

# THE INDEPENDENT BUDGET

Veterans Agenda  
for the 116<sup>th</sup> Congress

## Critical Issue Update



# **THE INDEPENDENT BUDGET**

**Special Report on the Status  
of Implementation of the  
VA MISSION Act**

# INTRODUCTION

The VA MISSION Act (Public Law 115-182) was signed on June 6, 2018 and became effective one year later on June 6, 2019. This historic legislation 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. *The Independent Budget* veterans service organizations (IBVSOs)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars of the United States (VFW)—supported the VA MISSION Act because if it is fully, faithfully and effectively implemented, VA could 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.

One year ago, we released, “*The Independent Budget Veterans Agenda for the 116th Congress*,” which contained comprehensive recommendations on the major issues facing veterans in accessing health care, benefits and transitional services. At that time, the IBVSOs determined that the implementation of the VA MISSION Act rose above every other policy priority. Therefore, we chose to deviate from our longstanding practice of enumerating multiple critical issues and instead designated a single critical issue for the 116th Congress: Fully and Faithfully Implementing the VA MISSION Act. In that report, *The Independent Budget (IB)* enumerated 26 specific recommendations to help ensure that the compromise reached among VA, Congress and veterans service organization (VSO) stakeholders would be fulfilled. This *IB* special report will evaluate the status of those recommendations and discuss what VA and Congress, working together with VSO stakeholders, must do to fulfill these recommendations.

Since the majority of the reforms contained in the VA MISSION Act have only been in effect since June 6, 2019, and others have not yet been implemented, it is still far too soon to judge whether the law will achieve its intended purposes to improve veterans’ access to high-quality medical care. Overall, the transition of VA’s community care program from the Veterans Choice Program (VCP) to the VA MISSION Act’s Community Care Network (CCN) was significantly better than the transition to the original VCP. Due to award protests during the contracting process, the new CCN providers (Optum and TriWest) were delayed in beginning to establish their local networks; however, both are aggressively building their provider networks and beginning to rollout their regional networks. The new urgent care benefit included as part of the VA MISSION Act has been very well received by veterans, although it too has not yet reached full coverage across the country. The VA MISSION Act’s capacity enhancements are only in the early stages of implementation and the Asset and Infrastructure Review (AIR) will not even begin until next year. Perhaps the biggest disappointment of the VA MISSION Act’s implementation is VA’s failure to expand the comprehensive caregiver assistance program to support World War II, Korean, and Vietnam era veterans, which will be discussed below.

Given the scale and scope of the reforms in the VA MISSION Act, *The IB* recommendations did not cover every aspect of the law, but instead focused on areas that we believed merited special focus and attention. Furthermore, with only eight months having passed since the law became effective, many of its provisions are either still in progress or yet to begin, though there are several that have already been rejected or ignored by VA or Congress. For these reasons, this special report should not be considered a final evaluation of the VA MISSION Act. Instead, it should be viewed as an interim progress report, best understood in the full context of other qualitative and quantitative assessments and reviews.

In this report we have provided a “current status” for each recommendation in three categories: “fulfilled,” “not fulfilled,” or “to be determined.” In order to be considered “fulfilled,” the overall intention of the recommendation must have been substantially achieved, notwithstanding the fact that some aspects have not. Similarly, to be considered “not fulfilled” there must have been either an action taken or intentional inaction that has resulted in VA or Congress not fulfilling the overall intention of the recommendation. In some cases, particularly those dealing with funding and resources, the status could change each year depending on the most recent budgets and appropriations enacted. For those recommendations that require future actions, or actions that will not be completed or the impact will not be known until some future time, as well as those for which we have been unable to obtain sufficient information to make an evaluation, we use the category of “to be determined.” A recommendation in the “to be determined” category may have been partially “fulfilled” or “not fulfilled,” but there remains a significant aspect that cannot be fully evaluated until a future time or until further information is obtained and assessed. For each recommendation, there is an explanation for why the category was assigned, and in many cases, supplemental recommendations about how VA and/or Congress can help to achieve the purpose of the recommendation.

It is our hope that this report will help to generate discussion and lead to action by VA and Congress, working together with the IBVSOs and other key stakeholders, to refocus and redouble efforts to ensure the law is fully and faithfully implemented as intended. Ultimately, we all share the same objective: to provide veterans with timely access to high-quality, veteran-focused health care, so they can achieve the best possible health outcomes. Moving forward, we hope to develop a deeper collaboration with VA and Congress as we work to fully and faithfully implement this major reform of the veterans’ health care system. America’s veterans have earned and deserve nothing less.



# STATUS OF IMPLEMENTATION OF THE **VA MISSION ACT**



# RECOMMENDATION 1

*CURRENT STATUS: NOT FULFILLED*

***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 VA MISSION Act contains two separate sections that each require market area assessments. Section 106 of the law establishes a “Quadrennial Veterans Health Administration review,” which requires VA to perform “market area assessments” every four years to inform a “VA Plan to meet Health Care Demand.” The first review was due no later than one year after enactment of the law. Section 203 establishes procedures for VA to make recommendations as part of AIR and requires VA to complete “capacity and commercial market assessments” to inform the AIR process. Although the law clearly intended these to be two separate and distinct assessments, since enactment VA has interpreted the law to require only one set of assessments to satisfy both statutory requirements.

Prior to the enactment of the VA MISSION Act, VA had already initiated three market area capacity analyses in order to develop and test a methodology for performing a complete set of market capacity assessments in all 96 of VA's health care markets. Based on that testing, VA initiated the first phase of the assessments encompassing one third of VA's Veterans Integrated Service Networks (VISNs), which was completed last year. The second phase began last year but has not yet been completed and the final phase is planned to begin this spring and completed later this year. VA has stated it will not release any of its market capacity assessments until after all have been completed.

Regrettably, despite clear statutory language and repeated statements of congressional intent by the bill's authors, VA has conducted these market capacity assessments with little transparency, and without any meaningful consultation with VSOs or veterans who use the VA health care system. In developing and reaching agreement on the VA MISSION

Act, Congress, VA, and VSO stakeholders worked collaboratively to address areas of concern, and it was fully expected that such collaboration would continue during implementation of the law. However, in respect to the market capacity assessments, VA has operated unilaterally. It is our understanding that during the market capacity assessment site visits, VA has not consulted with other federal or private health care providers to explore possibilities for realigning and optimizing the delivery of timely, high-quality medical care in the local CCNs. Instead, VA has relied on existing commercial databases of current capabilities for private community providers and existing sharing agreements with the Department of Defense (DOD) and Indian Health Service (IHS), which are static, backward-looking data sources.

