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About IDA

IDA is a private, nonprofit corporation that manages three Federally Funded Research and Development Centers. Our mission is to answer the most challenging U.S. security and science policy questions with objective analysis leveraging extraordinary scientific, technical, and analytic expertise.

This newsletter is prepared by IDA's health research team. For more information, visit https://www.ida.org/research-and-publications/research/health-research or email healthteam@ida.org.

JON RYCHALSKI, ASSISTANT SECRETARY FOR MANAGEMENT AND CHIEF FINANCIAL OFFICER OF THE DEPARTMENT OF VETERANS AFFAIRS (VA)

Jon Rychalski is responsible for directing the budgetary, financial, capital asset management, and business oversight functions. He is also responsible for corporate analysis and evaluation.

Prior to this appointment, Rychalski was the acting Principal Deputy Assistant Secretary of Defense for Health Affairs and the Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy. Health Affairs is responsible for providing a cost-effective, quality health benefit to 9.6 million active-duty, uniformed service members, retirees, survivors, and their families enrolled in the Military Health System (MHS).

In 1989, Rychalski entered federal service with a commission through Air Force Officer Training School. After 3 years as a line officer, he was commissioned in the Air Force Medical Service Corps (MSC). While an MSC officer, he served in a variety of capacities, including Patient Administration Officer, Medical Readiness Officer, TRICARE Flight Chief, and Resource Management Officer. He also participated in an Education with Industry assignment at Long Beach Memorial Medical Center in Long Beach, California, and completed a tour at the Air Force Surgeon General's office as a staff officer. He left active duty in 2001. Rychalski holds a master's degree in management from the State University of New York Institute of Technology; a bachelor's degree in accounting from National College; and a bachelor's degree in Business Administration from Carroll College.

The VA has had 20 consecutive years of funding raises. What do you see for the future of the VA budget and what are the major policy issues? Do the VA's shifting priorities change the investment/resourcing strategy?

For the years that I've been at VA, there has been a lot of support for veterans. I think it has been both bipartisan and bicameral, and I have seen this grow over time. I wouldn't be surprised if the events in Afghanistan this week don't solidify that even more. [The interview took place shortly after the withdrawal of U.S. troops in Afghanistan.] So, I think that the VA budget is going to continue to grow. Whether it will grow at the same rate is to be seen—the growth curve has been quite steep. I think that the big issues moving forward are going to be: "What is the infrastructure necessary for the mission?" By some estimates, we have upwards of $50 to $100 billion necessary in order to recapitalize and upgrade VA facilities as the population of veterans shifts. The other thing that has been growing has been the matter of compensable conditions for veterans such as burn pits, Agent Orange expansions, and there is some pending legislation called the "Cost of War Act" for presumptive conditions. That substantially expands the list of conditions that are presumptive for toxic exposures. What we are really seeing from Congress is a proposed dramatic expansion of consideration for benefits for veterans who have been exposed to toxic substances. This is going to be very substantial, from a resource standpoint, depending on which way the legislation goes. I think our secretary's position is that rather than this being done legislatively, the VA could be and should be in a lead role, and we could have done a better job of looking at all the available science to determine if there are connections between exposure and disease instead of relying on the more limited sources they have in the past. So, I view that as something that is going to expand significantly, and I think we are going to see a change in how it is approached

with the VA taking a more proactive approach to investigate the causal factors and doing the epidemiology to support these decisions.

The other thing is just the general increase in the utilization of VA health care. For the people that use the VA system, we have seen them use the system more, and with the expansion of the MISSION Act [the VA Maintaining Integrated Systems and Strengthening Integrated Outside Networks Act of 2018, Public Law 115-182], we have seen veterans take advantage of more of the programs, for example, community care, urgent care, and others. We've seen costs go up dramatically in those areas. I see these trends in VA continuing, and to the extent that we are successful in attracting veterans, whether they are new or existing veterans to use the system, and they like the service and benefits they are receiving, I think you will see increases in the reliance on the VA system. I think collectively we will see the VA's budget grow, and these are many of the big ticket items.

The VA has undertaken an unprecedented period of modernization and reform. From your perspective, how can the department ensure the success of multiple, concurrent enterprise-wide modernization initiatives? Have there been any unforeseen challenges?

