



**THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON**

August 2, 2016

**The Honorable Barack Obama
President
The White House
Washington, DC 20500**

Dear Mr. President:

Two years ago, you tasked me to transform the Department of Veterans Affairs (VA) for the 21st Century. Since then, VA has established a comprehensive, enterprise-wide transformational process named MyVA, which has already increased Veterans' access to health care and begun improving Veterans' experience of VA's benefits and services.

The direction we have taken and the progress we have made has been largely validated by the Commission on Care (Commission) in its Final Report, which VA received on July 7, 2016. After thoroughly reviewing the report, and receiving input from our Veterans Service Organizations (VSOs), I am pleased to say that 12 of the Commission's 18 recommendations are objectives VA has already accomplished or has been working toward for the past two years as part of the MyVA transformation. Although we differ with the Commission on some details and are pursuing alternative approaches where warranted, we agree with the Commission that many changes planned by MyVA, recommended by the Commission, and strongly supported by VSOs, will likely require resources and remedies that only Congress can provide. These issues and our many transformation efforts are summarized in the enclosure to this letter.

VA strongly disagrees with the Commission on its proposed "board of directors" to run the Veterans Health Administration (VHA). Such a board is neither feasible nor advisable for both constitutional and practical reasons. The U.S. Department of Justice has concluded that the Constitution prevents Congress from appointing persons to exercise authority over Executive branch agencies and as such, would prevent the proposed board from exercising the authorities assigned to it by the Commission. The Commission's proposal would also seem to establish VHA as an independent agency, undoing the work of the VSOs in creating VA as a Cabinet-level department. The powers exercised by the proposed board would undermine the authority of the Secretary and the Under Secretary for Health, as well as weaken ownership of the MyVA transformation and VHA performance. This could potentially disrupt and degrade VA's implementation of critical care decisions that affect Veterans. The proposed independent VHA agency would also run counter to our ongoing efforts to improve the Veteran's experience by integrating Veterans health care with the many other services provided to Veterans by the Veterans Benefits Administration and the National Cemetery Administration.

At present, VA is served by 25 advisory committees, including a newly reconstituted Special Medical Advisory Group, which consists of leading medical practitioners and

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administrators, and a newly established MyVA Advisory Committee, which brings together business leaders, medical professionals, government executives, and Veteran advocates. These advisory committees advise VA on strategic direction, facilitate decision making, and introduce innovative business approaches from the public and private sectors. With their help, the Department has begun the process of transforming VHA from a loose federation of regional health care systems to a highly integrated national enterprise, based on a new model of care with VA as both the payer and provider. This model will provide Veterans with the full spectrum of health care services and additional choice, but without sacrificing VA's foundational health services upon which many Veterans depend. Additionally, many VSOs fear that the Commission's vision would compromise VA's ability to provide specialized care for spinal cord injury, prosthetics, traumatic brain injury, post-traumatic stress disorder, and other mental health needs, which the private sector is not as equipped to provide.

In October 2015, VA submitted to Congress our *Plan to Consolidate Community Care*, which lays out our vision of a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. This plan incorporates feedback from key stakeholders, including VHA field leadership and clinicians, representing diverse groups and backgrounds. VA has already begun what work we can without legislation to make the plan a reality. Over the course of the last 12 months, our Choice Provider Network has grown by 85 percent. The network now has over 350,000 providers and facilities across the Nation. Over 930,000 unique Veterans have used the Veterans Choice Program (VCP). Over 100,000 Veterans with 40-mile eligibility used VCP through May 2016. Authorizations for care under the Veterans Access, Choice, and Accountability Act (VACAA) have increased by 82 percent over 9 months (October 2015 to June 2016), and VCP authorizations have quadrupled from approximately 380,000 in fiscal year (FY) 2015 to almost 2 million in FY 2016.

However, VA cannot accomplish the ongoing transformation through MyVA or recommended by the Commission without critical legislative changes and funding. VA has aggressively pursued these needed changes and funding. As you know, more than 100 legislative proposals for Veterans were included in your 2017 Budget. Many of these proposals are vital to maintaining our ability to purchase community care. We continue to work to move these critical initiatives forward and are encouraged by the fact that most have been considered in legislative hearings or included in omnibus bills moving towards floor consideration, like the bipartisan *Veterans First Act*, which passed the Senate Veterans Affairs' Committee unanimously. These bills include some of the provisions of the *Purchased Health Care Streamlining and Modernization Act* we submitted to Congress in May 2015, such as enhanced-use lease authority, compensation reform for medical professionals, and a measure of budgetary flexibility to respond to Veterans' emerging

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needs and overcome artificial funding restrictions on providing Veterans care and benefits. These provisions would go a long way toward ensuring the success of MyVA, but other important legislative issues still need to be addressed, especially the consolidation of VA's many purchased care authorities and modernization of VA's archaic claims appeals process.

Your strong support for Veterans has been critical to the progress made so far, but VA needs Congress' assistance to make the transformation intended by the Commission and already underway in MyVA to accomplish the changes needed to serve Veterans as they need and deserve to be served now and for generations to come.

Thank you for your continued support of our Nation's Veterans

Sincerely,

A handwritten signature in blue ink that reads "Robert A. McDonald". The signature is written in a cursive style with a long horizontal flourish at the end.

Robert A. McDonald

Enclosure

Enclosure
August 2016

**Department of Veterans Affairs
Review of the Commission on Care**

Over the past two years, the Department of Veterans Affairs (VA) has been working energetically, through its MyVA initiative, to transform the Veterans Health Administration (VHA) from a loose federation of regional health care systems to a highly integrated national enterprise, based on a new model of care with VA as both the payer and provider. This model will provide Veterans with the full spectrum of health care services, plus more choice, but without sacrificing VA's foundational health services that many Veterans depend on.

In October 2015, VA delivered to Congress a plan for evolving our current system into a high-performance network based on timely access to foundational services and integration of private-sector providers. Building on more than a decade of working with community partners through multiple mechanisms, this plan would consolidate the various mechanisms, expand our network of providers, and enhance the network's capability to deliver services essential to Veterans' health.