In order to achieve the VA MISSION Act's goal of creating a truly seamless, integrated network that provides the highest quality of care to injured and ill veterans, and does so in a way that reflects veterans preferences for accessing care, VA must begin to actively consult and collaborate with all stakeholders during all future market assessment activities.

We also note that based on the first set of market assessments, VA was required to issue a “Strategic Plan To Meet Health Care Demand” (Section 106(b)) no later than June 6, 2019, in order to help the development of the local integrated networks. That deadline passed eight months ago. Since then, there has been no indication as to when, or if, the required strategic plan will be forthcoming.

In terms of whether VA will maintain robust capacity and expertise in its own facilities wherever feasible, it is still too early to make any judgments. The CCNs operated by Optum and TriWest are still in the early stages of rolling out; so, it is unclear how VA will seek to rebalance and optimize the delivery of medical services between VA and community-delivered care.

However, based on VA's lack of transparency and collaboration during their market assessments to date, the current status of this recommendation is not fulfilled.



## RECOMMENDATION 2

*CURRENT STATUS: TO BE DETERMINED*

***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.***

*The IB* has maintained that 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 a full continuum of 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.

According to VA, it will leverage highly integrated partnerships with both the public and private sector to ensure veterans get the best care and services available, even if that is outside of VA. If the community provides a better outcome, and the care or service is not considered a foundational VA offering, veterans deserve the opportunity to get the best care rather than having to settle for sub-par outcomes. Ultimately, this means that VA will excel at the foundational service offerings available to veterans.

VA has not yet identified which of its 79 health care services will be treated as “foundational services” and remain available in all VA medical facilities. VA has also not provided information about its objective definition of what it considers “the best care and services,” what specific metrics and outcomes it will use to determine “the best care,” and how this information will be used to create high-performing integrated health care networks around the VA health care system, while maintaining its “foundational services.”

VA has not explained in a transparent manner when and how this information is being used to inform the network being built under the Veterans Community Care Program (VCCP) required by the VA MISSION Act. This consistent lack of transparency and accountability erodes public trust and confidence in the Department’s leadership. The lack of information regarding “foundational services” or at least a clear understanding of how VA will resolve its “make or buy” decisions leads *The IB* to categorize the status of this recommendation as to be determined.

## RECOMMENDATION 3

*CURRENT STATUS: NOT FULFILLED*

***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.***

Section 133 (b)(2) of the VA MISSION Act requires all non-VA health care providers joining the CCN or entering into a contract or agreement with VA to meet competency standards and requirements within six months of the contract, agreement, or other arrangement taking effect. Further, non-VA providers are required, “...to the extent practicable as determined by the Secretary, fulfill training requirements established by the Secretary on how to deliver evidence-based treatments in the clinical areas for which the Department of Veterans Affairs has special expertise.”

In VA’s June 5, 2019, final rule establishing the VCCP, VA indicated that it would establish competency standards and requirements for the provision of care by non-VA providers in clinical areas where VA has developed special expertise; however, VA would not be regulating these standards to permit flexibility, as such standards are based on clinical practice and can be subject to change.

According to VA, general military knowledge competency training was released last summer and is available to all CCN providers. Competency standards

and training for PTSD, TBI, and MST are currently being developed and will be available for providers later this year. VA is incentivizing providers to take this training by listing those who complete the training as “preferred providers” on the VA locator tool.

Because VA is incentivizing rather than mandating that all CCN and other non-VA providers meet the competency standards and complete the training requirements, *The IB* believes VA is not currently fulfilling our recommendation.

## RECOMMENDATION 4

*CURRENT STATUS: NOT FULFILLED*

***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.***

Section 101(g) provides that VA “...may develop a tiered provider network of eligible providers based on criteria established by the Secretary...” As discussed frequently during the development of the VA MISSION Act, non-VA health care providers with the greatest familiarity and expertise in treating veterans are more likely to ensure better health outcomes for veterans than providers without such experience or expertise.

In general, DOD health care facilities are the most logical alternative to VA in terms of cultural competence and expertise treating injuries and illnesses related to military service. VA’s academic affiliates, who help train future VA clinicians, are already embedded in the VA system and have deep experience treating veterans. The Indian Health Service (IHS) also has sharing agreements with VA and a history of treating veterans in tribal areas. We recognize that DOD, IHS, and academic affiliates may not always be the best option in all circumstances, but given their experience and expertise, as well as their existing relationships with VA, they should be considered preferred providers, with private community providers in a lower tier.

The current structure of the CCN does not make such distinctions, though VA could evolve the network in logical ways that would result in a tiered network. As discussed in the prior recommendation, VA intends to identify “preferred providers” based on completion of certain training requirements. We believe that VA can, and should, continue to evolve this concept by creating a higher tier for DOD, IHS, and academic affiliate providers who meet the competency standards and training requirements. However, the current status of this recommendation is not fulfilled.

## RECOMMENDATION 5

*CURRENT STATUS: TO BE DETERMINED*

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

Section 122 of the VA MISSION Act requires VA to develop and implement a training program for employees and contractors on how to administer non-Department health care programs. In response to comments in VA’s June 5, 2019, VCCP final rule, VA is providing training to TriWest and Optum, the new third-party administrators (TPAs), regarding administrative processes. According to VA, a three-pronged approach to training was developed, which covers a wide range of benefits available under VCCP—from the new urgent care benefit to new contractual arrangements to new technologies to support the VCCP, and more.

- First, to prepare staff for the launch of the VCCP, VA hosted a conference with a series of program-specific workshops for key VA Medical Centers (VAMC) and VISN stakeholders in May 2019. This conference provided a crucial forum for information exchange and educational training on key tools, programs, and insights needed for the successful transition to VCCP on June 6, 2019.