We have taken on a lot of modernization initiatives. We have the Electronic Health Record Modernization (EHRM), which is huge for us and not the first time we have attempted it. My own office is leading the Integrated Financial and Acquisition Management System (iFAMS), which is also not the first attempt—we've had two failed attempts. We also have percolating a transition in the logistics system and transitioning to DoD's Defense Medical Logistics Standard Support (DMLSS) and the web-based version of their system. In addition, there are a number of smaller initiatives. This leads a lot of people [to] say—and they're probably right—that a commercial organization would not take on three major modernization initiatives, but there is no question that it is sorely needed in the VA. Our systems are very antiquated. For example, our accounting system is over 30, almost 40, years old and is very unstable and difficult to use. The logistics system is almost nonexistent, and a new electronic health record (EHR), for the population we serve and the requirements, is much needed.

So maybe it is better just to jump into it. But to be successful requires very solid, advanced strategy and planning. It needs a lot of close integration, which is a little bit difficult in the VA because we are somewhat of a federated organization. So the close coordination is necessary, but this wasn't really resonant, and we did not have the strongest governance structures trying to bring all the parties together. In the last 4 years, especially the last 2 years, there has been a much more concerted effort to strengthen governance structures and ensure that we have the venues in place to do more effective planning and monitoring. They have started doing Operational Management Reviews and Program Management Reviews of the modernization initiatives, and I feel like there is much closer coordination. As you know, there was a strategic review of EHRM where they are taking a close look at the lessons learned from the first deployment and recalibrating how to move forward to make it more effective and efficient at the future deployment sites. We are doing the same thing to a certain extent with iFAMS. It's not a strategic review as much as looking at what they found with the deployment of EHRM to see if there is anything we can learn from their experience that could translate. I think the leadership of the big three modernization initiatives are now embedded in each other's working venues, so there is good situational awareness. There is no question that the VA sometimes needs to slow down a little bit to do more effective planning on the front end in preparation before we go out and pull the trigger on the solution. This is probably true for many organizations, but the VA is so big and complicated, it is a bureaucracy, it has this federated structure—it's even more important to make sure the plans are sound.

In contrast to DoD, which has dedicated acquisition professionals and program managers, do you think that not having a deep acquisition support staff has been a challenge for the VA? Or is that a capability the VA is developing to go along with these large enterprise acquisitions?

It has been because we don't do as much acquisition as DoD does. We don't have, for example, a CAPE [Cost Assessment and Program Evaluation] function or PA&E [Program Analysis and Evaluation] function that takes a look at some of these

things on the front end. As an example of that, we didn't do the life-cycle cost estimate of the EHRM program, or really for any of these programs, something you would never see in DoD. They have set milestones and gates that they have to go through. VA mostly delivers health care, and now we are going through these major modernization initiatives. We are now learning things that we could have or should have done because we do not buy these large systems all the time, and I think that has caused us some problems. However, going forward, it is not clear to me how much of the DoD acquisition functionality we will need. We have tried a couple of times to stand up a CAPE or PA&E function. We came to the determination that we don't need the same type of functionality in terms of major system acquisition or CAPE functionality that DoD has, but we do certainly need some of it. That's what we are trying to figure out—really what is the right mix for us moving forward based upon our needs.

The VA will be undertaking an evaluation of its brick-and-mortar infrastructure under the Asset and Infrastructure Review (AIR) Commission. What do you think it will take for the commission to be successful? Given the rapid pace of innovation within health care, how should the commission balance current needs with future capabilities?

I think there are two major pieces to make this successful. One is a really sound analysis of where we are currently, where the workload is shifting, and the types of needs that remain, and where those needs are located. Even more important than that, I think when it comes down to it, just like politics, all health care is local, and the commission's work is really going to have to make sense and resonate with the veterans, the VSOs [Veterans Service Organizations], and with members of Congress. When they make recommendations for where facilities should be located, the size of the facility, and the services that are offered, the people in those locations are going to have to look at the recommendations and say "that makes a lot of sense to me." If recommendations come out and there is a cognitive disconnect between what's being recommended and what people know to be true, then things will stall. I have seen this play out one or two times since being at VA. So, any recommendations made by the AIR commission are really going to have to make sense to the end user and members of Congress. If the report comes out and people think it is way off base, then it just won't work.