Many of the Commission on Care's (Commission) recommendations are aimed in the same direction and are already being implemented as part of VHA's MyVA transformation. VA finds 15 of 18 Commission recommendations feasible and advisable (#1-3, 5-8, 10-16, and 18) and 3 not feasible or advisable (#4, 9, and 17). VA is already implementing changes with the same intent as 12 recommendations (#1-3, 5, 7-8, 10-11, and 13-16); recommends alternative approaches to 2 recommendations to bring them in line with other MyVA reforms (#6 and 12); and will work with the President, Congress, Veterans Service Organizations, and other stakeholders on recommendation #18.

Many of the Commission's recommendations also require action by Congress. VA has aggressively pursued legislative changes and funding that would enable VA to achieve its MyVA vision. More than 100 proposals for legislative changes were included in the President's 2017 Budget. VA also submitted to Congress in May 2015 the *Purchased Health Care Streamlining and Modernization Act*, parts of which have been incorporated into the *Veterans First Act* in the Senate. Many of VA's proposals, which are vital to maintaining our ability to purchase non-VA care, are pending Congressional action.

Recommendation #1: VHA Care System

"Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which Veterans will access high-quality health care services."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach to achieve the vision described above.

In October 2015, VA submitted to Congress its *Plan to Consolidate Community Care*, which lays out our vision of a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. This plan incorporates feedback from key stakeholders, including VHA field leadership as well as clinicians, representing diverse groups and backgrounds.

Immediate steps to improve the stakeholder experience were identified and included in the plan, including reducing unnecessary steps in the processes to enroll and connect Veterans with community care; improving communications between VHA, provider, and Veterans; improving care coordination in the long term for Veterans through improved exchange of certain medical records; and aligning the Veteran's community care journey along five major touch points: eligibility, community care network, referral and authorization, care coordination, and provider claims payment.

Eligibility: The Plan recommends the creation of eligibility criteria to streamline the many different requirements for community care into standard criteria without opening community care to all enrolled Veterans. This is VA's principal point of difference with the Commission on its proposed VHA Care System. VA believes the Commission's recommendation to extend community-care eligibility to all Veterans by eliminating the Veteran Choice Program's (VCP) current time and distance criteria (30 days and 40 miles) is not advisable without Congressional funding due to the expected cost increase and desire to not sacrifice VA's four statutory missions: delivering hospital care and medical services to Veterans, educating and training health professionals, conducting medical and prosthetic research, and providing contingency support to other Federal agencies during emergencies. Many VSOs fear that the Commission's vision would jeopardize VA's ability to provide specialized care for spinal cord injury, prosthetics, traumatic brain injury, posttraumatic stress disorder (PTSD), and other mental health needs, which the private sector is not as equipped to provide. For this reason, VA opposes elimination of the current time and distance criteria.

Community Care Network: VA has since begun developing the requirements for the new community-care network contract, with standards and criteria developed from input by industry, facility staff, and program office staff representing a broad spectrum of needs. These standards and criteria will be included in the draft Request for Proposal (RFP) for the community care network that will open for bid later in calendar year 2016. **Legislation is needed** to improve Veterans experience by consolidating existing programs and standardizing eligibility criteria.

Referral and Authorization: To ensure that Veterans have access to the full spectrum of health care services, VA will focus on areas in which it can excel (VA-delivered foundational health services) and develop locally defined community partnerships for specialty care as needed. Standards and criteria for specialty care referrals are currently being developed for inclusion in the draft RFP. While the primary care provider will coordinate referrals for specialty care within the integrated VHA Care System, VA should be seen as the prime provider for special emphasis services. For example, VA is the leader in integrating primary care and mental health care and should be seen as the primary care provider for these services. When VA cannot provide a primary care provider, Veterans will be able to select from credentialed providers in the high-performing network.

Care Coordination: The Plan stresses care coordination with a focus on customer service, emphasizing the need for care coordination for Veterans who receive community care as well as in VA. This coordination would include both the primary care provider staff as well as other VA staff. In cases where VA cannot provide the care coordination for Veterans, the services may be provided through the community care network. In other cases, VA coordinators make more sense. This is true in the Alaska VA Healthcare System, where VA staff will fill an intermediary role currently performed by VCP contractor TriWest to make scheduling an inherently VA activity, in response to local concern that calling out-of-state VCP contractors resulted in delays in care coordination, mostly attributed to time-zone differences and a lack of understanding of Alaska's unique geography.

Provider Claims Payment: VHA is also already working to streamline reimbursement methodologies among its various community care programs and to develop a standardized, transparent process for reimbursing providers in an integrated delivery network. VHA and the Centers for Medical and Medicaid Services (CMS) are identifying CMS innovations in value-based payment methods on a limited basis. **Legislation is needed** to revise reimbursement rates under the Veterans Access, Choice, and Accountability Act to allow for flexibility from Medicare fee-for-service reimbursement methodologies to value-based methodologies of the future.

Legislation is needed to effectively consolidate existing community care programs, which would reduce confusion among Veterans, community providers, and VA staff. The Commission states that in order to achieve the recommendations, VA must have "flexible and smart procurement policies and contracting authorities." VA strongly agrees and has aggressively pursued legislative changes that would ensure that the appropriate level of flexibility is available to best serve Veterans. In May 2015, VA submitted the *Purchased Health Care Streamlining and Modernization Act* to Congress. This legislation supports key points of VA's *Plan to Consolidate Community Care* and would allow VA to enter into agreements with individual community providers outside of Federal Acquisition Regulations, without forcing providers to meet excessive compliance burdens.

VA is also concerned that the Commission's cost estimates do not accurately reflect the likely cost of its proposed system. From a baseline estimate of \$71 billion, the Commission estimates that the cost of its recommended option for Veterans' health care for fiscal year (FY) 2019 ranges from \$65 billion to \$85 billion, with a middle estimate of \$76 billion. However, the Commission estimates the cost could increase to \$106 billion in FY 2019 if VA is unsuccessful in tightly managing the network and focusing on costs. We appreciate the analysis underpinning the Commission's estimates, but caution that the cost of implementing the Commission's recommendation is likely to be significantly higher, for the following reasons:

- The estimates do not include the substantial investment in information technology (IT) resources that would be required to fully integrate VA care with community care or the administrative/contractual costs of operating the community-delivered services component of the integrated network.
- The estimates assume that VA can realign and consolidate personnel in five years to best provide health care to Veterans, which is an aggressive timeline.

