

Request for Public Comment
Department of Veterans Affairs (VA) Proposed Rule to Create New Regulations to Define and Implement the Veterans Community Care Program (VCCP)
RIN 2900-AQ46
Authorized by US Code Title 38, Section 1703

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Submitted jointly by:

American Psychological Association
Association of VA Anesthesiologists
Association of VA Psychologist Leaders
Association of VA Social Workers
Association of VA Surgeons
Association of Veterans Affairs Nurse Anesthetists
National Association of Veterans Affairs Optometrists
Nurses Organization of Veterans Affairs
Veterans Healthcare Policy Institute
Veterans Affairs Physician Assistants Association

EXECUTIVE SUMMARY

As those who provide care to millions of Veterans, we understand the need for an integrated community care program but believe VA's new proposed regulations will compromise the integrity of the Veterans Health Administration (VHA) model of healthcare by:

- requiring VHA to meet new drive time and wait time standards, whereas VCCP providers are not required to meet any access to care standard;
- proposing quality standards for VCCP providers that do not equal standards for VHA providers, especially for mental health care;
- incentivizing VCCP "over-treatment" often found with fee for service models;
- diverting VHA staff who perform clinical services to positions that administrate VCCP care; and
- failing to address that additional expenses for VCCP will likely be drawn from VHA's budget.

Instead, Veterans would be better served if standards were immediately amended to:

1. require that the drive/wait time standards (**access standards**) that apply to VHA also apply to VCCP care;
2. require that the same credentials, training, competence and quality that are established for VHA providers (**quality standards**) are required for VCCP providers before adding them to the network; and
3. require that the additional expense of VCCP care (**costs**) be appropriated separately and not drawn from VHA funding.

Our organizations do support sections of the proposed rule pertaining to:

4. judicious identification of underperforming clinics; and

5. the setting of some limits on non-VA prerogatives.

1. ACCESS STANDARDS

The most problematic regulations pertain to the drive time and wait time eligibility for VCCP care. By the VA's own conservative estimate in its accompanying Economic Regulatory Impact Analysis, the number of Veterans who are eligible for VCCP based just on the new distance/drive time standard will increase fivefold (from 8% of enrolled Veterans under the Choice 40-mile provision to 39% under the current proposed rule). Additional numbers of Veterans will become eligible for VCCP based on the new wait time standard, although perplexingly, the Impact Analysis concluded that there will be no net gain in enrolled Veterans gaining eligibility based on the new wait time criterion. An additional 5 percent of care currently provided at VA facilities will transition to community care secondary to the designation of underperforming clinics. Lastly, Veterans who live close to VHA facilities in the five states with the lowest population density will gain VCCP eligibility. In aggregate, the majority of enrolled Veterans will be eligible for non-VA care, paid for by VHA.

These are very high numbers and represent a massive restructuring of the basic model of VHA care. Of concern, the program is predicated on the inaccurate premise that Veterans will be afforded a shorter wait and a shorter commute for care. On the contrary, while VA is required to meet wait/drive time metrics, VCCP providers are not required to meet any standard whatsoever. Our apprehension is that unless VCCP can assure even shorter wait or drive times, the new standards will only serve to divert resources from VHA to the private sector without improving access, not to mention quality.

Specifically, the VA's proposed rules:

- State that a VCCP provider must be accessible, but never quantify VCCP length of wait or drive time, as they do for VA access/timeliness.
- Allow a Veteran who becomes eligible for VCCP by virtue of waiting 30/60 days for VHA care to wait as long as s/he wants for community care.
- State that the drive time algorithm will not be revealed.
- Exclude available fast public transportation in calculating drive time eligibility.
- Fail to compare local VHA clinic wait times to local VCCP wait times when designating underperforming Medical Service Lines. Vouchers could be issued to Veterans for community care that is even longer to access, defeating the justification for providing those vouchers in the first place.

2. QUALITY STANDARDS

Provider Qualifications

As a nation, we have the solemn responsibility to offer Veterans the highest quality care, whether provided in VHA or the private sector. The credentials, training, competency and performance standards that VHA requires of its own clinicians should be the benchmark for providers in the VCCP. Yet, the proposed standards avoid doing so. The proposed regulations indicate that the minimal qualification and quality standards used to contract providers for the Veterans Choice

Program will remain unchanged. Failure to ask the question “access to what kind of care?” can compromise the health and well-being of Veterans.

Specifically, the proposed regulations:

- Set no qualifications or quality standards for VCCP providers for their initial contract or renewal of contract. Standards are explicitly as low as they were in the Choice program.

One of the core justifications for the MISSION Act was to give Veterans comparative information on the quality of VHA and non-VA provider care in order to make healthcare decisions. While robust metrics exist for a limited number of inpatient process measures, there are very few accurate ones for outcome measures. Almost no measures exist that compare the quality of individual providers or clinics in the private sector to those within VHA. The regulations state that provider quality ratings will be published, but most of the relevant comparative information that Veterans need to make healthcare decisions will not be available.

