Veterans Healthcare Policy Institute

Strengthening Care for Veterans and the Nation

Policy Analysis: Making Community Care Work for Veterans Act of 2023

The Making Community Care Work for Veterans Act of 2023 has several sections that contain some useful improvements but does not go far enough in addressing problems with the Veterans Community Care Program.

Sec. 109 approaches a solution to a serious problem in the VCCP – that is the failure to require VCCP providers to provide VHA with data on the quality of the healthcare that they furnish. Despite the original law's mandate, VHA has never required third party administrators to collect or report such data. Lacking data, veterans have consistently been referred to care of completely unknown, and sometimes dubious, quality. That should never occur.

This section ostensibly fixes the gaping lack of data and accountability on VCCP's efficiency, effectiveness, quality, timeliness, and safety of care. But rather than requiring all VCCP providers to submit needed data during a veterans' treatment, the language exempts providers from submitting data if VHA deems that doing so *constitutes too heavy of a burden* on the provider's time and resources. This is too broad of an exemption. By its very nature, the collection of data is burdensome. To assure high quality veteran care and that VHA, as mandated, would coordinate with the VCCP, this kind of data collection cannot be exempted. By contrast, VHA is not exempt from data collection requirements, burdensome as they may be. Accountability and transparency should be mandatory for those who participate in VCCP and are paid to do so.

Not only does this provision provide too much latitude to providers, but it also fails to emphasize outcome data. The Institute of Medicine defines health care quality as "improvement of outcomes." Patients considering health care options benefit most from information about treatment effectiveness and symptom reduction.

This section also requires that a list of VCCP's "High-Performing Providers" (HPP) be published. This requirement could greatly benefit veterans if high performance was rigorously and transparently defined. Yet, as has been previously identified, serious problems with the HPP designation must be addressed and remedied: (a) A public reporting is needed of which specific measures comprise the HPP algorithms, (b) Calculating the HPP designation needs to be primarily based on outcome measures, which thus far has not occurred, (c) Behavioral and mental health conditions, which are intentionally "not included in HPP monitoring," must be included.

If all these problems are addressed and clearer legislative language is incorporated, only then is the bill's accompanying Sec. 302 beneficial. That statute expands the data collected on VHA care quality. VHA already obtains and reports far more data than does VCCP about veterans' care. The gap must be closed, not widened.

Sec. 110 would publish the "high compliance" of community care network providers that take VHA trainings (yet to be determined) and meet records timeliness goals. Public accounting of VCCP providers could potentially improve the program. However, as written, trainings that would lead to such a designation are voluntary not mandatory.

VHA providers are mandated to take specified trainings, e.g., suicide prevention, lethal means safety, complex toxic exposures, and military culture. VCCP providers have no requirements. This continues to encourage lower standards in the community program.

Rather than making critical training and timely submission of records mandatory, this provision provides financial incentives to providers. A vast literature on the failure of financial incentives to enhance quality (noted above) demonstrates that such incentives rarely work. They will also increase the cost of VCCP care for what may be minor improvements in quality at best and none at worst.

Sec. 111 prompts faster movement toward electronic interoperability between VHA and VCCP healthcare records. The utility of interoperability cannot be overstated. Care coordination for veterans receiving some of their care via VHA and some via VCCP is severely hampered by hard copy records.

Sec. 201 would help VHA recruit and retain Medical Support Assistants (MSAs), whom the bill rightly describes as "the linchpin" to ensuring that veterans are scheduled for care in VHA or in the community in a timely manner. We support these efforts if they particularly target MSAs who work in offices supporting the delivery of VHA inhouse care, (not the scheduling of private sector care), where the major retention difficulties lie.

Sec. 102 codifies into law the problematic Trump-era VCCP wait time and drive time access standards and makes it impossible for the VA Secretary to ever modify those standards. As Congress intended when it passed the MISSION Act, the VA Secretary is supposed to reassess whether the access standards to the VCCP need to be adjusted. One out of every three VHA patients now qualifies for VCCP based on drive time alone. That is at the core of why VA Secretary Denis McDonough predicted in September 2022, if use of private sector care continues to rapidly increase, "VA medical facilities, particularly those in rural areas, may not be able to sustain sufficient workload to operate in their current capacity." Myriad evaluations of the VCCP have documented that it is a costly and flawed experiment that delivers care that is not only less timely but also dangerously fragmented and of lower quality than the VHA. It is essential that access standards be allowed to be continually reevaluated and revised in terms of the care the private sector delivers and the overall impact on veterans who depend on VHA for their care. This provision of the bill should be strongly opposed.

Sec. 103 would allow VHA to designate telehealth appointments as meeting timely access standards, thus allegedly addressing the previous Administration's mistake that prohibited such designation.

