Analysis of the

Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act

May 15, 2024

Veterans Healthcare Policy Institute

Strengthening Care for Veterans and the Nation

The "Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act" (May 6, 2024, version) contains many commendable provisions that will improve the care provided to our nation's veterans. We are particularly encouraged by Sec. 110 — which would stimulate the “adoption of certain health information standards for Department of Veterans Affairs and certain health care providers." This language would significantly enhance the coordination of care for the millions of veterans who receive treatment both within the Veterans Healthcare Administration (VHA) and the Veterans Community Care Program (VCCP).

However, Sec. 101 and Sec. 105 are Trojan Horses embedded in the larger package and will be deeply detrimental to veterans and further jeopardize the VHA system. which. We strongly urge that the legislation be redrafted and these problematic sections removed before the bill is moved through Congress.

The bill’s CBO score — a $942 million outlay through FY 2026 — confirms that the legislation will come at an exceptionally high cost. If Congress chooses to fund approximately $1 billion for veterans’ care and benefits, priority number one must be upgrading existing infrastructure and bolstering VHA personnel. This is necessary to address the existing lack of capacity to meet the growing demand for services, especially following the implementation of the PACT Act of 2022 and the current seven billion dollar VHA deficit.

Below, we analyze the two highly concerning sections, as well as three other sections that warrant revision.

Sec. 101. Finality of decisions by veteran and referring clinician under Veterans Community Care Program.

This statute removes the commonsense authority of VHA administrators to override provider recommendations that a patient be referred to private care because it is in the veteran's "best medical interest."

While the “best medical interest" designation is theoretically appropriate for veterans in selected instances, there are far too many cases where this category is being misapplied. This happens, for instance, when it aligns with the veteran’s “preference.” MISSION Act regulations clearly state that "best medical interest" should not be used solely based on a veteran’s convenience or preference. When it is used in this manner, VHA's administrative oversight is an appropriate response.

According to the Independent Budget’s analysis of the MISSION Act, the "best medical interest" criterion "is to be considered when a veteran's health and/or well-being would be compromised if they were not able to be seen in the community for the requested clinical service. When using this community care eligibility criteria, the ordering provider should include the following considerations: nature or simplicity of service; frequency of service; need for an attendant; and potential for improved continuity of care. *'Best medical interest' is not to be used solely based on convenience or preference of a veteran*" (italics emphasis added).

As the Red Team Report noted, veterans do not have adequate information to make informed choices about VCCP versus VHA in-house care. Likewise, VHA and VCCP providers making referrals to the VCCP, and all enrolled veterans, need significantly clearer information that “veteran preference” does not fall under the category of "best medical interest." Legislation should remedy these glaring failures. This provision does the opposite.

This section permits “referring clinicians” to determine that a veteran should receive care outside the VHA. There is no definition in the legislation, nor one in statute, for a referring clinician. That lapse must be corrected so that only VHA, and not community care providers, are able to make the determination about “best medical interest.” Otherwise, private sector healthcare entities would be financially incentivized to retain veteran patients.

This highly misguided section should be eliminated entirely. Moving forward, VHA must retain – not lose – the authority to have the final say on whether VCCP referrals meet explicit eligibility standards. No other healthcare system in the country, or indeed in the industrialized world, pays for patients to go out of network simply because they prefer it.

Sec. 105. Standardized process to determine eligibility of covered veterans for participation in certain mental health treatment programs.

This section dangerously modifies the standards for veterans accessing residential mental health or substance use disorder care in the private sector. The stated intention of the change is to ensure quick screening and placement when a veteran is in urgent need of treatment for substance use, PTSD, or other mental health issues. This is a laudable goal, especially given the extant wait times for VA residential treatment programs. But there are three serious problems within this section – 1.) a complete

failure to address quality of care, 2.) timelines made unreasonable in the absence of significantly more funding, and 3.) timelines that ignore medical standards of practice.

Quality of care: The language contains no requirements that ensure private programs provide high-quality, evidence-and-measurement-based care. Unregulated quality of care in the private sector that prioritizes profits is an ominous concern. For example, two years 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* published a series of articles exposing the unscrupulous practices of private sector addiction treatment programs.

Last year, the VA's Office of Inspector General expressed similar concerns. At an April 2023 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."

Section 105 should be amended so that **contracts/agreements with non-VA facilities contain requirements for the same quality standards as the VHA requires of its own RRTPs**. To that end, the VHA must:

· Create certification requirements for covered treatment programs that include:

- Accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) or an equivalent organization
- Scientific evidence for a program's treatment approach
- A standard ratio of licensed independent practitioners (LIPs) per resident
- Mental health and substance use disorder LIPs take a minimum of four hours of VA's TRAIN courses corresponding to the patient population they serve, and four hours on military culture
- Semi-annual peer review quality assurance system
- Treatment planning

· Recertify programs every three years

· Mandate that mental/behavioral health measures be administered to every veteran participant at the point of entry, exit, and six months (if reachable) following discharge from the program. Require that the scores of veterans be sent to the VHA for data analysis and evaluation of each program, with VA providing technical assistance for testing administration

· Publish the program outcome data on VA's Access to Care website

Timelines creating administrative burdens: The new evaluation and placement standards outlined in the statute will place a significant administrative burden on the

VHA and strain its healthcare budget without providing adequate resources. The requirements for the VHA to screen veterans within 48 hours and place priority referrals within the next 48 hours are demanding, particularly for patients whose psychological or substance use conditions are largely unknown at the time of referral. Moreover, the inclusion of "self-referrals" in the statute will dramatically increase the number of veterans requiring rapid evaluation and placement. Completing full evaluations and referrals within such a short timeframe is only possible with significant additional funding for both clinical and non-clinical staff. We believe the Congressional Budget Office (CBO) did not take this into account when assessing the impact of these requirements.