- The estimates do not address the cost of realigning or divesting capital assets as additional care is delivered in the community. While VA agrees in principle with the Commission's recommendation to develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs (see Recommendation #6), we note that the realignment, consolidation, and divestiture of capital assets will require substantial resources and time.
- The estimates are highly dependent on Veteran enrollment in, reliance on, and utilization of VA health care, all of which are difficult to predict, as most Veterans enrolled in the VA health care system have other sources of health care coverage. Extending community care to more Veterans could cause Veterans who now rely on Medicare, Medicaid, or private insurance to use VA care for more of their health care needs because of lower copays or greater convenience, increasing VA's costs.
- Finally, we must caution that the estimates do not reflect the entire VA Medical Care budget as they do not include the cost of programs that are not modeled by the VA Enrollee Health Care Projection Model. These programs include readjustment counseling, non-medical homeless programs, Caregivers, Health Professions Educational Assistance Program, Income Verification Match, CHAMPVA, Spina Bifida, Children of Women Vietnam Veterans, etc. In total, they are estimated to cost \$8.2 billion in FY 2017.

Recommendation #2: Enhancing Clinical Operations

“Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach.

VHA is already engaged in processes to make full use of the skills held by VHA providers and other health professionals. VHA is a leader in the use of clinical pharmacists to increase capacity by renewing prescriptions or ordering medication refills independently, after the initial prescription by a licensed physician or nurse practitioner. In addition, many VA clinical pharmacists have a scope of practice that provides prescribing authority and enables them to run pharmacist-managed clinics focused on medication therapy management for chronic diseases. For example, about one third of all prescriptions for the treatment of the Hepatitis C virus are written by clinical pharmacists

VHA has also developed a draft regulation that would standardize full practice authority for advanced practice nurses, to assure a consistent continuum of health care services by the practitioners across VHA and decrease the variability in advanced nurse practice that currently exists as a result of disparate State practice regulations. The proposed draft regulation was published in the *Federal Register*, we are now reviewing comments

received. Implementation of full practice authority will increase Veteran access by alleviating the effects of national health care provider shortages on VA staffing levels and enabling VA to provide additional health care services in medically under-served areas. Implementing this policy, as recommended by the Commission, will allow VA to parallel the policies of other Federal agencies, including the Department of Defense (DoD) and the Indian Health Service, as well as many institutions in the private sector.

VHA's Diffusion of Excellence initiative is an operational infrastructure that allows for sharing of promising practices across the enterprise. This model incentivizes and institutionalizes the identification and diffusion of practices nationwide so that every facility has the opportunity to implement the solutions that are most relevant to them. In the first round of submissions, 13 Gold Status Best Practices were selected from more than 250 ideas through a series of reviews and a final "Shark Tank" competition. The next step assigned each Gold Status Best Practice and their originating Gold Status Fellows to Action Teams managed by the Diffusion Council for implementation VHA-wide.

VA seconds the Commission's call for Congress to relieve VHA of bed-closure reporting requirements under the Millennium Act. The Act's arbitrary requirements have not kept up with changes in the Veteran population or the health care environment. **Legislation is needed** to remove the Act's bed change reporting codified at 38 U.S.C. 8110(d) and the staffing level and service requirements specific to such bed changes under section 38 U.S.C. 1710B(b), while retaining staffing and service requirements for all other Extended Care Services. VA would replace the mandated congressional reporting of bed closures with a stronger, clearer, and more stringent internal process to review and if appropriate, approve bed closure proposals.

VA is already moving forward to hire and train more clinical managers and medical support assistants (MSAs). In response to Section 303 of the Veterans Access, Choice, and Accountability Act of 2014 (PL 113-146), each VA Medical Center now has a Group Practice Manager (clinical manager). Additional hiring and training of these group practice managers will continue through February 2017. VHA is also developing new training and hiring procedures for MSAs throughout the organization as part of MyVA. VA has developed and launched an MSA hiring project called "Hire Right, Hire Fast" and is currently piloting a new hiring procedure that allows for industry-standard bulk hiring of MSAs to hire MSAs within 30 days of a vacancy. Two-week, standardized onboarding training for all new MSAs is also being developed and piloted. Both new processes will begin being deployed nationally this fall.

Recommendation #3: Appealing Clinical Decisions

"Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach, taking into account important differences between the mission and authority of the VA health care system and other Federally-supported programs.

VHA is already in the early stages of developing a regulation in response to the Commission's recommendation. This regulation will establish a cohesive baseline national policy for clinical appeals. A clinical appeals regulation will be published for notice and comment in accordance with the Administrative Procedure Act. Recently enacted legislation in section 924 of the Comprehensive Addiction and Recovery Act of 2016 establishes an Office of Patient Advocacy in the Office of the Under Secretary for Health. In addition, in 2015 VHA established the Office of Client Relations to assist Veterans clinical care access concerns.

An interdisciplinary panel will be tasked with evaluating feedback from these offices and other Veteran support resources to improve the overall clinical appeals process, consistent with external benchmarks and factors described by the Commission, Federal regulations and statutes, and sound clinical practice. The resulting recommendations may differ in certain aspects from those envisioned by the Commission, but will undoubtedly be a uniform, fair, world-class clinical appeals process that protects Veterans and is fully compliant with law and regulation. VA's revised process will complement the Veterans Experience Office's efforts to better serve Veterans, make improvements based on customer feedback, and engage the community.

Recommendation #4: Consolidation of Improvement Efforts

“Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.”

VA finds this recommendation neither feasible nor advisable, but is already implementing an alternative approach that institutionalizes continuous improvement as part of VA's MyVA transformation.

Health care improvement takes place within a complex socio-technical system with multiple aspects of technology and technical expertise. Placing improvement under an engineering system, such as the Veterans Engineering Resource Center (VERC), may harness the technical aspects of improvement, but it will not provide the balance of critical cultural and people aspects. VA believes doing so would unbalance safety and efficiency and not be successfully transformational.

