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## House Amendment to S. 2372, VA MISSION Act of 2018

### FLOOR SITUATION

On Wednesday, May 16, 2018, the House will consider the House Amendment to [S. 2372](#), the “John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018” or the VA MISSION Act of 2018, under a rule. S. 2372 was introduced on February 5, 2018 by Sen. Johnny Isakson (R-GA) and passed the Senate by unanimous consent on March 1, 2018. The House Committee on Veterans’ Affairs ordered H.R. 5674 to be reported on May 8, 2018 by a vote of 20-2. The House Amendment is comprised of H.R. 5674, as reported by the House Committee on Veterans’ Affairs.

### SUMMARY

The House Amendment to S. 2372 strengthens and improves the Department of Veterans Affairs (VA) healthcare system for the benefit of the nation’s veterans. The bill consolidates VA’s multiple community care programs and authorities and provides further funding for the Choice Program. It would establish an Asset and Infrastructure Review (AIR) process to recommend actions to modernize and realign VA’s massive medical infrastructure and also expands VA’s Family Caregiver Program to pre-9/11 veterans and increases VA’s internal capacity to care for veteran patients in VA medical facilities through improvements to various recruitment and retention programs. Specifically, the bill:

#### **Title I: Caring for our Veterans**

Title I of the bill establishes a robust, consolidated VA community care program, referred to as the Veterans Community Care Program (the Program). Through the Program, veterans who are enrolled in the VA healthcare system or otherwise entitled to VA care would be granted access to care in the community. Access to community care would be required under the Program if VA does not offer the care or services the veteran requires, if VA does not operate a full-service medical facility in the state in which a given veteran resides, if a given veteran was eligible for care in the community under the Choice 40-mile rule and meets certain other criteria, or if a given veteran and the referring clinician agree that furnishing care in the community is in the best medical interest of the veteran after considering certain criteria. Access to community care would also be required if VA is not able to furnish care within designated access standards developed by VA after consultation with certain other

entities and published in the Federal Register and on VA's website. Care may be authorized in the community if a given medical service line within a VA facility fails to meet certain VA quality standards developed by VA or if veterans in need of an organ or bone marrow transplant have a medically compelling reason to travel outside the region of the Organ Procurement and Transplantation Network. Additionally, eligible veterans will be authorized two visits per calendar year at participating walk-in or Federally-qualified health care clinics.. walk-in care.

To resolve disputes regarding eligibility for care in the community under the Program, title I of the bill would require VA to provide veterans with a clinical appeal process to review community care eligibility determinations but prohibit such appeals from being appealed to the Board of Veterans Appeals. Title 1 of the bill would also require VA to develop and administer a number of training programs to ensure that veterans, VA employees, and community providers are fully aware of and educated on the Program, the VA healthcare system, and mental and physical health conditions that are common among veterans.

To carry out the Program, VA would be required to enter into a contract or contracts to establish a network of community care providers and authorized to establish tiered networks pursuant to such contract or contracts but would be prohibited from prioritizing providers in one tier over another in a manner that limits a veteran's choice of providers. Title I of the bill would authorize VA to pay for services not subject to a contract or agreement but deemed necessary by VA nevertheless. In such cases, VA would be required to take reasonable efforts to enter into a formal agreement, contract, or other legal arrangement to ensure that future care and services provided by the provider in question are covered.

Title I of the bill requires VA, to the extent practicable, to reimburse community care providers under the Program at Medicare rates, authorizes VA to pay higher rates in highly rural areas, and requires VA to incorporate value-based reimbursement models to the extent practicable to promote high-quality care. The VA is required to reimburse community care providers in a timely manner, and is authorized to contract our claims processing to a third party.

Title I of the bill authorizes VA to enter into provider agreements called Veterans Care Agreements (VCAs). VCAs would not be subject to competition or other requirements associated with federal contracts and the same affirmative action moratorium that applies to TRICARE contractors and subcontractors pursuant to OFCCP Directive 2014-01 would apply to VCA contractors and subcontractors. Veteran eligibility for care under VCAs would be subject to the same terms as VA care itself and the rates paid under VCAs would, to the extent practicable, be in accordance with rates specified for the Program. Title I of the bill would also authorize VA to enter into VCAs with State Veterans Homes and eliminate competitive contracting actions and other requirements associated with federal contracts for State Veterans Homes.