- **Quality of mental healthcare**

The proposed regulations undercut Section 133 of MISSION Act which established evidence-based psychotherapy (EBP) as the criteria by which Veterans should receive treatment for Posttraumatic Stress Disorder (PTSD), Military Sexual Trauma (MST) and Traumatic Brain Injury (TBI). For PTSD alone, more than 4,600 VHA providers throughout the system have completed advanced EBP training. This expertise is totally ignored in the proposed regulations. Instead, the regulations insert a substitute argument that Centers of Excellence are the main places where PTSD is treated and there are too few centers to give most Veterans access to excellence in PTSD care. Nothing could be further from the truth about widespread access to PTSD expertise within the VHA.

The regulations then propose that VHA purchase trauma services that can be conveniently delivered by non-VA providers whose experience and qualifications have not been vetted. This underscores the willingness to sacrifice quality for access.

- **Eligibility for care that is in the Veteran’s “best medical interest”**

Although the regulations indicate that VA remains the authorizer of all VCCP care, (“VA must ultimately determine that such care is clinically necessary”), there is other language to explicitly allow VCCP providers to determine whether VCCP care is in the best medical interest. This hastens the conversion of VHA into becoming an insurance company more than a provider of care. Further, VCCP care is fee for service, which by nature leads to large increases of ancillary and specialty services. VCCP doctors and hospitals benefit from over-treatment and have an inherent conflict of interest designating what constitutes the best clinical outcome. There is a vast literature critiquing the kind of unnecessary care to which patients are subject in a fee for service environment. The U.S. spends one out of seven health care dollars on futile treatments -- which are avoided in VHA because staff are on salary with no incentive to over-treat.

- **Staffing**

Throughout the document, VHA staff are assigned responsibilities to make appointments, coordinate care, obtain documentation, collect Veteran copayments, discuss options with Veterans, etc. There is

no assessment of, or accommodation made for, extra staff needed to perform this huge expansion of workload. Even if the 43,000 current vacancies in the VHA were filled, how can the new duties be effectively undertaken without significant numbers of additional staff? If these duties are executed by diverting staff from other clinical care needs, remaining staff will become overburdened with more appointments in shorter periods of time, which would sacrifice quality.

- The Impact Analysis recognizes that meeting the wait time regulation would require significant increase in staffing, but never considers the better option of adding FTEs to VHA to meet those standards. It erroneously implies that providers are “available” in the community but not VHA.

3. COST IMPACT

The Impact Analysis predicted that the new access standards would significantly increase the number of Veterans who receive VCCP care, all of which must be reimbursed by VA. The Administration’s budget proposal falls far short of covering associated VCCP costs¹.

- The Impact Analysis dismisses the probability that the enormous shift in services and associated costs of VCCP care would be drawn from VHA’s budget, starting VHA down a path toward downsizing, and ultimately, under the Asset and Infrastructure Review Commission, to the closure of facilities and services.

We would like to acknowledge that the regulations include two beneficial elements:

4. UNDERPERFORMING MEDICAL SERVICE LINES

The proposed rules for designating underperforming medical service lines contain some very constructive ideas. Before identifying underperforming clinics, VHA will first consider whether statistical differences are skewed by small sample sizes or Veteran co-morbidities, whether differences are clinically meaningful, if there are simple fixes (e.g. new equipment), whether underperformance was 18+ months old and has already been addressed and how closure would impact other interdependent VHA clinics.

5. AUTHORIZATION LIMITS

There are attempts to retain some ability to authorize care and/or contain costs:

- VHA is intended to remain the authorizer of VCCP care.
- VHA has to authorize additional care beyond current episode of care.
- Emergency hospitalization in the community should transfer the Veteran back to VHA as soon as it is safe to do so.
- Drug prescriptions in VCCP are limited.
- VCCP equipment is allowed only if urgently needed.

SUMMARY

The VHA offers timely access to high quality health care and should remain at the center of all care

for our nation's Veterans. When VHA cannot meet demand, then an integrated community care program whose providers equal or exceed the same standards of access and quality is needed to augment services.

FOOTNOTE:

¹ The Independent Budget Statement on VA's FY 2020 Budget Request March 12, 2019 www.independentbudget.org

CONTACTS:

American Psychological Association hkelly@apa.org

Association of VA Anesthesiologists avaa.orl2019@gmail.com

Association of VA Psychologist Leaders president1@avapl.org

Association of VA Social Workers president@vasocialworkers.org

Association of VA Surgeons VASurgeons@gmail.com

Association of Veterans Affairs Nurse Anesthetists avana@assnoffices.com

National Association of Veterans Affairs Optometrists executive.board@navao.org

Nurses Organization of Veterans Affairs tmorris@vanurse.org

Veterans Healthcare Policy Institute execdiretor@veteranspolicy.org

Veterans Affairs Physician Assistants Association vapaaexecutivedirector@gmail.com