Ongoing VA transformation efforts have been achieved by specifically aligning VERC assets with enterprise priorities so that appropriate engineering perspectives and skills are interwoven with current organizational priorities. To institutionalize VHA's commitment to continuous improvement, VHA will realign the VERC and the operational improvement arm of Strategic Analytics for Improvement and Learning (SAIL) under the Principal Deputy Under Secretary for Health. This will elevate the health-system subject matter experts who drive transformation in VHA's organizational structure, while continuing to use the VERC to ensure that supporting engineering resources are available across all VA transformational efforts.

Additionally, VA's enterprise approach to improving performance—through Lean Six Sigma (Lean) tools and training, Leaders Developing Leaders training, MyVA Performance Improvement Teams, MyVA Communities, the MyVA Ideas House, and many other initiatives across the VA system—has taught us the value of a central repository for local programs and ideas, both successful and unsuccessful. To that end, VA and VHA have embraced the Integrated Operations Platform (IOP) hub, a knowledge-management technology platform developed by the VERC in partnership with subject matter experts. The IOP consolidates information on continuous improvement activities across VA in key programs, and as a result, best practices and innovation activities are currently visible in one common platform.

VA has invested significantly in developing Lean capacity at local levels so that problem solving is done at the lowest level and with a team of safety, quality, and improvement professionals. This prepares the local facilities to improve their current environment while scanning constantly for emergent new problems.

Recommendation #5: Eliminating Healthcare Disparities

“Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.”

VA finds this recommendation feasible and advisable and is already working to address each of the Commission's concerns as part of VA's MyVA transformation.

VA's Office of Health Equity (OHE) was established in 2012 with the mission of championing health equity among vulnerable Veterans. The office developed the Health Equity Action Plan (HEAP) in 2014 in conjunction with the Health Equity Coalition and with concurrence from the Under Secretary for Health. The HEAP is VHA's strategic roadmap to reducing Veteran health disparities. It aligns with the goals of MyVA and the VHA Strategic Plan. VHA will make health equity a priority by directing implementation of the HEAP nationwide.

The appropriate placement of OHE within the VHA organizational structure, along with adequate resources, will be considered as a priority component of the broader VHA restructuring addressed in Recommendation 12. This will take into account funding and staffing levels commensurate with the scope and size of Federal offices of health equity established in the Department of Health and Human Services, based on direction in the Affordable Care Act. VA will also identify health equity leaders and clinical champions in each VA District, Veteran Integrated Service Network (VISN), and Medical facility who can catalyze and monitor actions to implement the HEAP and further advance the elimination of health disparities.

VA has undertaken systematic actions to identify and address healthcare disparities and inequality. Examples include the development of Hepatitis C Virus Disparities dashboard projected, scheduled for launch by the end of FY 2016; data support and research collaborations with the Quality Enhancement Research Initiative designed to identify health care disparities; establishment of a Population Health office that has developed clinical case

registries focusing on the needs of special populations; and establishment of the Women's Health and Lesbian, Gay, Bisexual, Transgender (LGBT) program offices. VA Medical Facilities constitute 20 percent of Human Rights Campaign's Health Care Equality Index participants in 2016, and they were the only facilities to achieve leader status in some States.

Recommendation #6: Facilities and Capital Assets

“Develop and implement a robust strategy for meeting and managing VHA's facility and capital asset needs.”

VA finds this recommendation feasible and advisable but recommends alternative approaches as part of VA's MyVA transformation.

VA believes that the Commission's recommendation is critical to enabling the successful transformation of the large-scale health care system to a higher-performing integrated network to serve Veterans. Without a strong suite of capital planning programs, tools, and resources, VA will not be able to fully realize the benefits and Veteran outcomes expected from implementing an integrated health care network. VA also strongly agrees with the Commission that greater budgetary flexibility and greater statutory authority are essential to meeting VA's facility needs, realigning VA's capital assets, and streamlining processes to divest itself of unneeded buildings.

VA recommends alternative approaches to two issues:

- Once VA determines its mix of health care services and how they are provided at the market level based on the integrated health care approach, realignment of VA's capital infrastructure framework will be needed. Instead of a realignment process encompassing both assets and services based on DoD's Base Realignment and Closure Commission, VA proposes an independent facilities realignment commission (IFRC) to focus solely on VA's infrastructure needs once the mission services are determined. The IFRC would develop a systematic capital-asset-focused realignment plan for infrastructure needs to be presented to the Secretary of Veterans Affairs and the President for decision, with Congress approving or disapproving the plan on an up-or-down vote.
- With regard to focusing new capital on ambulatory care development, VA proposes a balanced approach to maintain needed infrastructure and other key services (e.g., rehabilitation, community living centers, and treatment for spinal cord injury, traumatic brain injury, polytrauma, and PTSD), while at the same time appropriately investing in ambulatory care in needed markets. The balanced approach would be based on a market-by-market determination of the appropriate mix of services to ensure Veterans have access to needed care.

VA agrees with the recommendation to move forward immediately with repurposing or disposing facilities that have already been identified as being in need of closing. Continued focus in this area is needed and VA is already working towards this goal, subject to the availability of staff and resources.

VA also acknowledges that there will be anticipated challenges in implementing such large-scale realignments and restructuring of VA's footprint. **Legislation will likely be required** facilitating changes to VA's capital infrastructure to implement a transformation of this nature, including:

- Establishing an IFRC to develop a systematic capital-asset-focused realignment plan.
- Streamlining processes to meet the intent of laws and regulations, such as the National Historic Preservation Act and the National Environmental Policy Act that would make repurposing and divestiture more timely and effective.
- Potentially restructuring appropriations to allow for more flexible transfer and reprogramming authority, including potential threshold adjustments.
- Exploring methods (both legislative and administrative) to take advantage of private-sector financing.
- Revising the major medical lease authorization process to align the requirements in concert with practices at other Federal agencies.
- Granting VA authority to retain and utilize proceeds generated from real property divestitures.
- Expanding enhanced-use leasing authority.