In reading the original AIR Commission legislation, it sounded as if we were headed toward a potential downsizing of the VA footprint. In more recent coverage, it sounds as if the new administration may be advocating for an expansion. Do you have a sense of where we might be headed?

In the time that I've been here I have seen more demand for VA services, but I do think the model needs to change a bit from the fixed VA-owned facilities to more flexible solutions, like leasing. We have an enhanced use-lease program that we use for living facilities for homeless veterans, where we may donate a building, or a private investor will build a building and then they provide housing to homeless veterans in exchange for vouchers. The point is that the investor takes the risk and constructs the building. They can do it much faster and cheaper than we can. We have been trying to get the same type of flexibility for the construction of medical centers and clinics. There has always been a CBO [Congressional Budget Office] scoring issue associated with it, which has held us back. But I think the model has to change to be more flexible and

innovative. It requires significant lead time to allow us to design and build a facility, and it is not always the best solution in some cases. In other cases, it takes us just as long to complete a major lease as it does to build a facility. It takes several years for a major lease, which is just too long and people have lamented that—and I know they are working on ways to improve that. I think ultimately we will see that the VA footprint will stay the same or grow, but it will be in different locations than what we see today due to the shifting demographics. Regardless, we will need solutions that can enhance our flexibility and agility. I don't see the VA shrinking anytime soon.

As we look to the future, what are the major management challenges that the VA will face? Are there actions the VA could take now to mitigate these challenges?

Definitely some of the things we talked about, like getting our footprint right, getting facilities that are new and attractive, and it's the modernization initiatives that are underway. We have to get these done and make sure they are working as intended for veterans. One of the other big things is attracting and retaining a qualified workforce and having a satisfied workforce. We compete with all other health systems, we're a huge system, and we don't always enjoy the same advantage that they do when it comes to things like pay flexibility. One major challenge has been attracting providers, so we have been in discussions with USUHS [the Uniformed Services University of the Health Sciences] to get slots there to train physicians or with HHS [Department of Health and Human Services] to train doctors, nurses, and psychologists. So, I think many of the challenges are enduring, but the modernization initiatives are throwing in a new twist. And then I think it will be about how the VA transitions to being more proactive. The VA should be on the leading edge and more anticipatory than reactive. In a large bureaucracy, this can be a real challenge, but we don't want to be late to the game. The other thing is modernizing the compensation and claims process. VBA [Veterans Benefits Administration] and the Board of Veterans Appeals—some of that work is very labor intensive—so when we expand the number of people who are eligible or the list of presumptive conditions, their only way to react is to hire more people, train them, and it takes considerable time to train people to the point where they are fully productive and reliable. We are looking at ways to automate and accelerate the process.

Are there any challenges or lessons learned from working in the VA's federated structure?

There definitely are challenges. Just in the 4 years that I have been here, we've had periods of time where quite a few of the senior leadership positions are vacant to times where most of them are full. One thing I've learned is that to the extent you can, build an enduring governance structure that can be there as people come and go whether you have a secretary or not, a deputy or not, CIO [chief information officer] or not. Then you have a venue and process in place to keep the engines running, and not just running, but so that also all the planning and decisions are done in a disciplined way that is well documented. VA did not have a terribly strong governance structure when I first joined, and gradually governance has gotten stronger over time. The key is to get the processes in place to make sure that it can endure. This makes working in the federated structure much easier. In the absence of a formal process, you have everyone doing their own thing and collectively heading in the same direction, but in very different ways. The organization can continue to thrive with strong governance, strong processes supporting it, and trying to make it enduring so people get used to it. You can take the DoD as an example. We don't have the POM [Program Objective Memorandum] process or PPBE [Planning, Programming, Budgeting, and Execution] the same way DoD does, but everyone within DoD knows that process, the timelines, and what it entails. That is a good example of the kinds of enduring processes the VA needs to build, so that no matter who comes and goes, everyone within VA knows how we do things.