- Second, to facilitate the implementation of the VCCP, VA hosted live virtual trainings for VA stakeholders. During these sessions, VA staff had the ability to engage and ask questions to program managers and subject matter experts.
- Third, the Office of Community Care training team created 11 e-Learning courses made available to VA staff and contractors through the VA Talent Management System (TMS). The specific courses are in the table below.

e-Learning Courses	
An Overview of Community Care	Provider Exclusionary Management
Decision Support Tool (DST)	Urgent Care 101
Eligibility 101	Urgent Care 201
Eligibility 201	Veterans Care Agreements (VCA) 101
Emergency Care Reimbursement 101	What’s New in Community Care
Introduction to the Community Care Network (CCN)	

VA reported that since the trainings went live in Spring 2019, the courses have collectively been taken over two million times by VA staff and contractors across the country with a high level of satisfaction ratings that the content was useful and helpful. While the provision of this training meets the first part of our recommendation, until we can determine whether the training is adequately reaching all VA employees and contractors, and whether the content of the training will lead to tightly managed networks and seamless coordination of care for veterans, the status of this recommendation remains to be determined.

## RECOMMENDATION 6

*CURRENT STATUS: TO BE DETERMINED*

***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, veteran-centric process for scheduling appointments within the integrated networks, VA must receive sufficient resources to develop new scheduling systems, including self-scheduling options that veterans can easily access and use. To be successful, VA must receive sufficient funding, personnel, and IT support to develop these new systems on time. As VA begins implementation of its new, commercial off-the-shelf software for electronic patient records, every effort must be made to keep this vital project appropriately resourced and on schedule. This will ultimately lead to better communications between VA and its provider networks on all aspects of patient care and management.

Among their many duties and responsibilities, VA Medical Support Assistants (MSAs) are responsible for scheduling patients for treatment. While VA has increased its hiring in this occupation across the system over the last three fiscal years, there remains a vacancy rate of approximately 13 percent, and a higher than average turnover rate of about 11 percent [the average in the Veterans Health Administration (VHA) is approximately nine percent]. VA is to be commended for its efforts to address this problem by increasing the pace of hiring and onboarding this occupation through a program called Hire Right Hire Fast. This occupation is currently now well below the suggested Office of Personnel and Management timeframe of 80 days, averaging approximately 65 days from identifying the hiring need to the boarding of the employee. VA has also implemented new scheduler training, which includes technical and customer service skills and standardizing processes and procedures, with more than 58,000 employees completing the required training.

VA should review attrition rates in light of VA scheduling responsibilities being delegated to the Third-Party Administrators, as well as review those specific actions leading to such a high turnover rate to find ways to address this loss of experience and investment.

According to VA, the Veteran Appointment Online Scheduling (VAOS), formerly known as the Veteran Appointment Request (VAR) App, is enabled at 139 VA sites for veterans to request appointments for primary care, mental health, amputation services, audiology, clinical pharmacy, continuous positive airway pressure (CPAP) clinic, food and nutrition, MOVE! program, ophthalmology, optometry, sleep medicine, and social work.

Although 139 VAMCs out of 170 represents a majority, it is a fraction of the nearly 1,100 sites at which veterans receive care from VA. Moreover, not all 139 VAOS-enabled sites allow veterans to self-schedule and cancel appointments resulting in limited capability for veterans to manage and schedule their own medical appointments via a website and smart devices. Moreover, less than 500 appointment requests from approximately 300 individuals have been made for community care using VAOS.

On May 17, 2018, VA entered into a ten-year sole-source contract with Cerner Government Services, Inc. (Cerner) to acquire the Cerner Millennium Electronic Health Record (EHR) system to achieve health information interoperability, enhance business performance, and improve veteran and clinician user experience. This contract was amended to plan, manage, and support implementation of a stand-alone resource-based scheduling system—the Cerner Scheduling Solution (CSS)—in all VA facilities five years in advance. The Chalmers P. Wylie Ambulatory Care Center in Columbus, Ohio, has been chosen as the pilot site for CSS, with Go-Live scheduled for April 2020. Subsequently, the Louis Stokes VAMC in Cleveland, Ohio, will serve as a larger pilot site for CSS. This critical effort will require new and dedicated funding.

While progress has been made towards achieving the purposes of this recommendation, this effort is still in progress; thus, the current status remains to be determined.

## RECOMMENDATION 7

*CURRENT STATUS: TO BE DETERMINED*

***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.***

On January 5, 2019, VA published its final access standards for the VCCP. For primary care, mental health care, and non-institutional extended care services a veteran can choose to be seen by a covered non-VA provider, if VA cannot schedule an appointment for the covered veteran with a VA health care provider for the required care or service within 30 minutes average driving time of the veteran's residence; and within 20 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.

For specialty care, a veteran can choose to be seen by a covered non-VA provider if VA cannot schedule a specialty care appointment for the covered veteran with a VA health care provider for the required care or service within 60 minutes average driving time of the veteran's residence; and within 28 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.

*The IB* does not believe VA access standards are sufficiently specific to the different types of care provided by the Department. VA uses two variables: average drive time and wait time. *The IB* believes VA's access standards are just as arbitrary as the 30 day/40-mile access standards under the Choice program. The lack of clarity about how VA calculates the "average drive time," particularly how the effect of traffic is factored into the result, also raises



questions about whether these are appropriate measures.

As we wrote in our recommendation last year, “Unless these standards are realistically achievable and clinically appropriate, either veterans or the VA system will suffer negative consequences.” Unfortunately, there are signs that such standards may not be achievable. For example, the contracts with the new CCN providers (TriWest and Optum) have lower access standards compared to those that VA adopted. In fact, VA acknowledges that some areas of the country do not have enough public or private health care providers to meet these access standards today. Further, VA has not yet been able to meet even the previous 30-day wait time access standard. Since 2014, the number of veterans waiting at least 30 days for primary care appointments has risen from 406,000 to over 740,000.

While the access standards are relatively easy to understand and apply in most circumstances, there remain questions about how average drive time is calculated, uncertainty over whether VA’s adopted access standards can be achieved for every veteran seeking care, and concerns about how these access standards will affect the overall VA health care system. Since these standards have been in effect for less than a year, and the CCN providers have not yet completed taking over their regions, there is not yet sufficient data to answer these questions. Thus, the status of this recommendation remains to be determined.