Further analysis will be required to determine the specific level of resource investments required to implement the Commission's recommendations. It is clear that significant additional resources will be required. In addition, divestiture of unneeded VA assets is unlikely to generate significant savings because of the upfront resources required to execute the divestiture and minimal market value of the majority of VA's assets. Without the proper resources, tools, and authorities, attempts to divest of assets or streamline capital project execution will not be effective.

Recommendation #7: Modernizing IT Systems

“Modernize VA’s IT systems and infrastructure to improve veterans’ health and well-being and provide the foundation needed to transform VHA’s clinical and business processes.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach, understanding that investments in IT will force difficult decisions concerning the allocation of limited financial resources among all VA programs and services, as well as across the Federal government.

As part of the MyVA Breakthrough Initiative to transform VA IT, VA will soon appoint a Senior Executive System (SES)-equivalent position for a Chief Health Informatics Officer (CHIO), reporting to the Assistant Deputy Undersecretary for Health for Informatics and Information, to collaborate with the VA Chief Information Officer (CIO) and the IT Account Manager toward developing a comprehensive health IT strategy and supporting budget proposal. The CHIO and ADUSH will be responsible for prioritizing all health technology

programs and initiatives, with strategic technological guidance from the VA CIO and IT Account Manager for health. To comply with the Federal Information Technology Acquisition Reform Act (FITARA), the CHIO does not take the place of the VA CIO, but instead works in concert with IT management to ensure that health initiatives are appropriately prioritized within the portfolio, while the CIO works with VA senior leadership so that all technology initiatives are prioritized holistically, thus ensuring complete Veteran care. VHA and VA's Office of Information and Technology (OI&T) are already collaborating on the vision and strategy for a single integrated Digital Health Platform (DHP).

VA has also established five district senior-executive Customer Relationship Manager positions to work with the local VHA, Veterans Benefits Administration, National Cemetery Administration, and staff office leaders, aggregate feedback for analysis by VHA and OI&T senior leadership, and enhance a continuous feedback loop. The VA CIO recently established the Veteran-focused Integration Process program within the Enterprise Program Management Office (EPMO) to facilitate continuous improvement and constant collaboration.

The Commission recommended that the VA CIO develop and implement a strategy to allow the current nonstandard data to effectively roll into a new system, and engage clinical end-users and internal experts in the procurement and transition process. VHA is currently working with OI&T to ensure that the Veterans Information Systems and Technology Architecture (VISTA) data is mapped to national standards. The new CHIO will be responsible for engaging clinical end-users in the transition to the new DHP. The Under Secretary for Health and the CIO will establish a joint program office responsible for the implementation of the DHP. This process will be focused on delivering and coordinating high-quality care for Veterans.

The EPMO is responsible for portfolio management and has adopted a policy of "best-fit, buy-first" in its Strategic Sourcing function. This ensures that existing best-in-class technology solutions are purchased whenever possible, rather than being developed and maintained by VA. These functions, in combination with the role and focus of the IT Account Manager, will provide the required focus for VHA to implement a comprehensive commercial off-the-shelf IT solution to include clinical, operational, and financial systems.

Recommendation #8: Modernizing Supply Chain

"Transform the management of the supply chain in VHA."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach.

VA believes the components of this recommendation that suggest establishment of a Chief Supply Chain Officer (CSCO) and realignment of all procurement and logistics operations under the CSCO executive position are feasible and advisable, but it recommends an alternative approach to fulfill the Commission's intent. The structural solution recommended by the Commission would not adequately address underlying management challenges associated with organizational complexity and the need to improve integration processes

impacting the supply chain. Realignment of VHA's supply-chain structure, including roles and responsibilities of the various VA Central Office staff offices, health networks, and medical facilities, should derive from and be integrated with the transformation of the overall VHA health care organization structure. The intent of the Commission will be met by addressing alignment issues as the supply-chain breakthrough initiative evolves and is synchronized with VHA's overarching strategies to transform VHA's organizational structure.

As an alternative, the intent of the Commission is already being addressed in an effective manner under the current MyVA Breakthrough Initiative to transform VHA's supply chain. This initiative is a more comprehensive approach to fulfilling the Commission's intent and is already driving much needed improvements in data visibility and quality, synchronization of technology deployments, standardization, contract compliance, and training. Already in FY 2016, VHA supply-chain transformation efforts have yielded approximately \$45 million in cost avoidance. VHA has also developed a two-year supply-chain transformation stabilization guidance that will put VHA in a far better position to make effective decisions and investments beyond FY 2018 for vertically aligning VHA's management structure and for more efficient sourcing and distribution of all clinical supplies and medical devices. This will increase the availability of supplies for the care of Veterans and result in cost avoidance for American taxpayers.

With regard to the component of the recommendation asking VA and VHA to establish an integrated IT system to support business functions and supply-chain management, although feasible it is more advisable that technology investments beyond those currently in the pipeline should be avoided until such time that a mature supply-chain baseline is established, upon which prudent future IT investment decisions can be based. This is especially important given VA's Financial Modernization System initiative and emerging plans for a new DHP, both of which will impact legacy and contemporary supply-chain systems and interfaces, as well as influence system-improvement alternatives and investment decisions over the next two to five years. Supply-chain system improvements must be integrated and synchronized with enterprise financial and health care system enhancements to achieve efficiencies in service delivery and support analysis of integrated data to meet VHA's current and future needs.

Finally, as suggested, VHA will continue to use VERC capabilities to support the transformation of supply-chain management in accordance with the MyVA Breakthrough Priority Initiative #12: VHA Supply Chain Transformation. As a point of clarification, the Commission report is technically incorrect in that the VERC is not leading the MyVA supply-chain modernization initiative; rather, the VERC is a highly valued enabling organization engaged by the VHA Procurement and Logistics Office to support the MyVA initiative.

Recommendation #9: Governance Board

“Establish a board of directors to provide overall Veterans Health Administration (VHA) Care System governance, set long-term strategy, and direct and oversee the transformation process.”

VA finds the Commission's recommendation neither feasible nor advisable due to its unconstitutionality. However, VA believes the intent of the Commission can be achieved regarding the term appointment of the Under Secretary for Health.

