members have made clear the many negative unintended consequences of not upholding the decision to use community care as a clinical decision made between a patient and their provider. It is optimistic to hear VA working toward solutions in overcoming this range of arbitrary barriers, such as when a patient lives within close proximity to a VA facility based on miles, but must overcome geographical difficulties such as mountains. VA must adapt lessons learned from the Veterans Choice Program and study recommendations from industry experts, such as the *Transforming Health Care Scheduling and Access: Getting to Now* independent review conducted by the National Academy of Medicine, formerly known as the Institute of Medicine, to establish access standards that are appropriate for the users

of the VA health care system. The VFW warns VA against adopting arbitrary standards which would fail to address the uniqueness of the VA health care system and the needs of our nation's veterans.

It is important for VA to establish access standards that define objective criteria for access to VA community care networks. Unless these standards are pragmatic and clinically appropriate, both veterans and VA will suffer negative consequences. VA must establish standards that are sensible for VA's capacity, and comparable to measures of local health care systems outside VA. As with access standards, quality standards must balance the need to maintain the unique features of VA that effectually serve veterans, but are different than those in the private sector.

The VFW also has concerns with feedback from facilities that veterans are being automatically placed into community care based on arbitrary guidelines without discussion or input from their providers. The VFW continues to oppose patients being involuntarily placed into community care simply because their appointments may not be scheduled within 30 days. First and foremost, veterans and their providers must remain part of this process to ensure patient understanding and continuity of care. Second, many of these patients would prefer to stay with VA. Finally, not every appointment must be fulfilled within the 30 days. If the appointment is not medically necessary in that timeframe, veterans must be able to choose whether to wait for VA or seek care through the community care networks.

The VFW also urges VA to account for how the implementation of a new electronic health care record impacts productivity. In partnership with the Defense Health Agency (DHA), the VFW has kept a keen eye on the implementation of the Military Health System GENESIS electronic health care record, which is the same system VA has elected to adopt for the VA health care system. While the VFW hopes VA adopts lessons learned from DHA to ensure a more seamless implementation, we are certain VA medical facilities will experience a temporary reduction in productivity that comes with change management. However, military treatment facilities report an eventual increase in productivity after full implementation. The VFW suspects VA medical facilities will experience a similar trend in productivity, which will lead to a temporary increase in demand for community care.

This and other temporary spikes in demand for community care, such as snowbirds, will require VA to adjust its community care networks and VA medical facility capacities to ensure veterans can receive the care they need where they need it. VA must make certain that temporary increase in demand for community care does not jeopardize the long-term viability of capacity at VA medical facilities. That is why the VFW urges VA and Congress to consistently evaluate whether VA should be expanding its community care networks or increasing internal capacity. This must be done by hiring more doctors or having VA deploy a quick reaction force of VA doctors to areas facing temporary spikes in demand for care.

VA facilities with service lines that fail to meet established quality standards will undergo remediation. Patients who rely on the 36 service lines that fall under the quality standards will have the opportunity to choose if they would rather stay with a VA doctor or use private sector doctors in their community. It is important that VA take into account what options veterans use and where they would prefer to go when developing remediation plans. VA must also take into account the ability for VA medical facilities to provide severely disabled veterans, such as those in spinal cord injury centers or polytrauma network sites, a full continuum of care. Simply closing such service lines in favor of community care would fail veterans who prefer to see a VA doctor and those who are unable to use community care.

To ensure access and quality standards are fully vetted and understood, the VFW urges VA to issue notice of proposed rulemaking in the Federal Register to allow sufficient time for public comments. It would be unacceptable for VA to issue an interim final rule, which does not allow for public input, specifically if stakeholders were not incorporated in developing it. Aside from stakeholders who must be consulted in the development of these rules, veterans and individuals who will be impacted by them must have their voices heard and considered through public comment. Doing so may mean that VA will not meet the deadlines established in the law. To the VFW, it is more important that VA produce high-quality and accurate regulations than it is for VA to rush the decision-making process and repeat previous mistakes in order to meet such deadlines. Also, there must be an organized outreach campaign for veterans who use VA once these regulations are finalized. Since the VA MISSION Act became law, VA has worked with VSOs to design pamphlets and other educational materials to share with patients when the law is ready to be implemented. This must be done so thoroughly and on multiple platforms, while also promising that all VA employees who will be involved in this transition completely understand the program and are able to explain it to patients.

As the regulations for the VA MISSION Act continue to be planned and implemented, the VFW looks forward to continuing to prioritize the remaining sections of the law. This includes working with VA and Congress to perfect billing, market assessments, expansion of the caregiver program, provider education and training programs, and the asset and infrastructure review.