## **RECOMMENDATION 8**

*CURRENT STATUS: NOT FULFILLED*

***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.***

The entire purpose of the VA MISSION Act was to ensure that veterans could receive timely, high-quality care, regardless of where they lived. To this

end, Section 104 of the law, now 38 USC 1703C(a)(1), states that:

*“The Secretary shall establish standards for quality regarding hospital care, medical services, and extended care services furnished by the Department pursuant to this title, **including through non-Department health care providers....”***

Ensuring that veterans receive the same high-quality care from non-VA providers was a core principle underlying the agreement reached among stakeholders supporting the final compromise that became the VA MISSION Act. Veterans will not benefit from expanded access to non-VA care if that care is not both timely and high-quality. However, despite this clear statutory language and repeated statements of congressional intent from authors of the legislation, VA did not apply the same quality standards to non-VA providers operating in the new CCN.

In March 2019, VA submitted a document titled, “Report to Congress on Health Care Quality Standards,” stating its intent to use 31 initial measures to assess quality. Subsequently, on October 3, 2019, VA published a notice in the Federal Register adopting standards for quality, which included 27 initial measures, largely mirroring the prior report to Congress. However, VA did not apply these standards to non-VA community care providers.

Similarly, VA’s access standards for driving and waiting times were also applied only to VA, not community providers in the CCN. As VA acknowledges, timely care is a core attribute of quality care. Yet, VA deviated significantly from its own access and quality standards in establishing contracts with Optum and TriWest. For example, while VA’s wait time standard for primary care is 20 days, the contract with Optum establishes a 30-day requirement. For specialty care, the VA drive time standard is 60 minutes, but the Optum contract sets the drive time at 100 and 180 minutes for rural and highly rural veterans, respectively. Further, it is not even clear whether Optum must meet those standards 100 percent of the time, as VA must do, or what consequences or accountability measures are in place.

We recognize that establishing appropriate quality metrics is an ongoing and iterative endeavor, not just for VA, but for the entire public and private health care sectors. However, when VA itself cannot meet an access or quality standard, it makes little sense to refer veterans to a non-VA provider unless that care is at least the same or better quality and can be delivered in a more timely manner. If the private sector is unwilling or unable to match VA's access and quality standards, VA must consider whether it needs to find new community partners or whether the access and quality standards are realistic and feasible.

VA has stated its intention to work in conjunction with other public and private health systems towards developing quality standards and metrics; however, veterans currently have no assurance that care delivered through the CCN will be at least the same quality that VA is required to provide. Therefore, the current status of this recommendation is not fulfilled.

## RECOMMENDATION 9

*CURRENT STATUS: TO BE DETERMINED*

***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.***

Key to maximizing the value of both VA medical facilities and the CCN under the VA MISSION Act is the determination of when care should be provided by community providers. While The IBVSOs believe that most veterans have expressed a preference for care within the physical walls of VA facilities by VA providers, we recognize that such care cannot always be delivered with the current resources at VA's disposal. The IBVSOs also recognize, however, that clear and consistent criteria for the provision of care by community providers must be developed and implemented in order to make sure that VA can fulfill its mission to care for veterans.

Under the VA MISSION Act, a veteran may be eligible to seek care in the CCN if, "...the Veteran and the referring clinician agree that it is in [the Veteran's] best medical interest to see a community provider." 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.

According to VA, "best medical interest" is to be considered when a veteran's health and/or well-being would be compromised if they were not able to be seen in the community for the requested clinical service. When using this community care eligibility criteria, the ordering provider should include the following considerations: nature or simplicity of service; frequency of service; need for an attendant; and potential for improved continuity of care. "Best medical interest" is not to be used solely based on convenience or preference of a veteran. VA indicates that its providers have received training via announcements, live webinars, national calls, and online.

VA's definition of "best medical interest" leaves a lot of room for varying and changing interpretations in the future. It does not provide an adequate definition of "best medical interest," the criteria for selection, or the process involved, including any right to appeal or reconsideration. It is also not yet clear if VA's criteria are being consistently applied or if veterans are being provided sufficient information to make truly informed decisions about their medical treatment options. The IBVSOs strongly urge VA to define all three. Without goalposts and markers, it is difficult to chart a course to a goal or determine how the journey is going. For these reasons, the status of this recommendation remains to be determined.

## RECOMMENDATION 10

*CURRENT STATUS: TO BE DETERMINED*

***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.***

Section 101(e) of the VA MISSION Act [now U.S.C. 1703(m)(2)(B)], authorized VA to designate medical service lines that were not complying with VA's quality standards, thereby triggering eligibility to use the CCN for veterans seeking such care at VA. Once a service line is so designated, VA is then required to implement a remediation plan to bring the service line into compliance with the quality standards, per Section 109 of the Act.

Last September, VA began reviewing all medical service lines at each health care facility. The factors VA used for consideration, per 38 CFR 17.4015, are:

- Clinical significance
- Likelihood and ease of remediation
- Recent data
- Number of affected veterans
- Impact on patient outcomes
- Collateral effects

According to VA, very few facilities reviewed had failed to meet established quality standards, with the exception of the flu vaccination standard; however, VA already does far better than the private sector on that measure. Among those with subpar quality measures, only three also failed to meet timeliness standards. In explaining the decision not to designate any service lines, VA cited additional considerations, such as new leadership, recent favorable trends, and the fact that veterans at these sites already have eligibility for community care based on waiting times.

The IBVSOs recognize that comparing quality between VA and community providers is difficult, particularly at the service line level, and we believe it is appropriate for VA to be cautious in having more veterans seek non-VA care without assurances that the quality will be at least as good as VA. However, we are concerned that VA is not yet using this authority as an opportunity to improve the quality of VA's own service lines through focused remediation efforts and the provision of additional resources. In the future, we hope that VA will use this authority as an opportunity for self-improvement so that veterans have access to the highest quality care.

Given that VA has not yet designated any service lines for remediation and the uncertain role that "additional considerations" will play in future decisions, the status of this recommendation remains to be determined.

## RECOMMENDATION 11

*CURRENT STATUS: TO BE DETERMINED*

***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.***

As noted under Recommendation 10 above, VA has not yet designated any medical service lines for remediation, as authorized by Section 109 of the VA MISSION Act. As such, it is not possible to determine at this time whether VA has received, or will allocate sufficient funding, personnel, and other resources to improve the quality of care of its service lines.