Title I of the bill requires VA to perform market area assessments on a number of key factors at least once every four years. VA would be required to submit the assessments to Congress and to use them to determine the capacity of the Program's provider networks and access and quality standards. VA would also be required to submit a strategic plan to Congress, no later than one year after the date of enactment and at least every four years thereafter. The strategic plan would be required to specify the demand for care and the capacity to meet such demand both at each VA medical center and in the community. VA would be required to take a number of elements into consideration when developing the strategic plan and to identify emerging issues, challenges, and opportunities and recommendations to address them.

The title also addresses safe opioid prescribing practices by non-VA medical professionals, improved information sharing with community health care providers, and the participation of VA providers in the national network of state-based prescription drug monitoring programs.

The title sunsets the Choice Program one year after enactment of the bill, which is the expected date the Program should be implemented. The title authorizes VA to use any unutilized Choice funding to sufficiently balance community care accounts.

Finally, Title I makes improvements to telemedicine efforts, embraces innovation for care and payments, improves access for veterans and live donors to transplant procedures, and expands the eligibility for the Family Caregiver Program to pre-9/11 veterans.

## **Title II: VA Asset and Infrastructure Review**

Title II of the bill requires VA to establish a nine member Asset and Infrastructure Review (AIR) Commission. The AIR Commissioners would be appointed by the President, with the advice and consent of the Senate and in consultation with Congressional leaders and congressionally chartered, membership-based veterans service organizations. 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. Title II of the bill 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.

The Commission must incorporate feedback from veteran service organizations, conduct meetings and hearings open to the public, and update information through online publication of any VA proposals.

Title II also calls for the improved training of construction personnel, a requirement to review enhanced use leases, and an assessment of VA health care provided throughout the US territories in the Pacific.

## **Title III: Improvements to Recruitment of Health Care Professionals**

Title III provides scholarships to medical students in exchange for service to VA, increases the amount of education debt reduction available through Education Debt Repayment Program from \$120,000 to \$200,000 over five years and from \$24,000 to \$40,000 annually, establishes a specialty debt repayment program at the Department, and rolls back limitations on bonuses for recruitment, relocation, and retention.

Further, Title III establishes a pilot program for supporting four years of medical school education costs for two veterans at each of the five Teague-Cranston Schools and at four historically black colleges and universities. The covered medical schools would include Texas A&M College of Medicine, Quillen College of Medicine at East Tennessee State University, Boonshoft School of Medicine at Wright State University, Edwards School of Medicine at Marshall University, the University of South Carolina School of Medicine, Drew University of Medicine and Science, Howard University of Medicine, Meharry Medical College, and Morehouse School of Medicine. The medical schools that opt to participate in the program would be required to reserve two seats each in the class of 2019.

## **Title IV: Health Care in Underserved Areas**

The Department of Health and Human Services' Health Resources and Services Administration (HRSA) defines a medically underserved area as an area designated by HRSA as having too few primary care providers, a high infant mortality, a high poverty or a high elderly population.

Title IV of the bill requires VA to: (1) develop criteria to designate VA medical facilities as underserved facilities; (2) consider a number of factors with respect to such facilities, including the ratio of veterans to providers; the range of specialties covered; whether the local community is medically underserved; the type, number, and age of open consults; and whether the facility is meeting VA's wait time goals; (3) perform an analysis annually (if not more often) to determine which facilities qualify as underserved; and (4) submit a plan to Congress, within one year of enactment and not less frequently than annually thereafter, to address underserved facilities.

Title IV of the bill also requires VA to carry out a three-year pilot program to furnish mobile deployment teams of medical personnel to underserved facilities and to consider the medical positions of greatest need at such facilities and the size and composition of teams to be deployed. It would also require VA to establish a pilot program to establish medical residency programs at covered facilities, including VA facilities, a facility operated by an Indian tribe or tribal organization, an Indian Health Service facility, a Federally-qualified health center, or a DOD facility.