You have held senior leader positions in both the DoD and the VA. Are there any lessons that one department could learn from the other? Will we see closer collaboration between the MHS and the Veterans Health Administration (VHA) in coming years? The MISSION Act expanded access to civilian providers similar to purchased care. How does the department forecast the costs associated with the expansion?

We talked about some of the things I would mention already: building enduring processes, absorbing some CAPE- or PA&E-like function. I do think, though, the VA has an advantage over the MHS in the health care realm in

regards to some of the academic affiliations, so you just can't help but see that there is a lot of opportunity for some synergy or economies of scale between the two. For example, we have the Community Care Network contracts, which are very similar to the TRICARE contracts, and it doesn't take a genius to think that at some point you could just combine the two. I know we have a different population, and in some cases offer a different benefit package because of the service-connected nature of the VA, but I still think you could get economies of scale by combining both programs and structuring the contracts with the same provider networks. I think this is a tremendous opportunity. I'd say the same thing about facilities. We've had collocated facilities, the James Lovell Federal Health Care Center, but in the future, and especially with the AIR Commission, it makes a lot of sense that you would try to fuse parts of the VHA and MHS infrastructure to have more facilities that draw upon the same infrastructure and fixed costs. There could be several models, whether it is the same people providing care to both service members and veterans or something closer to James Lovell, or maybe it is VA people treating veterans in other facilities. I think there is opportunity there; it is just a slow process and not everyone agrees it is a good idea. It's certainly going to depend on the nature of the arrangement, where it would be, and how it would serve veterans and the military. But, from a business standpoint, the opportunity exists, so I think we may see more of it. With the changes in the MHS and consolidation under the Defense Health Agency, there might be even more opportunities where DoD and VA do more planning and work together, or are able to have more facilities together. Whereas 5 or 6 years ago, it seemed unlikely that a James Lovell could be a potential model for the future—it seems much more possible today.

With the expansion of the MISSION Act, veterans had many more avenues to seek care. Have there been any challenges from a resourcing standpoint in forecasting and meeting the demand?

The MISSION Act has driven the demand for community care off the charts. It has been extremely popular, especially since there was a court ruling about VA paying for emergency care for certain veterans, even for care that was not service-connected. This has collectively driven our community care costs to grow really fast. I think one of the things the Biden administration and our secretary has said is that they want to find the right mix of community care. They weren't presupposing what the right mix should be, but generally we promote the VA direct-care system because it offers veterans a venue that understands their needs, their history, their background, any emotional issues, or things like that. But the MISSION Act expanded the aperture pretty dramatically and we see people taking great advantage. We've been fortunate because we have received adequate funding for the expansion so far, but the uptake has far exceeded our expectations. Keeping Congress and leadership informed of how we are executing and where there is growth has been key to maintaining their support.

Policy Watch

ASSET AND INFRASTRUCTURE REVIEW (AIR) COMMISSION

W. Patrick Luan

In Section 203 of the MISSION Act of 2018 (Public Law 115-182), Congress calls for the VA to assess the modernization or realignment of the Veterans Health Administration (VHA) physical infrastructure. According to the VA's notice of final action, these assessments will: "identify strategic opportunities to position VA to increase health care access points in locations where the demand for VA health care services is not being met, enhance Veteran experience, account for social determinants, consider health equity factors and serve as the coordinator of Veteran health care and services."

The VA has already developed the criteria that it will use to assess and make recommendations on individual VHA facilities. The selection criteria are broken out into the following six domains: Demand, Access, Impact on Mission, Quality, Cost Effectiveness, and Sustainability. The VA secretary will use the selection criteria to make recommendations to the AIR Commission regarding the modernization and realignment of VHA facilities. These recommendations will focus on creating veteran-centric outcomes that maintain or improve health-care services through the most equitable methods and at locations that are most beneficial to veterans.

The AIR Commission could consider several points when developing its recommendations. First, concurrent with the commission's efforts are ongoing reforms within the Military Health System (MHS) to right-size its own footprint. In some markets, both the VA and the MHS have strong presences in the same geographic regions. While the health systems of large metropolitan areas have the capacity to absorb additional patients, smaller or rural markets may be more likely to suffer from access constraints if the Department of Defense (DoD) and the VA both shift a large portion of beneficiary care to contracted civilian partners. Situational awareness of the DoD's ongoing reforms is paramount to the commission's supporting analysis.