Also, as noted above, we hope that VA takes advantage of this remediation authority to improve the quality of care provided to veterans, and that sufficient funding is requested and appropriated in the FY 2021 budget. For now, the status of this recommendation remains to be determined.



## RECOMMENDATION 12

CURRENT STATUS: NOT FULFILLED

***VA 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.***

The IBVSOs were pleased that the VA MISSION Act included an “urgent care” option; although, the actual medical services authorized are better described as “walk-in care.” However, we strongly opposed VA’s regulatory action to exercise a discretionary authority in the law to apply copayment requirements on service-disabled veterans after their third visit to a CCN urgent care facility. In all other circumstances, VA is prohibited from collecting copayments from veterans receiving care related to a service-connected disability or from veterans with at least a 50 percent disability rating from VA, regardless of whether such care is received in a VA or CCN facility. Therefore, we call on VA or Congress to remove this urgent care copayment requirement so that VA’s copayment rules for service-disabled veterans are consistent, regardless of the type of care or whether the care is provided directly by VA or through the CCN.

Furthermore, we recommend that VA reconsider its overall approach to using copayment requirements to regulate veteran usage of non-VA urgent care. For example, VA could institute a nurse advice line to help direct veterans to the most appropriate level and location for the care they are seeking, which at the DOD has shown promising signs of limiting patients’ use of unnecessary, more costly options, such as emergency care.

In addition, we continue to believe that enrolled veterans will be better served by a more comprehensive “urgent care” benefit, similar to what is standard in most public and private sector health care plans. We call on VA and Congress to work with VSOs and other experts to develop and implement such a plan.

Given the above, the current status of this recommendation is not fulfilled.

## RECOMMENDATION 13

CURRENT STATUS: TO BE DETERMINED

***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.***

VA must ensure veterans are aware of how VCCP operates, how community care integrates with VA’s network of care, as well as the evidence-based advantages and disadvantages of exercising VA or non-VA care options. Though VA informed VSOs and other stakeholders about how they intended to launch VCCP, The IBVSOs believe that the conversation was one-sided. VA developed its plan internally, kept it close-hold, and only once the plan was ready to roll out were VSOs contacted for the purpose of disseminating VA’s message. Such an approach fails to take advantage of VSOs’ collective knowledge and experience in reaching and educating veterans about new policies and programs.

VA must recognize that VSO stakeholders are critical partners in ensuring that veterans understand new, complex programs like VCCP. When VA works collaboratively with VSOs, we can help identify pitfalls in messaging or mitigate confusion among the populations we serve.

While VA did develop and implement an education program about VCCP, we remain concerned about its effectiveness and believe more can be done to promote the advantages of choosing the VA system. Moving forward, as changes to VCCP emerge—particularly adjustments to community care networks—VA must truly collaborate with its VSO partners and other non-VA stakeholders to ensure veterans understand how to most effectively navigate the new program. This education and outreach about the VCCP are a multi-year effort, and since this recommendation has been only partially fulfilled, the status remains to be determined.

## RECOMMENDATION 14

*CURRENT STATUS: NOT FULFILLED*

***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 minimum “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.

For FY 2020, *The IB* recommended over \$88.1 billion for VHA, which includes \$18.1 billion for VA's Medical Community Care account to fully and faithfully implement the VA MISSION Act. In December 2019, nearly a quarter into FY 2020, Congress provided \$83.9 billion in total budget authority, including \$15.7 billion for VA's Medical Community Care account. In all, Congress appropriated about \$4.2 billion less than what *The IB* recommended.

VA's revised appropriation request for FY 2020 did not include any additional funding for the Medical Services account despite an expected increase in demand due to the new access standards for the VCCP. VA did, however, request additional funding of \$98.8 million for the Medical Support and Compliance account to go toward the Office of Community Care.

Moreover, VA requested an additional \$4.5 billion for Medical Community Care to fund \$2.470 billion in VA MISSION Act related costs (i.e., \$2.2 billion for new access standards and \$260 million for urgent care) and \$2.1 billion for the consolidation of the new VCCP and to sustain community care obligation levels from traditional community care and the Veterans Choice Fund. Essentially, VA did not request sufficient funds for the VA health care system despite the increasing demand for care in VA facilities.

Congress unfortunately did not include any additional funding beyond VA's request for FYs 2020 and 2021. For FY 2021, Congress provided advance appropriations that substantially increase Medical Community Care funding by 12.4 percent whereas VA Medical Care funding only increased by 8.4 percent. This *IB* recommendation has not been fulfilled.

## RECOMMENDATION 15

*CURRENT STATUS: NOT FULFILLED*

***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.***

*The IB* agrees with the Commission on Care and Independent Assessment commissioned by the Veterans Access, Choice, and Accountability Act of 2014, commonly known as the Choice Act, which concluded that a lack of sufficient resources has hindered VA's ability to meet the rising demand on its health care system. The Veterans Choice Program (VCP) illustrated that demand for health care from veterans has outpaced VA's ability to increase capacity, whether it was delivered in the community or within the walls of a VA facility.

The VCCP was funded through emergency mandatory appropriations created by the Choice Act and subsequently replenished with additional emergency mandatory appropriations for a grand total of \$19.4 billion, \$615 million of which remained unobligated by the end of FY 2019 and was transferred to the

discretionary Medical Community Care account for FY 2020. However, even as the number of access points and options for enrolled veterans increased through the Choice program and now with the VA MISSION Act's CCN, demand for VA care continues to rise even faster.

VA health care is funded under the nondefense functions of the federal budget. Since the enactment of the Budget Control Act of 2011 (BCA), nondefense appropriations have been subject to sequestration-level budget caps. *The IB* is glad that BCA caps were amended in previous years to allow for continued increases in appropriations for VA health care. For FY 2020, however, Congress enacted appropriations for VA's medical care accounts that were nearly \$5 billion less than recommended by *The IB*. Congress's inability to meet the Administration's request for VA health care is greatly influenced by budget caps.

