VA MISSION ACT OF 2018

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The full name of the Act is the “John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018”

The Act is 89 pages long and has 97 sections!

The primary goals of the Mission Act were to:

- Consolidate VA’s multiple community care programs and authorities
- Establish an Asset and Infrastructure Review (AIR) process
- Expand VA’s Family Caregiver Program to pre-9/11 veterans
- Expand telehealth
- Increase VA’s internal capacity to care for veteran patients in VA medical facilities through improvements to various recruitment and retention programs
ACCESS TO VCCP

Establishes a consolidated VA community care program, referred to as the Veterans Community Care Program (VCCP). Access to Community Care is required if:

- VA does not offer the care or services the Veteran requires or does not operate a full-service medical facility in the state in which a given Veteran resides,
- VA is not able to furnish care within designated access standards
- A Veteran and the referring clinician agree that furnishing care in the community is in the best medical interest of the veteran
- A given medical service line within a VA facility fails to meet certain VA access and quality standards
- Eligible veterans will be authorized three visits per calendar year at participating walk-in or Federally-qualified health care clinics. To access this new benefit, Veterans will select a provider in VA’s community care network and may be charged a copayment.
PAYMENT TO VCCP PROVIDERS

▪ Except for payments for services in “highly rural areas”, the payments for services are “to the extent practicable” to be the Medicare rates.
  ▪ Highly rural areas are those areas within a county with “fewer than seven” individuals per square mile. (Alaska will use the VA Alaska fee schedule absent another agreement.)

▪ The Act also contains “prompt payment” provisions mandating payment within 45 days of receipt of a paper claim, or 30 days from receipt of an electronic claim. Claims may be processed through a third party contractor.

▪ The Act creates a Center for Innovation for Care and Payment. Whether this is to be the Medicare and Medicaid analog is not clear. However, the authorization will exist to carry out pilot programs and develop innovative approaches to payment systems and delivery system models similarly designed to reduce cost and/or enhance quality.
OBJECTIONS TO VCCP

Independent reviews routinely predict that veterans’ health care that is outsourced from the VA to the community increases, not decreases, costs.

- Further, to manage the care veterans receive in the private sector would require contracting out to a third party administrator, adding even more costs.
- CBO estimates that implementing the bill would cost $46.5 billion over the 2019-2023 period
- AFGE and several VA professional groups are concerned that as more care goes to the community there will be fewer funds to support VA’s internal programs in the future (Congress recently increased VA budget to cover this cost in the near term)
VA’s Proposed Access Standards

VA proposed new access standards, effective when the final regulations publish, to ensure Veterans have greater choice in receiving care.

Access standards will be based on *average drive time* and *appointment wait times*.

- For primary care, mental health, and non-institutional extended care services, VA is proposing a **30-minute average drive time standard**.
- For specialty care, VA is proposing a **60-minute average drive time standard**.

Appointment wait-time standards of **20 days for primary care, mental health care, and non-institutional extended care services**, and **28 days for specialty care from the date of request with certain exceptions**.

- Eligible Veterans who cannot access care within those standards would be able to choose between eligible community providers and care at a VA medical facility.
A number of professional groups within and outside VA have objected to the proposed access standards and upcoming quality standards. They believe VA’s new proposed regulations will compromise the integrity of the Veterans Health Administration 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.
QUALITY STANDARDS

The VA MISSION Act strove to remedy an omission in the Choice Program – it’s failure to monitor the quality of healthcare services

- Directed the VA to set rigorous quality standards for VCCP
- Comparative quality scores for the VA and VCCP are to be made available to veterans and their providers to make informed care decisions.
- The data will also be used to establish and renew contracts for VCCP providers, designate underperforming VA clinics whose patients should be granted automatic VCCP vouchers
- Determine whether the VA should broaden pilot models of delivering private sector healthcare.
OBJECTIONS TO QUALITY STANDARDS

- **Use of substitute measures of quality.** For many diagnoses, there are few to no published quality metrics, and tangential measures are substituted instead.

- **Comparison to the wrong population.** Contrasting VA to non-VA health care is invalid because veteran and civilian populations are too dissimilar.

- **Lack of sufficient data.** VA and VCCP care quality cannot be accurately compared because many VCCP providers do not report data.
PROVIDER QUALITY STANDARDS UNDER CHOICE

Providers only needed (1) to be licensed and (2) not have adjudicated complaints against their license

- They were not required to have any specialized training in military culture or for treating PTSD or other mental health conditions

Quality standards are still be worked our for the Mission Act

- VA members are asking that VCCP providers be required to meet the same qualification and training standards that VA providers must have

- Insurance company awarded the contract wants VCCP providers to meet the same requirements as CHOICE providers
CONCERNS ABOUT QUALITY

- Community clinicians, as a group, lack military and veteran cultural competence, special clinical competence, or the access to a sophisticated array of therapeutic resources pertinent to military service health vulnerabilities.

- This is particularly important with Posttraumatic Stress Disorder (PTSD).

- Previous RAND and other studies revealed that when compared with VHA providers, psychotherapists in the community who treat PTSD are unlikely to have the skills necessary to deliver high-quality care.

