

## *Caring for Our Veterans Act of 2017*

Analysis by

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We appreciate the Senate Committee on Veterans' Affairs bipartisan efforts to make needed changes to how the Veterans Health Administration (VA) provides quality healthcare for our nations' veterans. Although the draft Caring for Our Veterans Act of 2017 contains positive provisions that would improve care, it also contains numerous provisions that markedly harm the continuity of and quality of care. The legislation introduces an untested, unworkable set of criteria for non-VA eligibility that would significantly increase unnecessary use of non-VA care. It would drain the VA system of needed staffing resources, and accelerate a one-directional, permanent flow of veterans' health care out of the VA and into the private sector. It glaringly accepts lesser standards for non-VA care than for VA care. We summarize key aspects below.

### **Elements That Undermine Provision of Quality Care to Veterans:**

1. Double Standards for Satisfaction and Timeliness of Care. In five different places, the bill establishes standards for VA care that aren't applied to non-VA care. Veterans are to be surveyed about their satisfaction with care they received from VA, but not with non-VA care. Veterans are given information on what to do when they have a complaint about VA care, but not about non-VA care. Service line's wait times are compared to other VA's, but not to their community. VA clinics, but not non-VA providers, must provide appointments within access guidelines.

**Both VA and non-VA care should always be held to the same high standards of care. Not holding community care providers accountable is a disservice to veterans and to the taxpayers who are paying for that care.** Criteria should be established as to whether VA facilities as well as non-VA sources of care are meeting the Department's wait-time goals. The bill should require the VA to verify that patients will receive care appreciably sooner before authorizing non-VA care. It should create a non-VA care oversight office that evaluates and publically reports how private sector care is faring. There also should be surveys and other avenues for veterans to comment on excellence in VA and non-VA care.

2. Unworkable Criteria for Outsourcing Patients to Non-VA Care. There will always be need for the VA to supplement the care it provides by utilizing non-VA partners. The 2014 Veterans Access, Choice and Accountability Act Care developed time and distance criteria for doing so, but those were quickly recognized as needing revision. This bill does not correct the issue, but instead proposes unproven, new criteria based on access and quality metrics. Such metrics are presently unwieldy and insufficiently granular to be useful. Neither the VA's Access and Quality Tool website <http://www.accesstocare.va.gov> nor Medicare's

Hospital Compare website <https://www.medicare.gov/hospitalcompare/search.html> have the data that's needed to make informed decisions.

- There is little data on effectiveness in reducing symptoms or functional deficits.
- There is little data on outpatient care.
- There is no data on community access.

The bill specifies that when a VA medical service line's access or quality metrics fall below the standard, all veterans in that clinic will automatically be authorized for non-VA care. However, that determination does not need to compare the VA's to the local community's data. Even if it did, contrasting VA with community scores is somewhat misleading, since they are not apples-to-apples comparisons. Private sector statistics are based on non-veteran patients who, on average, are younger and have fewer medical and mental health conditions than veterans.

**Quality metrics are still crude and generally do not measure outcomes, functional improvement or symptom reduction.** If the VA begins using them to shut down clinics or outsource care, 36 medical service lines – representing many tens of thousands of patients -- would become authorized to receive non-VA care when it may be unnecessary or not in the best interests of their medical needs. **This process will incrementally remove the option for veterans seeking to use the VA for care. There will be a steady flow of funds out of the VA and into the private sector.** If funds that could have been used to make improvements are diverted to pay for non-VA care, VA facilities that lag behind will never catch up. This is the steady route to privatization of VA healthcare.

Also, these metrics are more apt to obscure than help clarify an individual veteran's decision making. For example, suppose a veteran with PTSD checks VA's Access and Quality Tool website. The only published mental health metrics are two scores for antidepressant medication management, statistics that would be of no help to the veteran or his clinician in making a sound clinical decision where to obtain psychotherapy. Consider another example of a patient seeking primary care. Half of the VA website measures pertain to advising tobacco users to quit. The Medicare website has even less pertinent information for these kinds of outpatient decisions.