## **Title V: Other Matters**

Title V requires a report on bonuses to high-level employees of the Department, allows podiatrists to be named to a supervisory position in the Department the same manner as a physician can be, and alters the definition of a major medical facility project from projects that exceed \$10 million to projects that exceed \$20 million.

Further, Title V promotes the use and integration of mental health, substance use disorder, and behavioral health services in a primary care setting by placing peer specialists in care teams and establishes a medical scribe pilot program to increase the use of medical scribes in emergency department and specialty care settings at 10 VA medical centers.

Finally, Title V extends the current funding fee rates for mortgages closed on or after September 30, 2027, through September 30, 2028, extends the reduction in an amount of pensions furnished by Department of Veterans Affairs for certain veterans covered by Medicaid plans for services furnished by nursing facilities, and authorizes \$5.2 billion for the Choice Program.

## **BACKGROUND**

### **Title I Background:**

VA operates the nation's largest integrated healthcare system and provides care to approximately nine million veteran patients. The majority of the health care that veterans receive through the VA health care system is provided through medical professionals and support staff employed by VA and working in VA facilities that are managed and overseen by the Veterans Health Administration (VHA). However, since 1945, VA has also collaborated with medical professionals and support staff in the

community—who are not VA employees and who do not work in VA facilities—to provide veterans with timely, accessible, high-quality care. This is generally referred to as “community care”.<sup>1</sup>

The most recent VA community care program is the Choice program (Choice). Choice was established by the Veterans Access, Choice, and Accountability Act of 2014. Choice expanded the availability of community care to veteran patients by setting specific triggers upon which VA would be required to give veterans the option of receiving care in the community rather than in a VA medical facility. In general, veterans are eligible to receive care through Choice if they are unable to secure an appointment at a VA facility within 30 days or if they reside more than 40 miles from the nearest VA facility. Through Choice, veteran patients are referred to regional networks of community providers who are managed by Third Party Administrators (TPAs). However, under other community care programs, VA refers veteran patients to community providers through agreements with the Indian Health Service, the Department of Defense, academic affiliates, or other entities; through the Patient Centered Community Care program; or through national or local contracts or sharing agreements. Each of VA’s current community care programs and authorities contain different eligibility criteria, different reimbursement rates, different payment structures, different referral and authorization requirements, and different contracting approaches. According to VA, “this has resulted in a complex and confusing landscape for veterans, community providers, and [the] VA employees that serve and support them.” As a result, “veterans face excessive bureaucracy, access based on administrative eligibility, and minimal care coordination [which] inhibits the delivery of high-quality personalized care.” This led VA and the Committee to conclude that, “it is imperative for VA to modernize how care is provided through a high performing integrated network which includes care provided both in VA and in the community.”<sup>2</sup>

## **Title II Background:**

VA is one of the federal government’s largest property-holding entities with a capital asset portfolio that includes approximately 155 million square feet across more than 35,000 acres of land. Unlike many other federal agencies, the majority—86 percent—of VA’s capital asset portfolio is owned. VA also controls approximately 24.6 million square feet of leased space. Most VA facilities are medical facilities that are operated by VHA. Nationally, VHA’s portfolio includes 168 VA medical centers, 135 community living centers, 48 domiciliary centers, 737 community-based outpatient clinics, 22 health care centers, and 305 other outpatient facilities such as mobile treatment spaces. The average VHA building is approaching 60 years old, more than five times older than the average building age of a not-for-profit hospital system in the United States.<sup>3</sup>

## **Title III Background:**

VA currently has several programs to address recruiting in its professional ranks, including the Education Debt Repayment Program and the Health Professions Scholarship Program (HPSP). Despite these programs, VA maintains a significant number of physician vacancies across the VA healthcare system. VA’s considerable recruitment and retention issues are worsened by an aging workforce that is becoming increasingly retirement-eligible.<sup>4</sup>

## **COST**

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<sup>1</sup> See [House Report 115-671](#) at 2.

<sup>2</sup> *Id.* at 2-3.

<sup>3</sup> *Id.* at 18.

<sup>4</sup> *Id.* at 25.

A Congressional Budget Office (CBO) estimate is not currently available.

### **STAFF CONTACT**

For questions or further information please contact [Jake Vreeburg](#) with the House Republican Policy Committee by email or at 2-1374.