The U.S. Department of Justice has concluded that the proposed board of directors, as appointed and with the powers proposed by the Commission, would be unconstitutional for several reasons. Permitting Congress to appoint the board members would violate the Constitution's Appointments Clause (U.S. Const. art. II § 2, cl. 2), as well as the separation of powers, insofar as congressionally appointed board members would be exercising significant operational authorities within the Executive Branch. In addition, giving this board authority to reappoint the Under Secretary for Health would violate the Appointments Clause and the separation of powers. Finally, requiring the board to concur with the President in removing the Under Secretary for Health would give the board a veto authority over the President, impairing the President's ability to "take Care that the Laws be faithfully executed," (U.S. Const. art. II, § 3), and violating the separation of powers.

The proposed board would also seem to separate VHA from VA without necessarily insulating VHA from political pressure or improving VHA oversight or operations. The powers exercised by the proposed board would undermine the authority of the Secretary and the Under Secretary for Health and weaken ownership of the MyVA transformation and VHA performance, potentially disrupting and degrading VA's implementation of critical care decisions affecting Veterans. The independence granted VHA would run counter to our ongoing efforts to improve the Veteran's experience by integrating Veterans health care with the many other services VA provides through the Veterans Benefits Administration and the National Cemetery Administration. Furthermore, VA is already advised by the Special Medical Advisory Group, which consists of leading medical practitioners and administrators, and by the MyVA Advisory Committee, which brings together business leaders, medical professionals, government executives, and Veteran advocates with diverse expertise in customer service, strategy development and implementation, business operations, capital asset planning, health care management, and Veterans' issues. These committees already provide VA with outside expert advice on strategic direction, facilitating decision making and introducing innovative business approaches from the public and private sectors.

The Commission correctly notes that frequent turnover of the Under Secretary for Health has had a negative impact on VHA and greater stability in this important leadership position is needed. VA supports a term appointment of the Under Secretary for Health spanning Presidential transitions to ensure continuity of leadership and continued transformation of VHA. Previously, 38 U.S.C. § 305 provided for a four-year term for the Under Secretary for Health with reappointment possible, but this provision was removed in 2006. A term appointment could be reinstated, beginning with the current Under Secretary for Health. This is critically important at this juncture given the need to see the ongoing transformation of VHA through to completion. Under Secretary for Health candidates are currently recommended by a commission established solely for that purpose. More analysis is needed to determine length of tenure and timing of reappointment.

Recommendation #10: Leadership Focus

“Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA’s MyVA transformation, with some modifications in approach.

Recent or ongoing actions serving the Commission’s intent include:

- VA has established the MyVA Task Force to guide VA through the transformation and established a Department-wide MyVA transformation office, which has formulated an integrated plan for transformation and is organizing the work on 12 breakthrough priorities.
- Metrics and key performance indicators are in place for each breakthrough priority. Each breakthrough priority has a designated, accountable official who is a member of the senior leadership team and a near-full-time responsible official in charge of driving progress.
- One of the 12 breakthrough priorities in the MyVA Transformation is employee engagement, for which we have a comprehensive action plan.
- VA has also established a MyVA Advisory Committee (MVAC) consisting of business leaders, medical professionals, government executives, and Veteran advocates. VA leadership meets quarterly with the MVAC, leveraging them as a corporate board from which to seek counsel on the overall transformation.
- MyVA has engaged leaders and employees throughout the organization via Leaders Developing Leaders (LDL) (over 54,000 participants to date), VA101 (over 79,000 participants to date), various skills trainings, LDL projects, breakthrough pilots, broad communications to include the MyVA Story of the Week that goes out every Friday to all employees, and local initiatives.
- VA established MyVA district offices to facilitate transformation efforts throughout VA and also now conducts quarterly surveys of the VA workforce and incorporates this feedback into VA’s transformation actions.
- Secretary, Deputy Secretary, and Under Secretary for Health have provided role models for transparency, Veteran focus, and principles-based leadership.
- VHA programs and program offices and the Office Human Resources & Administration (HR&A) representatives have held regular meetings in the past year to discuss a single, benchmarked concept for organizational health and coordinate messaging.
- VHA’s National Leadership Council has endorsed personalized, proactive, patient-driven healthcare as one of VHA’s strategic goals and strongly supported the formation of organizational health councils.
- Many VHA facilities and networks have some version of an organizational health council already existing.
- All program offices and facilities receive employee survey data annually down to the workgroup level to facilitate action planning and improve employee engagement. Brief pulse surveys have recently been implemented to measure employee engagement at the facility level quarterly.
- VHA’s National Center for Organizational Development has use of Prosci change management materials and is pursuing a system-wide license.

Recommendation #11: Leadership Succession

“Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA’s MyVA transformation, with some modifications in approach.

VA is consolidating leadership training behind a model we created as part of our MyVA transformation called ILEAD. Previously, VA had multiple leadership models across VA, which led to no common language or culture of leadership, and the models were not customized for VA. The enterprise-wide ILEAD model will incorporate the principles of “servant leadership” and VA’s ICARE core values, aligned with the Federal Executive Core Qualifications. VHA and the VA Corporate Senior Executive Management Office are in the first stages of developing a competency model for VHA’s senior leadership positions that will incorporate VA’s ILEAD model with the technical competencies essential to successfully leading VHA’s complex clinical operations. The VHA senior leader competency models will ultimately cascade down through the organization and be incorporated in its hiring, development, performance assessment, and advancement programs.

VHA has outlined a leadership talent management strategy, benchmarked against the best practices in private industry, and begun initial development of processes and tools to give VHA greater insight and control over its health care leadership succession pipeline. Initial efforts are focused on creating a cadre of leaders to fill future medical center director positions. At the individual level, VHA senior executives serve as mentors to staff members, coaches for VHA leadership development programs, and models through their own leadership behavior.