When Congress deliberated the Bipartisan Budget Act of 2019, which amended the BCA budget caps for FYs 2020 and 2021, it considered whether to exempt the VA MISSION Act expenditures from nondefense caps. VA estimates the law will cost \$8.9 billion in FY 2020 and \$11.3 billion in FY 2021. A bipartisan proposal to exempt the projected cost from FY 2020 and 2021 caps was rejected by Congress and the Administration. Doing so left the Appropriations Committees hard-pressed to allocate the Military Construction, Veterans Affairs, and Related Agencies Subcommittees enough resources to meet the growing demand for resources for the VA health care system. We continue to call on Congress to make structural changes to the federal budget and appropriations process to ensure that the full demand for care through VA is able to be funded by Congress each year. Until such permanent changes are made, this recommendation is unfulfilled.

## RECOMMENDATION 16

CURRENT STATUS: FULFILLED

***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.***

Section 152 of the VA MISSION Act established a new VA Innovation Center to, "...develop innovative approaches to testing payment and service delivery models in order to reduce expenditures while preserving or enhancing the quality of care furnished by the Department." The law provided VA with a very broad waiver authority, however, as part of the compromise that cleared the way for this section. Specifically, Congress would have to approve such waivers. In order to remain faithful to the overall compromise agreement of the VA MISSION Act, we recommended that VA not seek to resuscitate proposals that had been rejected, particularly those that sought to reduce the level of care offered by VA in order to increase non-VA private sector care.

Last December, VA submitted its first Innovation Center pilot program waiver request to Congress, which proposes to increase access to dental services for enrolled veterans ineligible for dental services through VA by connecting them with community-based, pro bono, or discounted dental service providers. On January 13, 2020, the House approved the waiver request, which must also be approved by the Senate. The IBVSOs also have no objection to this pilot program from the Innovation Center.

While this first action by the Innovation Center complied with our recommendation, we are concerned that the waiver request submitted by VA, and approved by the House, did not provide any details about what specific authorities would be waived. In the future, we urge Congress to require that VA specify which authorities will be waived, along with a justification for each such waiver. However, for now, this recommendation is fulfilled.

## RECOMMENDATION 17

*CURRENT STATUS: TO BE DETERMINED*

***VA must fully and faithfully implement the provisions of the VA MISSION Act that would enhance VA's ability to hire quality medical personnel, as well as provisions to expand VA care to rural and underserved areas.***

In addition to expanding access to community care, the VA MISSION Act included significant provisions to increase VA's internal capacity to provide care. Section III of the Act created or enhanced a number of programs to support VA's recruitment and retention of health care professionals, including the VA Health Professional Scholarship program; Education Debt Reduction program; Specialty Education Loan program; Veterans Healing Veterans Medical Access and Scholarship program; Recruitment, Relocation and Retention Bonuses program; and a new pilot program on Graduate Medical Education and Residency. Section IV of the Act provided VA with new authorities to improve access to care in underserved areas through expansion of VA's telehealth programs and the establishment of new health programs in rural and underserved areas.

While some of these new authorities and programs have already begun, VA was unable to provide *The IB* with sufficient information to allow us to assess whether all of the authorized capacity enhancement programs are being fully and faithfully implemented. For now, the status of this recommendation remains to be determined.

## RECOMMENDATION 18

*CURRENT STATUS: NOT FULFILLED*

***Congress should amend Section 203(b)(3) of the VA MISSION Act to fully align the "Capacity and commercial market assessments" required for the VA Asset and Infrastructure Review (Title II, Subtitle A) with the "Market Area Assessments" required under Title I, Subtitle A --Developing an Integrated, High-Performing Network.***

As noted in Recommendation 1, the VA MISSION Act contains two separate sections that each require market area assessments. Section 106 of the law establishes a "Quadrennial Veterans Health Administration review," which requires VA to perform "market area assessments" every four years to inform a "VA Plan to meet Health Care Demand." Section 203 establishes procedures for VA to make recommendations as part of the Asset and Infrastructure (AIR) and requires VA to complete "capacity and commercial market assessments" to inform the AIR process.

Although the law clearly intended these to be two separate and distinct assessments, for two separate purposes, VA has interpreted the law to require only one set of assessments to satisfy both statutory requirements. The first round of Section 106 market assessments was intended to inform VA as it established the CCN, which would then be repeated every four years to improve and optimize each local network. The Section 203 assessments were intended to provide an updated look at VA's infrastructure, after the CCN was established in order to inform the AIR process, which was intentionally scheduled to occur after the local networks had been established and provided time to stabilize. This approach more accurately captures data reflecting changes to veterans' patterns of seeking care under the new eligibility criteria once the CCNs were fully operational, and after capacity enhancements in the VA MISSION Act were fully implemented. Therefore, we call on Congress to work with VA to ensure that market assessments utilized for the AIR process contain accurate data that reflects all of the changes implemented by the VA MISSION Act, even if this requires new market assessments or a delay in starting the AIR process. In addition, it is critical that VA conduct these market assessments, as well as all aspects of the AIR process, in a transparent manner, fully collaborating with VSOs and other key stakeholders from the beginning of the process.

Given the critical importance of properly realigning VA's health care infrastructure for decades to come, it is more important to get this done right, than to get it done quickly. For now, this recommendation has not been fulfilled.



## RECOMMENDATION 19

*CURRENT STATUS: TO BE DETERMINED*

***In consultation with VSO stakeholders and Congress, VA should develop and implement a communications plan over the next two years to increase awareness and understanding among veterans, the public, and the media about the purposes and processes involved in the asset review.***

As noted in *The IB* policy recommendations report for the 116th Congress, previous attempts by VA to realign its infrastructure have been significantly hampered and curtailed due to public and congressional opposition over local and parochial concerns. For that reason, we recommended that VA partner with VSOs to develop and implement a communications plan to educate veterans, the public, and the media about the coming AIR process well in advance of 2021 when it commences. To date, VA has not reached out to The IBVSOs to discuss such a plan and we are unaware of any other outreach or activities by VA to undertake such a joint communications initiative before the AIR process begins. We again urge VA to work with us and other VSOs on such an undertaking as soon as possible, because it will be less effective as the AIR process nears, and particularly once it begins. For now, the status of this recommendation remains to be determined.