- Section 133 of the MISSION Act aimed to correct the deficit. It instructed the VHA to establish competency standards for Community Care Network (CCN) providers who deliver PTSD treatment. The VHA formed a workgroup to develop criteria, due out this spring, which will be handed to Optum Public Sector Solutions, the entity contracted to oversee the CCN.
ASSET AND INFRASTRUCTURE REVIEW COMMISSION (AIR)
Requires VA to establish a 9-member AIR Commission appointed by the President and consented to by the Senate

The Commission would be tasked with considering recommendations made by VA and submitting a report to the President on VHA facility modernization and realignment

The report would then be submitted to Congress and absent a joint resolution of disapproval the recommendation would become law.

Includes additional authorities to allow VA to take action as may be necessary to carry out any recommended VHA facility modernization or realignment and to transfer or lease properties to historic preservation organizations.
OBJECTIONS TO “AIR”

AIR is loosely modeled after the Department of Defense’s Base Realignment and Closure (BRAC) process, and yet differs substantially from BRAC.

- If three military bases are consolidated into two, the DoD saves many expenses of operating the 3rd base when all of the servicemembers are redistributed and absorbed by the two receiving bases.

- If three VA facilities are consolidated into two, the Veterans receiving care at the 3rd facility would NOT go to the other VAs. In nearly all cases, the other facilities are too far away. In the few densely populated areas where another VA is within reasonable distance, there is likely no capacity or space to absorb the redistributed veterans. The veterans from the 3rd facility would have to receive VCCP regardless of their wishes.
OBJECTIONS TO “AIR”

The VA can hand over a facility’s deed to any private entity (even for free), as long as the entity complies with environmental restoration requirements. There are no restrictions on what’s done with the property once it is environmentally cleared.

- The entity can turn right around and re-open the facility to provide private care for veterans, paid for by the VA.

- The bill explicitly ties Congress’s hands. There can be no motions to reconsider or amendments.

- The administration may fill the Commission with healthcare executives who have a huge stake, and a conflict of interest, in VA privatization. These commissioners make the final set of recommendations, and it takes only five members to pass recommendation. While three seats are reserved for recognized Veteran Service Organization members, even if they voted at a bloc their votes will have little to no influence on the outcome.
The MISSION Act will expand eligibility for VA’s Program of Comprehensive Assistance for Family Caregivers (PCAFC) under the Caregiver Support Program. The PCAFC is currently available to eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. The expansion implemented by the MISSION Act will open the Program to eligible Veterans who served pre-1975 and their caregivers.
The MISSION Act gives VA greater ability to recruit and retain the best medical providers through greater access to an education debt reduction program.

- Increases the maximum amount of VA's education debt reduction program for physicians from $120,000 to $200,000 over five years, not to exceed $40,000 per year.
- Authorizes the program to be used as a recruitment and retention tool for Vet Center employees serving in mental health positions.
- VA will also pilot a scholarship program for 18 eligible Veterans to receive medical training in return for serving in a VA hospital or clinic for four years.
- Establishing peer specialists on VA Patient Aligned Care Teams in at least 15 VA medical centers by May 31, 2019, and in at least 30 VA medical centers by May 31, 2020, to promote integration of services for mental health, substance use disorder, and behavioral health in a primary care setting.
Section 403 would require VA to establish a pilot program to expand the number of medical residencies in health care facilities operated by VA, the Department of Defense, Indian Health Services, and other entities.

- Under the proposed pilot program, VA would be authorized to pay stipends and benefits to eligible medical residents at certain health care facilities. For certain locations, the VA would be required to reimburse those facilities for curriculum development, staff support, and costs related to accreditation of the residency program.

- CBO estimates that about 110 additional medical residents would join the program each year, that each resident would take an average of three years to complete the program, and that the average annual cost for stipends and benefits would be $70,000 per participant.
PILOT PROGRAM FOR MEDICAL SCRIBES

Section 507 would require VA to establish a two-year pilot program to increase the number of medical scribes (or personal assistants to physicians) employed at the department.

- CBO estimates that VA would need to hire 40 medical scribes (20 term employees and 20 contractors) in 10 medical centers. CBO expects that the pilot would run from the end of fiscal year 2018 through the end of fiscal year 2020.
Section 402 would require VA to establish a program to provide mobile deployment teams of medical personnel to provide health care at underserved VA facilities.

- CBO estimates that each team would include three health care providers, and that the cost to employ the staff of each medical team would be about $500,000.

- Costs for transportation and room and board of $64,000 per team.

- VA will start with 10 mobile deployment teams in 2019 and growing to 15 in 2020.

- CBO estimates that implementing this section would cost $24 million over the 2019-2023 period.
TELEHEALTH &
MISCELLANEOUS
Act states that a covered health care professional may practice:

- “At any location in any State”, regardless of where they or the patient are located, if they are using telemedicine to provide treatment to the Veteran,
- Provided they have an “active, current, full and unrestricted license”
Act would increase the fees charged to veterans who obtain loans guaranteed by VA

- Will extend the current limitation on pension amounts that can be paid to certain veterans who receive benefits from Medicaid.

Section 106 requires that VA conduct market area assessments on the health care services provided by the department.

- Every four years, this section also would require VA to develop a strategic plan to meet the demand for health care provided by the department.
“It is the ethical responsibility of VA providers to inform Veterans that it is in their best medical interest get their treatment at VA when the quality of treatment from a community provider is either not known or at a level that is lower than what the VA would offer.”

May 30, 2019
VA Psychologists’ Leadership Conference, San Antonio
QUESTIONS?