VA MISSION Act of 2018
H.R. 5674

Analysis by
Veterans Healthcare Action Campaign
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(*An independent organization, not representing the Department of Veterans Affairs)

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We understand that the bipartisan *VA MISSION Act of 2018* will be marked up on May 8, 2018. As a collective group who has previously presented statements for the record to your Committee, we want to convey our appreciation of the provisions of the bill that would improve how the Veterans Health Administration (VHA) provides healthcare into the future. We also wish to express our serious concern with components that will accelerate a one-directional flow of patients and resources out of the VHA to private sector providers, many of whom are ill equipped to take care of veterans' complex needs. Problematic provisions include:

- Access to walk-in care at non-VHA facilities without pre-authorization.
- Establishment of a Commission that will close VA facilities and force veterans into community care.
- Problematic expansion of automatic eligibility for care from non-VHA providers.
- Insurance payment pilot programs that would pave the way for fuller privatization of the VHA.

We also are concerned that the bill diminishes the quality of care veterans receive by creating less rigorous standards for non-VHA providers than VHA providers, and by failing to fully commit to adequately staffing VHA facilities. We summarize these, and other key aspects below, and suggest alternative language that would accomplish the bill's objectives in a more productive manner.

Problematic Access to Expensive Walk-in Care in the Community Without Pre-authorization

This newly proposed benefit (Sec. 105, p. 49) allows walk-in, non-emergency care in the community. It isn't simply intended for veterans to obtain a same day visit, like for a flu shot at Walgreens or pink eye treatment at an urgent care center. This benefit allows veterans to seek open-ended care in the community for almost any condition. The only exclusion is for "longitudinal management of conditions." The program would provide vouchers, for example, for treatable mental health diagnoses such as PTSD, depression, anxiety, insomnia, substance use, marital problems and stress associated with the transitioning to civilian life. The provision would likewise allow veterans to seek treatment at community clinics for primary care and specialty care other than for "management."

The first two visits at walk-in clinics per year are free, as if to imply that copayments for subsequent services would dissuade further utilization. Yet, copayments will be stratified by

enrollment group as currently exists for in-house VHA care and are likely to be nominal for high priority groups. **The benefit may be used frequently, placing enormous financial strain on an already stretched system.** That's even more the case because **veterans would not need VHA pre-authorization to use the benefit; the VHA would be sent the bill after treatment.**

There is also concern that the kind of providers who staff these clinics are less experienced in detecting and treating underlying conditions to which veterans are highly vulnerable. For example, a nurse practitioner in a community clinic is less likely to explore how insomnia stems from combat related PTSD. Walk-in-care by definition fragments the consistent, coordinated, integrated VHA healthcare approach so essential with to our nation's veterans.

Moreover, there is no stipulation that requires walk-in clinics to refer veterans back to the VHA for needed and appropriate follow up care. Although it may not be intended, this type of same-day service may move more veterans into the community thus depleting services and care within the Veterans Healthcare System.

Recommended Solution:

a. Veterans have access to walk-in care for a maximum of <u>two</u> visits yearly at no cost, and no additional visits.
b. Walk-in care facilities refer veterans who use this benefit to nearest VHA facility for follow up care.

<u>Establishing an Asset and Infrastructure Realignment Commission that Will Close VA Facilities and Force Veterans into Community Care</u>

The goals of achieving structural efficiencies and saving taxpayer money without sacrificing high-quality healthcare for veterans are laudable and timely. However, establishing a commission (Section 201, pp. 126-175) with the potential to close down VHA facilities will likely produce the opposite result. It would **leave veterans to fend for themselves in the fragmented private health care system. The intrinsic expenses would drain the VHA of resources needed for staffing up the VHA and fixing its problems, jeopardizing its long-term viability.**

This bill differs in important ways from the Department of Defense's Base Realignment and Closure (BRAC) process upon which it is modeled. When a military base is closed, all its servicemembers move and are absorbed by other bases. In contrast, when a VHA is closed, its veterans would NOT go to other VHAs. In nearly all cases, other facilities are too far away and/or have little capacity to absorb the veterans. The **veterans enrolled at the closed facility would immediately be forced into non-VHA care.** Those who prefer and rely on VHA's care would no longer have that choice. In many regions, there isn't a large enough supply of private sector options. Veterans emphatically prefer the VHA system and its facilities to be improved, not dismantled**.**

Closing VHA medical centers and CBOCs would **vastly increase, not decrease, overall costs**. There are two main reasons for this budget-busting impact. (1) There are nearly as many "eligible" or "enrolled" veterans who do not use the VHA as those who do. When a local VHA is closed, veterans who use it as well as those who do not would become eligible for vouchers, and outlays will skyrocket. (2) Managing the influx of veterans receiving care

in the community would require contracting with a third-party administrator, adding more costs, and as has been seen with the current Choice program, more inefficiencies. Closing facilities will drain money out of the entire VHA system, leaving less available to preserve VHA's capacity to offer care.