## RECOMMENDATION 20

*CURRENT STATUS: NOT FULFILLED*

***Congress must continue to appropriate, and VA must continue to request and properly allocate, sufficient funding to maintain VA's existing health care infrastructure and expand capacity to deliver care in locations where demand for care justifies additional VA infrastructure.***

Although the AIR process does not formally begin until 2021, history has shown that once a review of VA assets is planned, Congress tends to scale back infrastructure funding until the process is complete. In the past, particularly during the Capital Asset Realignments for Enhanced Services (CARES) process

in the early 2000s, reduction of infrastructure funding not only limited VA's capacity to meet rising demand, it also endangered veterans and VA employees in aging facilities, some of which required immediate improvements for life-safety problems. To avoid this problem with the AIR process, Congress specifically required that VA continue to request sufficient construction funding. However, for FY 2020, *The IB* estimated that VA needed a minimum of \$3.5 billion for major and minor construction, whereas VA requested and received less than half that amount. *The IB* recommends that VA and Congress significantly increase funding for VA's infrastructure as required by this provision beginning immediately, not just once the formal AIR process gets underway in 2021. For now, this recommendation has not been fulfilled.

## RECOMMENDATION 21

*CURRENT STATUS: TO BE DETERMINED*

***VA must continue to increase its internal capacity and expertise to maintain existing infrastructure, and build or lease new facilities, by hiring additional personnel and implementing the covered training curriculum and the covered certification program required by the VA MISSION Act.***

Regardless of the scale and scope of infrastructure changes that ultimately come out of the AIR process, VA must improve the management and oversight of its capital asset portfolio. Additionally, VA must begin to increase the number of construction professionals in the Department to prepare for greater construction activity during and after the AIR process. Without additional information about VA's progress in hiring additional personnel, the status of this recommendation remains to be determined.

## RECOMMENDATION 22

*CURRENT STATUS: NOT FULFILLED*

***Congress and the Administration must resolve problems caused by Congressional Budget Office (CBO) and Office of Management and Budget (OMB) budgetary scoring rules for leasing federal facilities that have made it so difficult for VA to extend current or initiate new leases for health care facilities.***

As a result of decisions by OMB and interpretations by CBO, under current congressional Pay-As-You-Go (PAYGO) rules, Congress is required to offset the full 10-year lease cost of new or extended leases during the first year; thereby, scoring it as if it were the same as a capital purchase. Due to the enormous overall score of such leases, Congress has been unable to overcome the PAYGO requirements for offsets and VA has had greater difficulty leasing new and necessary facilities. This problem must be resolved prior to initiation of the AIR Act provisions in order to ensure that the infrastructure modernization and realignment can be successful. For now, this recommendation has not been fulfilled.

## RECOMMENDATION 23

*CURRENT STATUS: TO BE DETERMINED*

***VA must accommodate a more variable set of family members serving as caregivers.***

While older veterans' participation in VA's comprehensive caregiver program is unlikely to fluctuate, their caregivers' involvement likely will. Younger veterans tend to rely consistently on a spouse or a parent for care. Older veterans, on the other hand, are less likely to have a spouse still capable of the physical demands of providing daily care for their serious, chronic, and disabling conditions. We anticipate adult children, nieces, nephews, or other family or community members of veterans to provide care in greater numbers. It is not uncommon for families to rotate primary caregiving responsibilities after a period of time. This trend is likely to continue as the parents of post-9/11 veterans age out of their caregiving role in the decades to come.

Effective communication with caregivers by caregiver support coordinators; adequate provision of mental health services and respite; and tailored training that addresses issues of aging and disability will be critical. Caregivers for pre-9/11 veterans are more likely to endure physical strain. Maintaining a veteran with severe physical disabilities means they are bending and lifting for a duration that is likely to jeopardize their own health. Consequently, VA must be able to accommodate rotating caregivers, and provide the training they need in order to sustain their veteran and maintain their own health.

As of this writing, regulations have yet to be proposed to improve VA's Comprehensive and General Caregiver Support Program to address the dynamic nature of older veterans' support system of family caregivers; therefore, the status of this recommendation remains to be determined.

## RECOMMENDATION 24

*CURRENT STATUS: NOT FULFILLED*

***VA must implement and sustain the IT system required, prior to extending eligibility.***

Congress judiciously required an IT system be in place prior to expansion of the comprehensive family caregiver program to properly manage and support the program, avoid the delays in access, and immediately identify resource needs. The law required such implementation by no later than October 1, 2018, and a report to be submitted to Congress and the Government Accountability Office (GAO) on the implementation as well as the certification of the IT system to begin the first phase of extending eligibility.

In March of 2019, VA redirected its efforts for a third attempt to implement an IT solution to fully support the VA Caregiver Support Program. The new IT project referred to as the Caregiver Record Management Application (CARMA) uses a commercial product to be configured to meet both VA's needs and the requirements under the VA MISSION Act.

GAO has identified the need to collect and report to the national program office complete staffing data for the Family Caregiver Program that includes program office funded staff, VAMC funded staff, and staff that assist the program as a collateral duty at each VAMC. GAO has also recommended VA identify and use an interim solution to collect data on the caregiver program's required quarterly contacts and annual home visits until a new IT system is implemented.

VA has indicated multiple versions of CARMA, each offering additional capabilities, will be released in order to meet VA MISSION Act requirements. The first CARMA version was released in October 2019, replacing the existing IT system and allowing improved program reporting such as system-wide reports on the completion of the required quarterly contacts with family caregivers and annual visits to veterans' homes. The second release, planned for January 2020, is intended to refine initial functionality and improve stipend processing capabilities. Additional product releases are expected at least through the summer of 2020 to incorporate new capabilities, such as online application submissions for veterans and the ability to connect to existing VA systems that manage veteran and caregiver identity and relationship management.

According to GAO, however, it is unclear what additional work may be necessary to accommodate the expansion of the comprehensive family caregiver program given that the Department is only in the early stages of planning. Further, the Department has not yet established a target date for certifying CARMA. According to VA Office of Information and Technology officials, the cost for CARMA is estimated to be between \$5.7 million and \$6.3 million, but additional costs for licensing and modifications to legacy systems are also expected.

In April 2019, VA awarded Acumen Solutions the CARMA Phase 1 Minimum Viable Product (MVP) Task Order in the amount of \$3,841,491.19 to perform implementation and integration services. The scope of the Phase 1 MVP is to replace the existing system, Caregiver Application Tool, used by the Caregiver Support Program with an application built on the Salesforce platform. The new system will

have improved functionality to process and manage program applications, allow for manual determination of eligibility, provide improved program monitoring and tracking, and capture call records and referrals by the Caregiver Support Line.

