Veterans Healthcare Policy Institute (VHPI)

Request for Information from the Public
Regarding Health Care Access Standards for Veteran Community Care Program

December 5, 2021

The Veterans Healthcare Policy Institute (VHPI), a non-partisan think tank focused on the provision of quality healthcare to veterans, is pleased to respond to the Department of Veterans Affairs (VA)'s Request for Information from the public to assist in reviewing the health care appointment access standards for the Veterans Community Care Program (VCCP), as well as the utilization of virtual health services, as established by section 1703B of title 38, United States Code, the VA MISSION Act of 2018.

We support the MISSION Act's intention to guarantee that veterans receive quality health care in a timely manner. However, because VCCP providers are not required to meet any access standard whatsoever, veterans provided private care are not assured quicker appointments or shorter commutes for care. **The interim access standards are eroding, not enhancing, the quality of veterans' healthcare. Unless VCCP can assure shorter wait or drive times, the new standards will only serve to divert resources from VA to the private sector without improving access.**

Below, we summarize the core problems with the interim access standards and suggest remedial adjustments.

Access Problems

- **The drive time standard doesn't ensure that veterans have shorter travel times to receive VCCP care.** The interim standard requires a VA clinic/hospital to be within a 30/60-minute travel time, but VCCP providers are not required to meet any drive time standard. A VCCP referral is offered regardless of whether a VA facility is geographically closer than a non-VA one. A 2021 study of veterans obtaining VCCP cataract surgery found that more than a quarter of those procedures occurred in facilities further than the closest VA facility.
- **The travel standards are too lax.** The interim 30/60-minute travel time standard means that one-third of all veteran patients are automatically eligible for non-VA care, even where a VA facility is the closest care available. That percentage represents a massive restructuring of the basic model of furnishing veterans' healthcare.
- **The wait time standard doesn't ensure that veterans receive timely care in VCCP**. Wait times in VA are typically shorter than those in the VCCP. Nonetheless extant standards cause thousands of veterans to be sent to the private sector if the VA cannot schedule an appointment within 20 or 28 days. That's because the interim standard

requires VA – but not VCCP -- to meet a specific length of time it should take veterans to receive care. GAO reviews in 2013, 2018 and 2020 chastised the VA for this lapse, and emphatically recommended that VA establish an achievable VCCP wait-time goal and even "the same wait-time measure to that care that it uses to monitor wait times for care at VAMCs."

Telehealth

- **Telehealth appointments with VA providers, even if available with little to no wait, do not qualify as meeting the interim access standard.** A double standard exists regarding the offering of telehealth appointments by VA and VCCP. If a veteran desires in-person care and VA is unable to furnish in-person care within 20 or 28 days, that veteran is offered care by a VCCP provider. There is no requirement that the VCCP provider furnish that care in-person. Thus, the veteran may be referred to the community only to find that their VCCP provider will conduct a virtual visit. The VA's capacity to furnish telehealth within 20 or 28 days isn't being recognized as meeting the access standard. Hundreds of thousands of VCCP telehealth visits are occurring yearly in mental health, which is all-the-more inexcusable given that the VA is the recognized telemental health world leader.

We are deeply concerned that unless these problems are resolved, vouchers will continue to be granted to millions of veterans without any assurance that they will receive faster, more convenient, or higher quality care in the private sector. That in and of itself would be a grave disservice to our veterans. But it may also potentially harm veterans by accelerating a one-directional flow of patients and resources out of the VA to private sector providers, many of whom are ill-equipped to care for veterans' complex needs.

The share of veteran care being furnished by the private sector is growing yearly and presently 34 percent of visits are now provided by the VCCP. This shift will lead to fewer options for other veterans to seek VA care, since payment for non-VA services comes at the expense of existing VA facility staffing, services and programs, and -- as the pending Asset and Infrastructure Review (AIR) Commission may decide -- facility closures.

Finally, the Request for Information asks the public to respond to the question: **Are current regulatory access standards cost effective while maintaining quality standards?** The short answers are "no" and "no."

Interim access standards are not cost effective, since they over promote use of non-VA care which is more expensive than VA care. The 2020 veterans' ambulance study showed definitively that non-VA emergency care is 21 percent more costly than VA emergency care. Nor do the standards maintain quality, since assessment of VCCP's quality of care for many of the conditions common to veterans – e.g., mental health diagnoses – aren't examined. Plus, few of the quality metrics assess what the Institute of Medicine (IOM) defines as health care quality, i.e., improvement of outcomes. In fact, a recent CBO assessment of the VCCP explicitly stated that, although care coordination is critical to "patients with chronic, or multiple conditions", it is uneven at best between VA and the VCCP. The report also stated that the quality of care delivered by VCCP providers is "unknown." Indeed, the report went on to say that it was

unknowable because “participants in VA’s network are not required to report VA’s quality measures, and providers’ quality varies.”

Recommendations

VHPI recommends that VA make the following adjustments for the permanent standards to accomplish the MISSION Act’s goal of increasing access to receive care:

1. Require that the VA drive time and wait time standards also apply to VCCP care providers.
2. Change the drive time standard for accessing primary or mental health care from 30 to 60 minutes, so that all wait times are measured by the singular 60 minute timeframe.
3. Allow both telehealth and in-person care to satisfy the wait time standard for VA access to treatment.

SUMMARY

The VA offers access to high quality health care and should remain at the center of all care for veterans. When VA cannot meet demand, only then should non-VA providers who equal or exceed the same standards of access and quality be used to augment services for our nation's veterans.

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