Veterans Healthcare Policy Institute (VHPI)

Critique of

S. 1863: Guaranteeing Healthcare Access to Personnel Who Served Act

July 6, 2021

A new Congressional bill – S. 1863 – proposes a number of healthcare initiatives intended to benefit our nation's veterans. While it would advance the use of evidence-based treatments, the bill's significant shortcomings overshadow any of its merits and it consequently warrants close scrutiny.

At its core, S. 1863 fails to establish access or quality standards which would allow Congress to hold Veterans Community Care Program (VCCP) providers accountable for the care they provide enrolled veterans. Of greatest concern is that this bill not only neglects to correct fundamental omissions embedded in the VA MISSION Act of 2018 -- it permanently locks them in place. It also preemptively abandons the Veterans Health Administration's (VA) mandated review and upgrade of VCCP eligibility standards, which is underway and will be completed next year.

In the three years since the VA MISSION Act was enacted, VCCP providers have resisted adhering to the VA's own high internal standards – standards which Congress, in the interest of protecting the nation's veterans, frequently revise and strengthen. This bill would effectively block lawmakers and VA officials from fulfilling their mandate to assure that veterans receive high quality and timely care, no matter where it is delivered. Refusing to apply rigorous standards to both private sector and VA providers gravely dishonors veterans.

Furthermore, this bill could imperil veterans because it would balloon community care costs and likely lead to severe cuts in VA services and/or increasingly restrictive healthcare eligibility requirements for veterans.

Below, we elaborate key components of the legislation, inherent problems and potential solutions.

Access Standards and the Result When They Are Not Met

Sec. 101 purports to apply the identical access standards to VCCP care that currently pertain to VA care. That's not the case.

1. When VA doesn't meet applicable access standards for a veteran seeking an appointment, s/he is immediately given the option of VCCP care. By contrast, when VCCP doesn't meet a standard, there is no immediate consequence. Even if, at that point, the VA can provide

an appointment more quickly and more conveniently, s/he doesn't have to be referred back to the VA.
2. VCCP Third Party Administrators (TPAs) are given broad waivers that allow them to circumvent the access standards; VA is given no similar waivers.
3. At the point of evaluation three years following the bill's passage, there are no consequences for TPAs failing to meet the standards.

We believe that legislation must provide ironclad assurances that veterans get the same quality of care and health outcomes, in a timely and convenient manner, whether provided inside or outside the VA. This bill neglects to meet that simple but vital bar.

At the Senate Veterans Affairs' Committee hearing June 23, 2021 on this bill, VA testified "MISSION Act also requires the Secretary to conduct a review of the Department's access standards no later than three years "after the date on which the Secretary establishes access standards" and to submit a report to Congress on "the findings and any modifications to the access standards with respect to the review." While it has only been 2 years since the MISSION Act access standards were established by regulation, Secretary McDonough has directed an internal review to assess the impact of the MISSION Act's access standards on Veteran access and outcomes, and VA's ability to continue to deliver high quality, evidence-based, integrated care. Placing these requirements in statute prior to the completion of the statutorily mandated review of VA's access standards will not only prevent the Department from incorporating any key takeaways from the access standards review required by the MISSION Act, but it will also eliminate VA's flexibility to react to changes in market conditions and other emerging issues."

At the same hearing, the Disabled American Veterans (DAV) agreed that "it would be premature to codify access standards before VA completes this review next year." We concur with VA and DAV that setting current access standards in stone would be premature before the full analysis of their impacts is concluded.

Pilot Program Establishing a Community Care Self-Scheduling Appointment System

Sec. 112 and Sec. 113 would create a self-scheduling appointment system. At first glance, the pilot program appears to be a positive advance for covered veterans who receive care in the VCCP. But, on close inspection, it could dangerously upend the VA's role in oversight, authorization and coordination of non-VA care for veterans. Additionally, it could balloon community care costs that could likely lead to severe cuts in VA services and/or restrictions in healthcare entitlement for veterans.