Recommended Solutions:

a. Prohibit the realignment of facilities if doing so will increase long-term costs.
b. Prohibit facility closures that will result in automatic utilization of private care.
c. Adopt the no-cost alternative idea (proposed in the Commission on Care Final Report): "Allow veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities are underutilized and might otherwise need to close." This plan would ensure veterans continue to have the option of local VHA care, and has many potential benefits:
    - bringing in new sources of revenue to contribute to the funding for veterans' healthcare,
    - optimizing patient safety, productivity, and cost-effectiveness by ensuring sufficient patient volumes in currently under-utilized facilities,
    - preserving mission critical veterans' programs that would otherwise need to be terminated in parts of the country.

Problematic Expansion of Automatic Eligibility for Non-VHA Care

1. **Automatic eligibility for non-VHA care based on problematic metrics**. There will always be need for VHA to supplement its services by utilizing non-VHA partners. However, this bill proposes that VHA implement an untested, problematic algorithm to grant all veterans in dozens of health care service lines automatic authorization for non-VHA care.

The first part of the algorithm (p. 12, line 16) pinpoints VHA service lines whose timeliness is slower than other VHA facilities. This utilization of VHA-to-VHA comparisons -- rather than VHA to non-VHA clinics -- completely contradicts the rationale for outsourcing care. VHA service lines whose wait times are shorter than those in their community could still be targeted if other VHAs have even better access to services.

The second part of the algorithm (p. 12, line 20) compares a service line's quality metrics to those at (undefined) non-VHA locations. A VHA service line could be designated as underperforming without ever comparing its performance to that of the local community. (Even if it did compare numbers, contrasting VHA with community metrics is misleading, since private sector statistics are based on non-veteran patients who, on average, are younger and have fewer medical and mental health conditions than veterans.) Furthermore, quality metrics generally don't measure the very things that matter most to patients -- functional improvements and symptom reductions.

Hence, without any attempt to verify that veterans will get better or faster care in their community, especially for the symptoms they need addressed, the bill grants automatic vouchers to tens of thousands of veterans. Once veterans have left the VHA system, it is highly improbable that they would return. **This process will progressively diminish the**

option to seek VHA care for other veterans, since there will be a steady flow of funds out of the VHA and into the private sector. This would lead to cuts in VHA staffing, services and programs.

2. **Automatic eligibility for non-VHA care based on state of residence.** The bill establishes that all veterans in the five lowest population density states (right now they are Alaska, Wyoming, Montana, N. Dakota, S. Dakota) will automatically be eligible for non-VA care. As with any overly inclusive expansion of non-VHA care, money that is unnecessarily diverted to the private sector undermines the financial strength of the VHA's system.

Recommended Solutions:

a. Commit to first staff up VHA facilities when problems in access to care are due to staff shortages.
b. Require VHA to be the first point of access and coordinator of care.
c. Purchase non-VHA care when:
   - the VHA is unable to provide timely, needed care, and
   - the private sector can verifiably provide it sooner, and
   - a covered veteran and his/her VHA provider both agree that non-VHA care is clinically indicated.
d. Mandate that PCP panel sizes used for VHA should apply to non-VHA providers. Verify that the panel size in the community is in fact smaller than VHA's before referring a veteran to a community provider.
e. Require that metrics used for decisions to refer to community care be based on functional and symptom improvement.
f. Require that any referral to outside care must follow a VHA diagnostic assessment.
g. Conduct thorough studies in every state to assess the capacity and readiness of private sector providers to care for the complex conditions and needs of veterans before referring to those providers.

Pilot Programs that Undermine VHA Mission as a Provider of Care

The bill mandates the creation of pilot VHA programs that use insurance models of paying for care (Sec 152 p 101). The VHA may subsequently "expand (including implementation on a nationwide basis) the duration and scope of a model" (p. 11, line 17). This will pave the way for turning the VHA into a payer, rather than a provider, of care. We must register the same level of alarm that Veterans Service Organizations expressed in November 2017 when it was revealed that shifting to a TRICARE model was being considered for VHA operations.

Recommended Solutions:

a. A better pilot is the aforementioned suggestion to allow veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA facilities are underutilized.