Timelines ignoring medical standard of practice: Setting a 48-hour admission target for veterans with substance abuse issues may unintentionally encourage dangerous medical practices and fall short of providing the optimal care required for long-term recovery, especially for those with complex dual diagnoses. Withdrawal from certain substances, particularly alcohol, can be life-threatening, necessitating thorough assessments and appropriate medical treatments. Prioritizing the least restrictive, personalized treatment options that align with veterans' psychosocial needs has been shown to yield the most favorable outcomes for maintaining sobriety. This nuanced approach is best pursued after initial stabilization and detoxification, which may take longer than the proposed 48-hour timeline. Veterans with co-occurring addiction and mental health conditions require sufficient time to stabilize, carefully consider their treatment options, and collaborate closely with providers to ensure the most effective and sustainable path to recovery.

We recommend that this section be removed.

There are three other sections of the bill that we recommend be modified and/or removed.

Sec. 107. Pilot program to improve administration of care under Veterans Community Care Program.

This section grants latitude to the VCCP third-party administrators to offer extra pay to private sector providers for participating in the VCCP. Instead of making critical training and timely submission of records mandatory, this provision offers financial incentives to providers in exchange for nothing. A vast body of literature on the failure of financial incentives to enhance quality demonstrates that such incentives rarely work. It is deeply concerning that financial incentives are being offered to providers to join the VCCP in lieu of requiring them to meet quality control measures or fulfill any training requirements.

VHA providers are required to take specified trainings, such as evaluation and management of suicide, lethal means safety and acute suicide interventions, military cultural competency, whole health, prevention and management of disruptive behavior, and, in the wake of the PACT Act, training in toxic exposures. These trainings are one

of the reasons why the VHA has a better record of delivering higher quality services compared to the VCCP. VCCP providers have no requirements, and this double standard continues to encourage problematic care in the community program.

The trainings that VCCP providers undergo are not published in the provider directory, leaving veterans without any information about this nominal level of competence. This information must be made publicly available to veterans to ensure transparency and informed decision-making. This was a Red Team recommendation.

This section should be deleted. It is essential that the VHA prioritizes the quality of care provided to veterans, both within its own facilities and through the VCCP. By offering financial incentives without proper quality control measures and training requirements, this section risks compromising the standard of care that veterans receive and further draining of resources from the VHA.

Sec. 122. Authority for Secretary of Veterans Affairs to award grants or contracts to entities to improve provision of mental health support to family caregivers of veterans.

We wholeheartedly support the provision of government-paid mental health support services to the family caregivers of veterans. However, the model of care delivery designed in this section is predicated on the erroneous assumption that the VHA, if fully funded, isn't the appropriate system to provide care. VHA already provides services for family members of veterans with serious medical and psychological conditions, and these services allow family members to work in conjunction with VHA providers within an integrated network of care to ensure families are not only benefitting from treatment themselves, but that they become de facto partners in care, powerful agents for the veterans' whole health benefit. The $10 million allocated yearly in this section for family caregivers should be directed to the VHA, and only when the VHA cannot provide services in a timely or convenient manner should VA utilize private entities.

Sec. 149. National Veteran Suicide Prevention Annual Report.

We recognize the many benefits of this section and enthusiastically support it.

The section would expand a key VHA document, the National Veteran Suicide Prevention Annual Report, and most importantly, it mandates that the report's findings be shared with the public. This recognition of the pivotal role that publicizing and utilizing data plays in forming policy that affects veterans' suicides is commendable.

However, as has been written elsewhere**,** the language needs a simple amendment. While the bill requires the VHA to disclose its important suicide data, it doesn't require the disclosure of data generated by recipients of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. This program includes 80 non-profit, private, and

government groups, ranging from veterans' associations to social service agencies to tribal nations, who are aiding the VHA in the fight against veteran suicide in local communities. These organizations are generating a treasure trove of invaluable information that could help policymakers, veterans, social scientists, public health officials, and others drive down the still distressing number of veteran suicides.

Unfortunately, most of that information is rolled up into aggregate numbers for the whole program, making it impossible to determine whether a particular organization's services are effective or not. An amendment to the Not Just a Number Act must require the VHA to analyze the pre-post figures, itemize them for each grantee, and place them in the public domain. Results should include items such as whether and how much scores on the five measures improve for veterans who complete the grantee's services.

By making this simple amendment, the Not Just a Number Act will ensure that the valuable data generated by the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program is made available to the public, enabling a more comprehensive understanding of the effectiveness of various interventions, and ultimately contributing to the development of more targeted and effective policies to reduce veteran suicides.