3. Lack of Clarity about Whether VA Is the Authorizer of Care. The bill is ambiguous about who makes the final decision when there are disagreements about eligibility for non-VA care. For services the VA doesn't provide, the bill explicitly, and rightly, grants veterans the choice to receive non-VA care. But for services the VA does provide, when the veteran disagrees with a PCP recommendation for VA rendered care, she can appeal. If the appeal reaches no agreement, there is no language about who makes the final call. By contrast, the current House Choice bill H.R. 4242 stipulates that the veteran has that prerogative, and this stipulation has significant ramifications. It shifts the final say in their eligibility to receive services from a non-VA provider from the VA to the veteran. It undercuts VA's ability to control costs if veterans can opt for private sector care even when the local VA is able to provide treatment that is less expensive, clinically superior, quicker and/or closer. A statement is needed in the Senate bill that would clarify this. Such a statement might read: **"...the Secretary shall give due consideration to the veteran..." to make it clear that the veteran's desires will be considered, but not determinative unequivocally.**

Consider this recent instance: A 70-year-old veteran scheduled a visit with his VA primary care physician. VA surgeons had evaluated him and recommended a laparoscopic inguinal

hernia repair that they could perform that month. The veteran was adamant that the operation be done by a Choice Program surgeon that a civilian friend had used. His immovable request was granted. Under the existing regulations, the supplemental Choice Program account paid the invoice. Under the new legislation, the local VA would have to draw down its resources to pay, even though it could have done the surgery as effectively and quickly.

4. Expensive Options for Walk-in Care. This new benefit allows veterans to seek walk-in, non-emergency care in the community, as long as it is not for “longitudinal management of conditions.” That could include primary care, and much specialty care. **It’s not only expensive, it ignores that community providers have less expertise in detecting and treating underlying conditions to which veterans are highly vulnerable.** For example, a practitioner is less likely to explore PTSD as the reason for chronic insomnia, the impact of traumatic brain injury on mood and decision-making, or that a particular condition – asthma induced by burn-pits or diabetes produced by Agent Orange exposure– is related to military service. It also undermines VA’s integrated healthcare approach. There are no protocols stipulated that require walk-in clinics to refer veterans back to the VA for any further care that is needed. One could easily imagine a situation in which private sector providers make arrangements with (or set up) walk-in clinics to funnel veterans into private sector referral networks at higher cost.

#### **Elements that are Steps in the Right Direction But Need To Go Further in Order to Enhance the Provision of Quality Care to Veterans:**

1. Allocations. The bill provides \$3 billion to keep Choice operating and \$1 billion for VA educational, training and employment incentives. There is no money for staffing or infrastructure that would strengthen VA’s capacity to provide care. While these allocations are urgently needed, the three to one ratio of non-VA to VA funding reinforces the notion that outsourcing is a preferred solution when VA’s are understaffed. That’s not a solution that saves money, but is one that accelerates privatization of veterans care.

2. VA as Coordinator of Care. The bill identifies local VA offices of community care to serve as coordinators of intersecting VA-community care. This is a useful structure, although it requires a significant increase in staffing. The bill does not recommend any additional funding for this role, which means funding would have to come out of budgets for the staff who provide care to veterans. Supplemental VA allocations are warranted if this is to be effective.

3. Modification of Pay Caps for Nurses. The bill includes a much-needed increase in pay rates for nurses in areas where there are shortages. We applaud the committee for including this language and would like to see other pay caps removed and locality pay changes made permanent.

4. Expanded Provider Networks. The bill’s goal is to develop high-performing networks that link the private sector to the VA. However, the responsibility for developing these networks is given to outside contract entities. It would be less expensive and assure higher quality if the VA managed this process. As above, VA management of private sector providers would require funding for additional staff.

5. Reappraisal of Capacity and Quality. The bill authorizes the Secretary to conduct an annual evaluation of gaps in the services provided, the quality and timeliness of services rendered. The VA must submit a plan for addressing and remediating these gaps, including a budget that reflects needed resources to help remedy such gaps. As noted above, these evaluations should examine VA and non-VA alike.

6. Peer Specialists in PACT Pilot. No other healthcare is as veteran-centric and veteran-sensitive as the VA'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 is highly beneficial.

7. Improved Telemedicine. As we've indicated in previous analyses, expanding telemedicine is an effective means of reaching rural veterans. The provisions of the bill keep VA at the forefront of anywhere-to-anywhere health services.

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

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