Second, the VA supports a vast medical education and training enterprise. The VA's academic affiliations offer long-standing support to medical trainees at partner institutions across the country. A 2016 VA news release indicated that at least 70 percent of practicing physicians in the United States trained in the VA health-care system at one point in their careers. However, drastic changes in physical infrastructure may have unintended consequences for the medical training pipeline. To the extent possible, the VA should keep academic partners informed and mitigate any effects on graduate health education.

Third, the COVID-19 pandemic has accelerated adoption of many IT capabilities for health-care purposes. Virtual health capabilities have quickly filled gaps and enabled veterans to continue receiving care during the pandemic. As the pandemic wanes, it is unclear how much in-office care will be displaced by virtual health. Perhaps physical infrastructure will need to be reconfigured to enable more effective virtual health visits. Furthermore, as the VA continues to deploy its new electronic health record, centralized and interoperable data will permit better population health management, resourcing, and forecasting.

Fourth, the COVID-19 pandemic has brought renewed attention to the VA's fourth mission to support the national health system during times of crisis. In regions hit hardest by the pandemic, the VA provided critical support to local health systems. The AIR Commission should consider how the VA's infrastructure fits into emergency operations plans used during times of disaster or contingency.

Lastly, the VA leverages other federal agencies to reach subpopulations of veterans. For example, the Indian Health Service and the VA partner to provide care to American Indians and Alaskan Natives, although other veterans can receive care in tribal facilities. These types of federal partnerships could be expanded to meet health-care needs in other geographically remote or underserved regions.

The AIR Commission's decisions will rest upon the strength of independent and transparent analysis of VHA's infrastructure, utilization, and outcomes. It is crucial that the analysis supports evidence-based decision-making and reflects the reality of the local health-care markets. The AIR Commission's work is critical during a time of unprecedented modernization within the VA. The decisions made during the commission's review will shape the VA's delivery of health care for decades to come.

Research Spotlight

COMPARING THE VA'S DIRECT AND COMMUNITY-BASED CARE: ACCESS, EXPERIENCE, AND OUTCOMES

Sarah K. John

Like the Military Health System, the Department of Veterans Affairs (VA) delivers health care directly to veterans through its network of facilities as well as through contracted civilian providers. For the VA, direct care has long been the dominant delivery system. However, this is beginning to change as access to community care providers expands as it did under the Choice Act of 2014 (Public Law 113-146) and the VA MISSION Act of 2018 (Public Law 115-182). In 2014, community care accounted for roughly 10 percent of VA health care. By 2019, its share had risen to over 17 percent, or approximately 13.6 billion beneficiaries. Today, the VA estimates purchased care obligations will total over 21 billion beneficiaries by FY 2022. As veterans' access to and use of VA community care expands, the VA will need to monitor the quality of care and of the user experience across systems to inform future care-delivery investments. In this research spotlight, we highlight three recent studies that compare veteran access, experiences, and outcomes across the VA's direct and purchased health-care delivery systems.

- Vanneman et al. compared veterans' experiences with outpatient care delivered directly by the VA with the experiences of veterans who purchased community-based care following the 2014 Choice Act. The study, which used survey data from 2016 and 2017, examined three categories of outpatient care: primary care, specialty care, and mental health care. Veteran satisfaction was assessed using four dimensions of experience: access, communication, coordination, and an overall provider rating. For the non-access dimensions, veterans reported better experiences with VA-delivered care relative to community-based care. Some categories showed sizeable differences (e.g., ratings for primary care coordination differed by 15 percent) but others showed relatively minor differences (e.g., ratings for specialty care providers differed by 2 percent). For the access dimension, community care was rated higher for specialty care. Access ratings for primary and mental health care did not vary significantly between systems. Improvements in various experience dimensions were observed in both systems over the study period. However, the gaps in reported experiences between settings remained unchanged.