In five pilot Veterans Integrated Services Networks (VISNs), the "Community Care Self-Scheduling Pilot Program" would create an option for authorized veterans to self-schedule appointments in the private sector. This may save veterans some time and the onus of contacting VCCP/VA.

Yet, if such a program were instituted, the collateral damage could be massive. That's because current VCCP eligibility criteria maintain the VA's ability to manage outsourcing costs by

requiring preauthorization for *each discrete* VCCP episode of care. For example, VCCP may be offered when there is a delay in VA availability to treat one problem, but not offered for a separate problem for which VA treatment is immediately available. The self-scheduling bill could dismantle this essential management process.

What follows are projected scenarios that illustrate the problems that could result from the self-scheduling program:

Scenario #1: During a visit to his VA primary care physician, veteran A complains of persistent insomnia. He and his doctor agree that therapy is warranted. Since the wait for insomnia treatment inside the local VA exceeds 20 days, veteran A qualifies for VCCP and a referral is entered into the system. The veteran then self-schedules appointments for his insomnia with a listed VCCP psychologist.

Three months later, veterans A who is now registered in the VCCP decides to obtain treatment for his PTSD and unwittingly self-schedules appointments with another VCCP psychologist. When the local VA is billed for the PTSD treatment, payment is denied, noting that there was immediate availability for VA provision of PTSD treatment. In other words, the veteran was not eligible or authorized for psychotherapy for PTSD through VCCP. The veteran is informed that he is responsible for 100% of the non-authorized therapy expenses, creating severe financial consequences for him.

Scenario #2: Same situation as #1 but neither the veteran nor the VA pay the VCCP provider.

Scenario #3: Same situation as #1 but the VA decides to pay for the care, even though there was no eligibility or authorization for that care.

Now multiply these scenarios across multitudes of veterans with many types of conditions. Scenario #1 will justifiably outrage the thousands of veterans saddled with the cost of their private sector care. Congress is apt to step in to resolve this issue by allowing veterans who qualify once for any service in VCCP to qualify for all care in the VCCP.

In scenario #2 VCCP Third Party Administrators will be rightfully infuriated and force VA to pay, since they are the private sector option established by the MISSION Act. Scenario #3 will end up with VA assuming veterans' financial obligations for non-authorized VCCP care.

In all three instances, eligibility for VCCP will be thrown wide open. Simply qualifying for one VCCP service could qualify a veteran for all VCCP. Plus, eligibility for VCCP will become automatic if the current criteria of "in the veteran's best medical interest" is switched to "if the veteran wants private sector care regardless of whether they meet standards" (as some in Congress are already pushing). As a result, the VA healthcare system could transform to more of a *payor* of services (like an insurance company) than a *provider* of services.

Should this happen, community care costs will skyrocket which will then lead to cost-cutting measures. These could include reduction of VA services and/or restricting which veterans are eligible for VA healthcare. Additionally, self-scheduling will aggravate the perilous

fragmentation of care that is epidemic in the private sector, as well as channel veterans to private sector providers, whom, as VHPI has long documented, are apt to provide them with care that is of lower quality and higher cost. The result: The VA as we know it will be lost.

The self-scheduling bill language, which emphasizes "covered individuals" instead of "episodes of care" won't avert this catastrophe. It states that the VA "shall commence a pilot program under which covered veterans eligible for hospital care, medical services, or extended care services under subsection (d)(1) of section 1703 of title 38, United States Code, may use an internet website or mobile application that has the capabilities specified in section 113(a) to request, schedule, and confirm medical appointments with health care providers participating in the Veterans Community Care Program."

To conclude, the VA already has an online process for VCCP-eligible veterans to directly self-schedule appointments. The veteran must first receive a VA letter that gives a green light to contact their preferred provider and for what treatment. A new VCCP self-scheduling pilot program that bypasses VA authorization review could undo the very foundations of the Department. The only way to prevent this catastrophe from occurring is to permanently ensure – as now exists -- that VA administrative intermediaries explicitly authorize each treatment for which appointments are sought outside the VA. Further, provisions for hiring sufficient VA staff to fulfill the authorization and monitoring function must be included in legislation or initiatives regarding community care options.