But it then adds an extremely consequential – and system crushing -- qualification. Even when the VHA can provide telehealth within the 20/28-day wait time or 30/60-minute drive time access standard, a veteran would be allowed to indicate that his/her preference is to receive telehealth from the VCCP anyway.

As we note above, the VA MISSION Act was very clear that veterans would get the option to choose whether to receive care in the private sector or the VHA if and only if they already qualified under the six eligibility rules. This original carefully constructed language was the firewall that ensured the long-term viability of the VA healthcare system.

The Sec. 103 statute has perilous implications. Veterans are offered a VHA telehealth appointment when the access standard is met but are nonetheless given the option for telehealth in the VCCP. In short order, they will be given that same "preference" prerogative for in-person appointments. At that point, the firewall alluded to above will be completely broken.

A far better – and more fair -- legislative fix would ensure that VHA-delivered telehealth shall count as meeting access standards, but that no veteran would be required to accept a telehealth appointment, either in the VHA or VCCP, when they want to see their provider in-person.

Sec. 303 modifies the standards for veterans accessing residential mental health or substance use disorder care in the private sector. The intention is laudable -- to ensure quick placement when a veteran is in urgent need of treatment for substance use, PTSD, or other mental health issues. The VHA has, at times, been too slow initiating such care.

The statute ensures diligent tracking of the timeliness of screening and treatment placement. But the opposite is true for the quality of care. There is not a single requirement (or even mention) pertaining to the essential elements of care – high-quality, evidence-based, measurement of outcomes, or prompt exchange of medical records.

Unregulated quality of care in the private sector that prioritizes profits is no trivial matter. To cite just one example, a year ago, two unscrupulous operators of addiction treatment facilities in Florida were convicted of a $112 million fraud scheme that included medically unnecessary services. In 2017, The New York Times also did a series of impressive articles exposing the unscrupulous practices of private sector addiction treatment programs.

The Office of Inspector General recently voiced the same concern. At an April 2023 HVAC hearing, Dr. Julie Kroviak, Principal Deputy Assistant Inspector General stated, "Our office has published reports related to community care detailing delays in diagnosis and treatment, lack of

information sharing or miscommunication between providers, and significant quality of care concerns."

The statute must be amended to assure that quality standards are applied to VHA and non-VA providers. VHA should be mandated to do the following (which is supported by language in the MISSION Act and the Parker Gordon Fox Suicide Prevention Grant Program bills):

- create its own certification requirements for a facility participating in the Mental Health Residential Rehabilitation Treatment Program. The certification standard should include that there is:
  - scientific evidence for a program's treatment approach,
  - a standard ratio of licensed independent practitioners (LIPs) per resident,
  - semi-annual peer review quality assurance system,
  - treatment planning,
  - accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) or equivalent organization, and
  - forwarding of treatment records to VHA within 30 days of a veteran leaving residential care,
- recertify programs every three years,
- mandate the mental/behavioral health measures that are required in the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program be administered to every VA-paid veteran participant at the point of entry, exit, and six months (if reachable) following discharge from the program. Additional measures could be added at the VHA's discretion, for example, the Brief Addiction Monitor (BAM) or PTSD Checklist (PCL).
- require that the scores of veterans be sent to the VHA for data analysis and evaluation of each program. VA will provide technical assistance for testing administration,
- publish the program outcome data on VA's Access to Care website https://www.accesstocare.va.gov/,
- require mental health and substance use disorder LIPs to take a minimum of four hours of VA's TRAIN courses corresponding to the patient population they serve, and four hours on military culture.

The statutes' new referral, review and placement standards will add significant administrative burden and strain on VHA's health care budget absent new, dedicated resources for those purposes. The demands on VHA to screen and find a placement for "priority" referrals within a 72-hour window are considerable, and too rushed, especially for patients who have not already been recently evaluated. Adding "self-referrals" to the mix is certain to balloon the number of veterans needing evaluation. Funding for additional staff is essential. Plus, there must be assurance that supplemental medical center funding would go to increased staffing so that VHA can meet this tight review deadline mandate.

CBO score is urgently needed for this section.

Sec. 104 removes VHA administrators' authority to override provider recommendations that a patient should be referred to private sector care because it is in the veteran's "best medical interest." As we explained in detail for Sec. 106 of the HEALTH Act, there are too many instances when providers' only justification for the "best medical interest" recommendation is that a veteran "prefers" non-VA care. Regulations are very clear that "best medical interest' is not to be used solely based on convenience or preference of a veteran." When it is used as such, then VHA's administrative oversight is the appropriate response.

Going forward, VHA must retain – not lose -- the authority to have final say on whether external referrals meet explicit referral standards. Further, VHA employees making referrals to the VCCP need far better education about what does and does not constitute "best medical interest."