- Devila et al. also compared veterans' experiences with outpatient care delivered directly by the VA versus purchased community-based care. Using the same four measures of veteran experience as Vanneman et al., these authors focused specifically on how the care experience varied for veterans living in urban settings versus rural settings. They found that, overall, rural veterans rated community-based care the same (in the case of specialty care) or better (in the case of primary care) relative to urban veterans. However, rural veterans generally rated VA care higher than community-based care. Again, the exception was access to specialty care.

- Harris et al. compared risk-adjusted complication rates following major surgery for total knee arthroplasties delivered directly by the VA versus purchased community-based care. In general, the analysis found lower complication rates

for VA delivered care than for purchased care (2.9 versus 3.2 percent, a statistically significant difference). However, when the analysis was performed at the hospital level, five VA hospitals were found to have complication rates that were significantly higher than those for purchased care. This difference highlights the need to consider facility-specific factors when allocating patients between the VA direct and purchased care systems.

Collectively, these studies highlight two conclusions. First, as intended, the expansion of VA community-based care has improved veterans' timely access to outpatient care—most notably, in specialty care. Second, on average, veterans appear to have better experiences with outpatient care provided directly by the VA. While the case studies described here are too limited to draw broad conclusions about the overall quality of direct versus community care, they suggest this topic deserves greater attention. Furthermore, the VA provides care for a unique population with complex health needs and has developed myriad solutions to tailor care to meet these varied and exclusive needs.

As VA policy-makers contemplate future make-versus-buy investment decisions, they will require access to consistent metrics that comparably measure care quality, access, and cost across systems. The Department of Defense's Annual TRICARE Report to Congress could serve as a potential model for transmitting this information. Perhaps more importantly, the VA must study how to improve the veteran experience in its community care program. The community care experience will likely continue to improve under the current system as users become more familiar with it and work through initial challenges.

Furthermore, the interoperability of health-care information across systems could promote the continuity of care through patient-centered and seamless technology solutions. However, the VA may also want to pursue innovative and value-based ways to reform purchased-care contracting. Value-based reforms would provide the VA with additional care management tools such as preferred-provider networks, patient-centered medical home models for primary care, outcome-based payment schemes (rather than volume-based), and others. Ensuring veterans have access to tools for comparing providers and civilian facilities based on customer experience and professional rating systems (i.e., Leapfrog Group or Healthgrades) could also help improve the community care experience.

VETERANS AFFAIRS/MILITARY HEALTH SYSTEM (AS OF 9/23/2021)

Jamie M. Lindly

Recent congressional committee and subcommittee activities related to the Department of Veterans Affairs (VA) and the Department of Defense (DoD) during the budget reconciliation process have centered on enacting a continuing resolution (CR), raising the debt ceiling, and expanding government programs. While legislation to keep the government operating appears to be moving through the House, the Senate appears reluctant to embrace a CR that includes debt ceiling relief. Lengthy amendment processes, disjointed strategies for continued government operations, and disagreement between chambers mean fiscal year (FY) 2022 may start with a bevy of potentially unpredictable congressional and administration activities.

Senate Armed Services Committee Releases FY 2022 National Defense Authorization Act (NDAA) (9/22/2021): Although completed in July, the Senate version of the NDAA for FY 2022 was filed only recently for full Senate consideration. Once both the full House and Senate chambers pass their respective versions, the NDAA can go to the still undefined, joint conference committee for consideration. Given the amount of legislative action remaining, the NDAA will most likely not be in place by the start of FY 2022.

New Member of the House Veterans Affairs Committee (9/17/2021): Representative Jake Ellzey has joined the House Veterans Affairs Committee after winning the special election for the sixth district in Texas. A graduate of the Naval Academy, he served as a fighter pilot for 20 years and has deployed to both Iraq and Afghanistan. After leaving the military, he was a commissioner on the Texas Veterans Commission.

Presumptive Disability Extension (9/14/2021): The VA issued an interim final rule extending the presumptive period for qualifying chronic disabilities resulting from undiagnosed illnesses. The VA limiting entitlement to benefits would be premature given sufficient scientific uncertainty as to the cause and time of onset of illnesses suffered by Persian Gulf War veterans. Thus, the interim final rule extends the presumptive period for another 5 years, through December 31, 2026. Veterans seeking benefits would have until that time for their qualifying chronic disabilities to become manifest "to a degree of 10 percent" by that point.