Telehealth as an Access Standard

The bill states that "the Secretary shall not take into consideration the availability of telehealth appointments from the Department when determining whether the Department is able to furnish such care or services in a manner that complies with the eligibility access standards under such paragraph" (*Pg. 4, Line 19*). No such prohibition is assigned to VCCP. If telehealth appointment availability is not regarded as an appropriate access standard for VA, it shouldn't be regarded as appropriate for VCCP either.

Since many homebound or remote veterans find telehealth to be their preferable option, VHPI believes it should be considered as realistic access to VA care. At the very least, there cannot be double standards that make telehealth a suitable access option for VCCP but not for VA.

Publishing Information to be Used by Veterans in Scheduling Appointments

Sec. 101 attempts to empower veterans to make informed healthcare decisions using wait-time data. It mandates the VA to "publish on a publicly available internet website the average wait time to schedule an appointment at each Department medical center for the receipt of primary care and specialty care" (*Pg.9, Line 20*). Since having access to accurate information about wait times is considered to be critical to assuring that veterans receive care in a timely manner, why is that standard not imposed on VCCP providers?

This omission is negligent, and further allows the private sector to operate under lax rules. Veterans need contemporaneous data for both VA and VCCP to make informed decisions about what is in their best medical interest. A truly useful system must provide direct comparisons between VA and VCCP options concerning current wait times as well as location and quality metrics.

Evaluation of Effectiveness of Telehealth Treatment

Sec. 201 attempts to ensure that the rapidly expanding use of telehealth is as good as in-person treatment. It mandates "an assessment of the effectiveness and patient outcomes for each type of health care specialty delivered via telehealth or virtual health delivered by the Department" (*Pg. 33, Line 14*).

This is a worthy goal. Unfortunately, the section misses the mark. Without a matched control group, one cannot draw scientifically sound conclusions whether telehealth care is as effective as in-person care. Varying populations can, because of their differences alone, skew outcome results.

The bill grossly underestimates the fact that assessing the effectiveness and patient outcomes for every type of health care specialty is a gargantuan endeavor. To do it correctly will require significant resources and years of effort.

Troublingly, only outcomes and patient satisfaction of VA telehealth are measured. VCCP telehealth is not, guaranteeing, once again, that VCCP will not be held accountable.

Feasibility for VA Providing Electro-Convulsive Therapy (ECT) and Repetitive Transcranial Magnetic Stimulation (rTMS) for Treatment-Resistant Depression

Sec. 401 would direct the Secretary of VA to "complete an analysis of the feasibility and advisability of making repetitive transcranial magnetic stimulation available at all medical facilities of the Department of Veterans Affairs and electro-convulsive therapy available at one medical center located within each Veterans Integrated Service Network."

This is a highly promising section that represents veteran policymaking at its best. It would open up the possibility of more evidence-based interventions for treatment-resistant depression, one of the most challenging illnesses faced by the VA patient population.

Gap Analysis of Psychotherapeutic Interventions in VA

Sec. 403 calls for greater adherence to mental health clinical practice guidelines. It's gap and barriers analysis of evidence-based psychotherapies employed in the VA is good means of accomplishing that. But if Congress believes the use of these recommended psychotherapies should be widely implemented "across the entire health care system of the Veterans Health Administration" (*Pg. 52, Line 15*), it must hold VCCP to the same standards. Failure to do so is an abdication of responsibility to ensure that veterans receive high quality care not just in the VA, but also in the private sector.

Strategic Plan to Ensure Continuity of Care in the Event of a VA Facility Closure

The purpose of Sec. 102 is to ensure that when a VA health care facility is closed, enrolled veterans who are transitioned to the private sector receive commensurate quality care in a timely manner. But as written, this section won't accomplish that.

Additional language is needed that prohibits VA from closing any of its facilities until it first has an operational plan that guarantees enrolled veterans will receive care that is as good or better than the quality, veteran-specific, outcomes, cost-effectiveness and timeliness of care currently rendered at the VA facility. This plan also must include a comprehensive evaluation of private sector providers' willingness to accept VA payment rates.

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