*The IB* recommends staffing data collection and reporting should include VISN staffing for the Family Caregiver Program. In addition, *The IB* recommends, the Caregiver Support Program office demonstrate CARMA to VSOs and Congress to ensure it will address all the requirements identified by the VA MISSION Act and by the program office.

Despite having 16 months to prepare, VA failed to implement the required IT solution and delayed the expansion until later this summer at the earliest. As a result, thousands of aging and World War II, Korean, and Vietnam era veterans and their caregivers are forced to continue waiting for critical support. Congress must take action to ensure VA begins expansion of the program at the earliest possible date. Until then, this recommendation has not been fulfilled.

## RECOMMENDATION 25

CURRENT STATUS: TO BE DETERMINED

***Eligibility determinations must clearly prioritize the clinical needs of the veteran.***

In the years to come, the majority of caregiver program participants will be older veterans with greater challenges to their independence. Administrative and clinical eligibility and personal care needs assessments will likely be more difficult to resolve for elderly veterans—as will determining what personal care needs are a result of service-connected rather than nonservice-related conditions. Assessing the personal care needs of veterans based solely on service-connected conditions can be extremely difficult—especially when comorbid conditions contributing to the veteran's functional limitations is a common occurrence. Spending clinical time picking apart the degrees of personal care needs that would require a caregiver does not serve the well-being of the veteran and is an imprudent use of clinical time.



VA has not published its rulemaking to address issues concerning administrative and clinical eligibility determinations that will be used when the comprehensive family caregiver support program is extended to veterans severely injured before September 11, 2001. *The IB* recommends the proposed rulemaking include an unambiguous explanation of the process for determining whether a personal care need is a result of service-related or nonservice-related conditions when those conditions are inextricably intertwined. Until the regulation is final, the status of this recommendation is undetermined.

## **RECOMMENDATION 26**

*CURRENT STATUS: TO BE DETERMINED*

### ***VA must sufficiently staff and resource the Program of Comprehensive Assistance for Family Caregivers.***

Issues of insufficient resourcing and hiring of Caregiver Support Coordinators (CSCs) has burdened the program throughout portions of the country. VA must request sufficient resources for the management and staffing of this program. Without sufficient staff to respond to the needs of veterans, any efforts at successful expansion will be severely compromised.

VA's Office of Inspector General recommended in its August 2018 report that VA establish a staffing model to ensure medical facilities were well equipped to manage the program's workload, including processing veteran and caregiver applications and routine monitoring of the veteran and their caregiver. A September 2019 GAO report recommended VA collect complete staffing data on the Caregiver Support Program, establish a process to ensure the accuracy of the program staffing data, and establish an interim method to collect system-wide data on required contacts and visits by the VA medical centers.

At the start of FY 2020, there were nearly 19,300 post-9/11 participants in the Comprehensive Caregiver Support program. A total of 76,000 pre-9/11 veterans are expected to enter the program by full expansion. It is of the utmost importance that VHA right size and revise its program governance and workload as

quickly as possible. Caregiver support coordinators, adequate provision of mental health services, respite care, and tailored training that addresses issues of aging and disability will be critical for the expansion's success. Caregivers for pre-9/11 veterans are more likely to endure physical strain while maintaining a veteran with severe physical disabilities than younger caregivers. VA must be able to accommodate rotating caregivers and provide the adequate and relevant training they need in order to sustain their veteran and maintain their own health.

In support of the caregiver expansion, the program office is hiring more than 680 new staff. The additional personnel should help; however, *The IB* remains concerned whether this number is sufficient to accommodate new veterans and caregivers being enrolled in the program without accurate and detailed program workload and staffing data. *The IB* recommends VA accompany the proposed hiring of 680 additional staff with detailed justification about how it will successfully meet the increasing demand. Until such information is forthcoming from VA, or determined through other means, the status of this recommendation remains to be determined.



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For more than 30 years, *The Independent Budget* veterans service organizations (IBVSOs)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW)—have worked to develop and present concrete recommendations to ensure that the Department of Veterans Affairs remains fully-funded and capable of carrying out its mission to serve veterans and their families both now and in the future. Throughout the year, the IBVSOs work together to promote their shared recommendation, while each organization also works independently to identify and address legislative and policy issues that affect the organizations’ members and the broader veterans’ community.

#### **DAV (Disabled American Veterans)**

DAV empowers veterans to lead high-quality lives with respect and dignity. It is dedicated to a single purpose: fulfilling our promises to the men and women who served. DAV does this by ensuring that veterans and their families can access the full range of benefits available to them; fighting for the interests of America’s injured heroes on Capitol Hill; linking veterans and their families to employment resources; and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life. DAV, a non-profit organization with more than one million members, was founded in 1920 and chartered by the U. S. Congress in 1932. Learn more at [www.dav.org](http://www.dav.org).

### **Paralyzed Veterans of America (PVA)**

Paralyzed Veterans of America (PVA), founded in 1946, is the only congressionally chartered veterans service organization dedicated solely for the benefit and representation of veterans with spinal cord injury or disease. For more than 70 years, the organization has ensured that veterans receive the benefits earned through their service to our nation; monitored their care in VA spinal cord injury centers; and funded research and education in the search for a cure and improved care for individuals with paralysis.

As a life-long partner and advocate for veterans and all people with disabilities, PVA also develops training and career services, works to ensure accessibility in public buildings and spaces, and provides health and rehabilitation opportunities through sports and recreation. With more than 70 offices and 33 chapters, PVA serves veterans, their families, and their caregivers in all 50 states, the District of Columbia, and Puerto Rico. Learn more at [www.pva.org](http://www.pva.org).

#### **Veterans of Foreign Wars of The United States (VFW)**

The Veterans of Foreign Wars of the U.S. (VFW) is the nation’s largest and oldest major war veterans’ organization. Founded in 1899, the congressionally-chartered VFW is comprised entirely of eligible veterans and military service members from the active, Guard and Reserve forces. With more than 1.6 million VFW and Auxiliary members located in 6,200 Posts worldwide, the nonprofit veterans’ service organization is proud to proclaim “NO ONE DOES MORE FOR VETERANS” than the VFW, which is dedicated to veterans’ service, legislative advocacy, and military and community service programs. For more information or to join, visit our website at [www.vfw.org](http://www.vfw.org).





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