Army Releases Vaccination Rules (9/14/2021): The U.S. Army released rules governing mandatory COVID-19 vaccinations to be completed by December 15, 2021, for active-duty personnel and June 30, 2022, for National Guard and Reserve members. Soldiers who refuse the vaccine will receive commanding officer and medical counseling to determine whether religious or medical exemptions should be applied. Soldiers are not subject to adverse actions while those requests are pending. However, the Army makes clear that soldiers refusing the vaccine will be removed from command and command selection lists and possibly separated from the military. Across DoD, approximately 88 percent of the total force has received at least one dose of a COVID vaccine. The House version of the NDAA includes a provision that would prevent releasing a service member for refusing the COVID-19 vaccine with anything other than an honorable discharge.

House Veterans Affairs Committee Markup (9/13/2021): The House Veterans Affairs Committee (HVAC) marked up its portion of the budget reconciliation package before passing the bill, which now goes to the House Budget Committee for inclusion in the total reconciliation package. Among the many VA provisions was a $15.2 billion set aside for infrastructure, primarily hospital renovations and replacements. The proposed legislation gives the VA Secretary authority to enter into major medical facility leases (up to $1.8 billion) that have not been approved by Congress but have been requested in the President's budget for fiscal years 2022, 2023, and 2024.

Annual Suicide Report Released (9/08/2021): The VA announced that 399 fewer veterans died by suicide in 2019 than in the previous year. This is the first time since 2007 such a decrease has occurred, reversing an increase in suicide deaths by approximately 48 per year from 2005 to 2018. Executive Director for the VA's Suicide Prevention Program Matthew Miller called this 7.2 percent reduction "unprecedented" when he released the report. The reduction in veteran suicide for 2019 exceeded the reduction seen in the non-veteran population, pointing to success with the VA's public health approach. Of particular note was the rate decrease of 13 percent for female veterans. Miller said the VA's successes can be linked to use of evidence-based public health strategies across the Veterans Health Administration.

COVID-19 Policy Update (9/09/2021): The White House issued Executive Order 14045, "Requiring Coronavirus Disease 2019 Vaccination for Federal Employees," which required contractors, as well as all government employees, to be vaccinated. This change reverses previous policy that allowed non-vaccinated employees and contractors to be tested regularly for COVID-19 rather than having to be vaccinated. In the full plan, the administration also calls for increased testing in public schools as well as mask wearing. In addition, all staff of nursing home facilities will need to be vaccinated in order for the facilities to continue receiving Medicare and Medicaid reimbursement.

House Armed Services Committee Approval of FY 2022 NDAA (9/02/2021): The House Armed Services Committee approved its version of the FY 2022 NDAA after 16 hours of deliberations covering a range of social, operational, and strategic issues. The bill passed on a bipartisan vote of 57 to 2 made possible by passage of an amendment to raise the topline spending amount by almost $25 billion. This raises the House's NDAA topline to parity with the Senate version, which has yet to be formally released.

DoD Military Medical Billet Reductions (8/27/2021): While DoD continues to propose reductions to the number of military medical billets, the cuts will be smaller than originally proposed. The Defense Health Agency (DHA) told Congress that 12,801 billets should be eliminated, down from the FY 2020 request of 17,005 military medical billets spread across the military service branches. News of the reduction in billets came as the DHA prepared to take control of all military treatment facilities. The reductions, documented in a report required by Congress, are spread out over a longer period and will allow the military services to retain the end-strength for other non-medical operational purposes.

House Armed Services Committee FY 2022 NDAA Military Health System Provisions (8/26/2021): When the committee takes up the full FY 2022 NDAA, lawmakers will consider broad changes to the Military Health System. Medical issues introduced in the draft legislation were integrated electronic products for management of population health, development of a DoD digital health strategy, and improved medical operations to include treatment of combat casualties in civilian settings. Chairman Adam Smith's markup of the legislation envisions greater use of digital tools to improve care delivery and better integration of military and civilian health-care institutions. Furthermore, it calls for the DoD to examine its current and predicted biosurveillance and medical research capabilities.