Current VHA initiatives serving the Commission’s intent include:

- VHA made leadership development a priority of its MyVA effort, specifically to *develop and retain passionate leaders* to lead transformational efforts across the Administration.
- Filling key leadership position through a strong succession pipeline is identified as a priority for VHA in the 2016 *VHA Workforce and Succession Strategic Plan*.
- VHA has fully embraced the LDL philosophy—nearly 30,000 VHA employees have participated in the leader-led cascaded training since it began in September 2015.
- VHA’s National Leadership Council has adopted the VA leadership model, which now includes the concept of “servant leader.”
- VHA leaders are integrally involved in the development and conduct of its formal leadership development programs. Leaders serve as coaches and mentors to program participants, in addition to personally facilitating sessions on a wide variety of leadership topics.
- VHA established the Healthcare Leadership Talent Institute (HLTI) to provide coordinated focus to VHA’s talent management efforts. HLTI links VHA’s workforce-planning and talent-development programs through the design and

deployment of a set of talent management products and processes, which are in the pilot-testing phase.

- VHA is collaborating with the VA Corporate Senior Executive Management Office in implementing the December 2015 Executive Order on *Strengthening the SES*. These efforts include building a foundational leadership competency model for VA, instituting an executive rotation program to provide career-broadening experiences outside of each executive's current position, enhancing the SES performance management system, and outlining an SES-level talent-management process for VA-wide implementation.

Recommendation #12: Organizational Structures and Management Processes

“Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.”

VA finds this recommendation feasible and advisable but recommends an alternative approach to reorganizing the VHA Central Office (VHACO), consistent with VA's MyVA transformation.

VHACO has undergone a stepwise ascent to improving the organizational structure to be more responsive to field requirements through the development of large programs responsible for organizational excellence and developing the future state health care plan. Immediate reorganization would divert attention from key organizational priorities such as improving access to healthcare. Known challenges associated with reorganization (which occurs with the regularity of each presidential election cycle), are impaired employee engagement, loss of institutional knowledge, and diversion of attention from critical challenges such as insuring Veterans have same-day access to primary care and mental healthcare services. **Legislation would be required** to streamline appropriations, and review by oversight bodies would be impacted by the changes described. Finally, the reorganization for VHACO should derive from and be integrated with the transformation of the overall VHA health care organization structure. VHA will initiate a VHACO and VISN organization analysis at the beginning of calendar year 2017.

Recommendation #13: Performance Measurement

“Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach.

VHA is consolidating its healthcare operations metrics to provide a consistent, system-wide view of key performance indicators. In October 2015, VHA launched a Performance Accountability Work Group (PAWG) as a governance mechanism for performance measurement at all levels of the organization. The PAWG's first task was to conduct a systematic review of all existing performance measures (numbering over 500), which resulted in a core set of approximately 20 key indicators, aligned to industry-wide approaches. SAIL scoring system is a critical component of these indicators, as well as predictive trigger systems that are the main inputs into a health operations center, which will facilitate centralized quality management.

The leadership of the Office of Organizational Excellence (hereafter, 10E) has undertaken a strategic review across all current business processes to identify realignment opportunities—for instance, focusing ISO 9000 on its original target, which was the reprocessing of reusable medical equipment, and reinvesting the resources that will be freed up to enhance the ability of VERC to support the adoption of LEAN management approaches in support of the Under Secretary for Health's five priorities for strategic action.

We have also engaged a senior industry consultant to assist us with the process of executive recruitment and development; created a system-level VHA Performance Scorecard aligned along transformational priorities; simplified the template used for senior healthcare executive performance management plans; and started work to align business functions within the Office of Organizational Excellence to promote a unified approach to performance reporting, performance improvement, and the identification and spread of strong clinical and business practices.

Finally, the Diffusion of Excellence initiative (see Recommendation #2) sources best practices from frontline employees in the field, and brings the combined resources of 10E to support their implementation where appropriate in under-performing VA sites.

Recommendation #14: Cultural and Military Competence

“Foster cultural and military competence among all Veterans Health Administration (VHA) Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health care outcomes.”

VA finds this recommendation feasible and advisable and is already working to address the Commission's concern as part of VA's MyVA transformation.

VA has implemented training related to cultural and military competence, in some cases by partnering with external stakeholders (i.e., Equal Employment Opportunity Commission, the Joint Commission, Commission on Accredited Rehabilitation Facilities, DoD) and numerous national diversity-focused affinity and advocacy organizations. Examples of this coordinated training include Military Culture Training for Community Providers, Cultural Competency, Generational Diversity, Introduction to Military Ethos, Military Organization and Roles, Professional Stressors & Resources and Treatment Resources & Tools. From April 1, 2015, to July 22, 2016, the last four courses were accessed 2,533, 1,527, 1,172, and 1,070 times respectively. VA will continually assess its cultural and military

competence training portfolio for content, target audience, and training modalities to identify additional training needs.

VA Office of Diversity and Inclusion has mandatory training in the area of cultural competence as part of its Equal Employment Opportunity (EEO), Diversity and Inclusion, and Conflict Management training for all VA managers and supervisors and mandatory annual EEO, Workplace Harassment, and No FEAR training for all VA employees. VA also maintains programs focusing on targeted populations, including a LGBT Awareness Program (issues referenced in the Report), Office of Women's Health Services; Office of Health Equity; and a Center for Minority Veterans.

VHA also has a large portfolio of clinical training programs, including several in the area of cultural and military competence in healthcare delivery. The Office of Health Equity developed virtual patient cultural competency training under the Employee Education Service contract for the Virtual Medical Center project. Presently, military competence training is available to any provider, and they are encouraged to take the training. Providers currently under contract are not required to complete the course, but future contracts will require completion.

Recommendation #15: Alternative Personnel System

“Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.”

VA finds this recommendation feasible and advisable and is already working as part of VA's MyVA transformation, with some modifications in approach

VA supports the Commission's legislative proposal recommendation to establish a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority, provided outside stakeholders support the legislative and policy changes required to create this new system.

VA currently is preparing for consideration a legislative proposal for the FY 2018 budget process to modify 38 United States Code to give the Secretary the authority to establish a human-resources management system unique to VA.