Problematic Provisions of the Bill Besides Accelerating Privatization

Double standards.
The bill holds non-VHA care to lower standards than for VHA care: Veterans are to be surveyed about their satisfaction with care they received from VHA, but not with non-VHA care (p.46 line 23 and p. 57 line 15). Veterans are given information on what to do when they have a complaint about Department care, but not about non-Department care (p 79 line 18). Wait times are used for evaluating VHA service lines, but not community's (p 12 line 16). All VHA facilities must make evidence-based psychotherapies available to veterans, but non-VHAs must do so only "to the extent practicable" (p 90, line 12). Non-VHA providers will have access to, but are not required to undertake, the veteran-specific continuing education that VHA providers are mandated to complete (p 70 line 18). Non-VA clinicians have no mandate to complete the multitude of screenings that are required for in-house VHA care.

Recommended Solutions:

a. Non-VHA performance should be measured and publicly reported using the same metrics as VHA providers. Non-VHA providers must always be required to meet VHA's high standards for quality of services.
b. Non-VHA providers must perform needed screenings and be subject to the same continuing education and knowledge of military culture requirements as VHA providers.
c. Surveys must ask veterans about their non-VHA care as well as VHA care.
d. Non-VHA providers must be required to collect service related data that can be used to identify future healthcare problems.

Insufficient staffing resources
The bill downplays the importance of strengthening the VHA. Although it establishes processes to identify staffing gaps (p 23 line 20; p 63 line 20), there is no prioritizing or commitment to rectify staffing levels that fall below guidelines. It does encourage remediation of staff shortages through enhanced use of the special hiring incentives, including the Educational Debt Reduction Program (Sec. 303, p 183) though these are for rural areas and only for physicians. It says nothing about providing market rate salaries to VHA employees so that the VHA can compete with private sector. Without adequate funding, VHA shortages will be inevitable and services will erode.

The bill's focus on outsourcing VHA care will also discourage new recruits from filling much needed positions in the system. It will be hard to convince people to work with very complex patients, for less money than is offered in the private sector, if the VHA appears to be an unreliable employer. We are already hearing troubling reports of an exodus of VHA staff and administrators. Strengthening VHA should go hand in hand with any Choice program redesign.

Recommended Solutions:

a. Special efforts should be made to permanently fund and fill clinical, support and administrative vacancies in VHA facilities where wait lists exist due to demand outstripping capacity.
b. All VHA facilities should be assured of sufficient staff, space, IT, and financial resources to provide comprehensive, high quality care.
c. All VHA employees receive market rate salaries and are assured stable employment.

Payment of private sector providers
According to the bill, in the event that is practicable, private sector providers will be paid Medicare rates. This vague terminology "in the event that is practicable, opens the door for providers to be paid in excess of Medicare rates, not only in high rural areas. Already, health financing experts are highlighting the fact that physicians may be unwilling to accept complex veteran patients at Medicare rates. If physicians demand higher rates, then costs for veteran care will explode and more staff will be laid off, veteran eligibility may change, veterans may be asked to pay more out of pocket, or services and programs will be eliminated.

Elements that are Steps in the Right Direction (But Need Further Modification):

Enhanced VHA Coordination of Care and Training. The bill tasks the VHA with performing additional administrative tasks, including establishing and managing networks, coordinating care between VHA and these networks, developing and managing educational curriculum, soliciting and responding to complaints, educating veterans about private sector care, sharing records and documents, etc. These are important, yet daunting, responsibilities. The bill, however, provides no new allocations for staff to execute the sizable extra workload. By necessity, additional administrative positions will be paid for by downsizing clinical staff who provide care to veterans. This shift has already begun to occur. Fewer clinical staff translates to further delays and further outsourcing of care.

Recommended Solution:

a. Allocate supplemental funding to cover additional administrative facility and staff costs associated with this bill.

Enhanced Telemedicine (p.97) As we've indicated in previous analyses, expanding telemedicine is a highly effective means of reaching rural veterans. The provisions of the bill, especially enabling care that crosses state lines, keep VHA as the industry leader of anywhere-to-anywhere health services.

Recommended Solution:

a. Since VHA will soon be able to reach all eligible veterans wherever they live via telemedicine, there is no reason for the VHA to pay for non-VHA providers to duplicate this service.

Peer Specialist Pilot in Medical Center PACTS (p. 219)
No other healthcare is as veteran-centric and veteran-sensitive as the VHA's, and peer specialists are an essential part. They are uniquely suited to engage veterans in ongoing care and to instill hope and expanding their presence in PACT teams to help integrate Mental Health and Substance Use Disorder into Primary Care is highly beneficial.

Enhanced Hiring Incentives

We applaud Sec. 305 that allocates $20 million in bonuses for recruitment, relocation and retention incentives and increases the current amount of Education Debt Reduction payments.

Recommended Solution:

a. To maximize these incentives, a strong Human Resources Department with a full-time recruitment specialist is needed to fill critical positions. VHA must be given the tools and funding to hire and retain high quality health care providers across the spectrum of specialties.

As health care professionals providing services to veterans across the country, we would be happy to further assist with language that accommodates any of the issues mentioned in our analysis.

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