In the absence of a simple-to-administer alternative personnel system, VA has also proposed modifications to existing statutes to provide some relief to the currently complex personnel system and also help with recruitment and retention. These proposals include establishing an appointment and compensation system under Title 38 for VHA occupations of Medical Center Director, VISN Director, and other positions determined by the Secretary that have significant impact on the overall management of VA's health care system. VA is considering proposals to do the following:

- Eliminate Compensation Panels for physicians and dentists, which have been found to be administratively burdensome.
- Eliminate performance pay for physicians and dentists, which has been found to be extremely difficult to administer.
- Establish premium pay for physicians and dentists to allow flexibility in scheduling and eliminate the daily rate paid to these occupations based on 24/7 availability.
- Modify special rate limitation to increase the maximum allowable special rate supplement providing enhanced flexibility to pay competitively within local labor markets.
- Exempt VHA health care providers appointed to positions under 38 U.S.C. 7401 from the dual compensation restrictions for reemployed retired annuitants.

The VHA Strategic Human Resource (HR) Advisory Committee and Workforce Management and Consulting's Human Resource Development group are proposing a comprehensive VHA HR Readiness Program designed to improve the overall operational capabilities of the VHA HR community. The program will identify and integrate all existing and available internal and external training resources into a clear, consistent, and logical roadmap to readiness.

Under the MyVA program, the Staff Critical Positions Initiative was launched to improve hiring of key leadership and other critical positions throughout VHA. VHA is moving ahead with the "Hire Right, Hire Fast" initiative for MSAs. The initiative is being piloted at a number of facilities and will provide products and guidance in 2016, including additional screening for customer service tools, an interview scoring rubric, job posting templates, HR milestone scripts, and much more. These products are designed to increase the supply of MSAs, as well as emphasize the customer service principles and skills needed for success.

VHA has embarked on a Rapid Process Improvement Workshop effort within the HR community to examine the hiring process and identify improvement opportunities, to include operational processes and policies. Plans are also under development to establish a centralized architecture to designate lines of authority in setting training requirements, career paths, etc.

Recommendation #16: Effective Human Capital Management

"Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system."

VA finds the Commission's recommendation both feasible and advisable and is already pursuing the following initiatives as part of VA's MyVA transformation.

Hire Chief Talent Leader and Grant Authorities: VHA currently has a national search underway for its senior most HR executive position. Presently that role does not possess the authority recommended by the commission. It is anticipated that the HR&A transformation program, and the efforts associated with Recommendation 12 in conjunction with the Under Secretary for Health, would work together toward the optimal organization

structure for HR across VA and within the administrations including appropriate authorities. This process will help clarify the ideal roles and responsibilities of the VHA Chief Talent Leader.

Transform Human Capital Management: As part of MyVA, VA HR&A has launched the Critical Staffing Initiative to improve the hiring of key leadership and other critical positions throughout the VA. This effort has been working on near-term improvements to hiring medical center directors and other key medical center leaders. So far, this project has identified and is beginning to implement significant improvements to the hiring process and to proliferate hiring best practices across the organization. VA HR&A is currently planning a process to engage stakeholders across VA to identify next steps for implementing the recommendations outlined in recent study commissioned by VA. A concept paper entitled “VISN HR Shared Service Excellence” is also being evaluated. This concept paper incorporates a number of recommendations contained within the white paper noted above, but with specific emphasis on HR roles within the VISNs and VA Medical Centers. The Commission’s recommendations will be taken into consideration in the process.

Implement Best Practices: The VISN HR Shared Service Excellence paper is heavily weighted toward the sharing of best practices that have been developed in a few highly performing field HR organizations. Best practice sharing is also a significant component of the MyVA Critical Staffing initiative. Also, the HR&A transformation effort is intended to rely heavily on health care and other industry best practice models.

Develop HR Information Technology Plan: The Commission’s recommendation addresses an issue which VA’s early HR transformation efforts are just beginning to address. While there are currently efforts planned and underway to implement HR Smart for personnel and payroll records, and USA Staffing to enable the recruiting process (acknowledged by the Commission), VA would benefit from casting these and other anticipated efforts in a more strategic IT plan. Such a plan would better enable implementation and integration prioritization and capital planning.

Recommendation #17: Eligibility for Other-than-Honorable Service

“Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.”

VA finds this recommendation neither feasible nor advisable.

The Commission’s own estimates indicate this change would cost \$864 million in FY 2019, increasing to \$1.2 billion in FY 2033. This recommendation therefore appears to contemplate health care for anyone with an other-than-honorable discharge. While VA agrees with the principle of serving this population of Veterans, the cost of doing so makes the recommendation not feasible at this time.

Many Servicemembers with other-than-honorable discharges qualify for health care for service-connected conditions and other benefits under existing authorities. VA will continue to serve this population. VA is also drafting proposed regulations which will update and clarify 38 C.F.R. §§ 3.12 and 17.34 to improve processes and procedures relating to

character of discharge determinations and expand tentative health care eligibility for certain former Servicemembers.

These changes will address many of the concerns raised by the Commission. For example, the rules will provide improved guidance about the consideration of mitigating factors such as extended overseas deployments, mental health conditions, and other extenuating circumstances. Also, VBA has, within the past year, updated its manual to streamline its other-than-honorable adjudicative procedures to expedite health care eligibility determinations and improve the Veteran experience by shortening the wait time.

Recommendation #18: Expert Advisory Body for Defining Eligibility and Benefits

“Establish an expert body to develop recommendations for VA care eligibility and benefits design.”

VA finds this recommendation feasible and advisable.

Substantial changes in the delivery of health care have occurred since Congress last comprehensively examined eligibility for VHA care through passage of Public Law 104-262, *Veterans' Health Care Eligibility Reform Act of 1996*, and taking a close look at eligibility criteria in light of current (and projected future) resources and demand makes sense in the context of VA's ongoing efforts to reshape the future of VA health care. VA will work with the President, Congress, Veterans Service Organizations, and other stakeholders to determine the path forward in the tasking of an expert body to examine and, as appropriate, develop recommendations for changes in eligibility for VA health care benefits.

Recommendation 18 also includes a separate and distinct recommendation for VA to “revise VA regulations to provide that service-connected-disabled Veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.” While VA supports the objective, VA already has regulations (38 C.F.R. 17.49) and policy in place giving priority in scheduling to service-connected Veterans and believes these meet and fulfill the Commission's intent.