After a concerted effort, the bipartisan bill to reform the way care is delivered to Veterans has been signed into law. While there are a number of significant reforms, perhaps none are so critical as those related to the ability of Covered Veterans (the Veteran) to receive their care outside of the current VA system, and from private health care providers. Through the establishment of the Veterans Community Care Program, a system will be created which will allow qualifying services to be provided to Veterans who, under the provisions of the VA Mission Act of 2018 (The Act) are not able to receive timely and appropriate care to which the Veteran is entitled. While it will take some time to implement, providers may wish to begin to consider whether and how they would like to position themselves to serve this new population. What follows is an informational overview for potential providers of services to Veterans.

**Care Required To Be Provided Through Non-VA Providers**

The Act is structured to address both the conditions under which care is required to be furnished through non-Departmental providers, and conditions under which that care can be authorized to be furnished by those providers. As to the first element, subject to the necessary appropriation of funds being available, there is a mandate to provide hospital care, medical services, and extended care services if, in general, the following conditions are met:
1. The care or services required are not offered by the VA;
2. There is not a “full-service” medical facility in the State where the Veteran resides;
3. The Veteran was eligible under the existing Choice set of programs and continues to qualify for eligibility and meets certain residency conditions;
4. The Veteran has requested care or services and the available care or services does not meet “designated access standards”; or
5. The Veteran and the referring physician agree that furnishing care and services through a non-VA provider would be “in the best medical interest” of the Veteran, based on criteria developed by the Secretary.

This latter “in the best medical interest” condition will be the one of most interest. The criteria will include such things as the nature of the services and the distance the Veteran must go to receive those services, as well as the timeliness of appointments and the overall burden to access those services, as will likely be spelled out in some detail in regulations. What makes this element of particular significance is that the Veteran will have the discretion to continue to receive services from VA facilities, even if the criteria to go elsewhere are met, and apparently, the decision as to what is in the “best medical interest” of the Veteran is based on the Veteran reaching an agreement on that point with the referring physician. How that particular decision may be reviewed is not clear, but there is provision for its review which provides that it may be subject to the Department’s clinical appeals process, but not ultimately subject to the Board of Veteran’s Appeals.

From the authorization perspective, there are a number of conditions under which care may be furnished by a medical services line which has been determined is not compliant with specified quality standards. The quality standards in this instance include timeliness (determined by comparison with other VA facilities) and quality (determined by comparison of the two service line quality measures at non-Departmental facilities).

Of note, the Act specifically authorizes the creation of tiered networks based on criteria to be established. There is, however, a prohibition on prioritizing provider in a tier over any other tier in any fashion that limits the available choices for care under the applicable community care provisions. Given that limitation, it is not clear just how tiering would be implemented in an effective way such there providers would make the investment in new networks solely for this purpose.

**Provider and Provider Network Contracts**

The Act authorizes the Secretary to enter into “consolidated, competitively bid contracts” to establish provider networks to ensure sufficient access to services. The only real guidance on this point is that with respect to such networks, the Secretary “to the extent practicable” must be able to “ensure” that Veterans are able to make their own appointments “using advanced technology”, and the Secretary can be responsible for scheduling appointments. The Secretary will also have to develop methods to monitor the quality of care provided to Veterans through these networks. This will include, in particular, the timeliness of acceptance of referrals within the network and the scheduling and completion of appointments.
With respect to the providers themselves, contracts known as a Veterans Care Agreement (VCA) will be put in place with eligible providers. While a designated official may actually enter such agreements, the Secretary is directed to review any “material” agreement (defined as one in which the spend is $5 million or more) and determine the care being provided can be provided by the VA or through some other arrangement. To be an eligible provider, the provider must either be a Medicare or Medicaid participant, an Aging and Disability Resource Center (or like entity), a center for independent living, or otherwise be eligible through a certification process the Secretary is directed to establish.

The contracts do not require competitive bid procedures, nor are they governed by the normal federal contracting requirements, except the normal records access provisions allowing comptroller review. The Act does, however, provide that VCA contractors are subject to the laws related to integrity, ethics or fraud, as well as civil and criminal penalties, that would be applicable to Medicare program providers, as well as the laws related to employment discrimination. Finally, the contracting parties will not be treated as Federal contractors or subcontractors for purposes of the VA service contract labor standards.

The contract requirements themselves are mandated to have a series of provisions that would be fairly standard in such arrangements, e.g. to accept payment at the required rates. Of note, there will be an authorization requirement (inclusive of “prior written consent” for services outside an authorization) for all services, and a requirement that unless payments are rejected or refunded within 30 days of receipt, they are final.

**Payment Standards**

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.) If there is not a Medicare rate, then the Secretary will create an applicable rate. In addition, the Secretary is authorized to adopt value based reimbursement models.

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 also references the ability to pay for out of network claims for providers who have not contract. With respect to those claims, if the Secretary determines that the care was necessary, the provider may be compensated for the cost of the care or services provided. In addition, to prevent further non-contracted care from that provider, the Secretary is to “take reasonable efforts” to enter an agreement or “other arrangement” with that provider.

From the Veteran’s perspective, the payment must not be greater than that amount that would otherwise be paid for the same or comparable services at a VA facility. The Act further provides that a veteran may be required to pay co-payments for hospital or medical services if otherwise required for Veteran’s care. If a copayment is required, for walk in care, after the first two walk-in episodes, it may be adjusted.
based on the priority group of enrollment, as well as the number of episodes of care, or other factors the Secretary may define.

**Access and Quality**

To address issues with Veterans care that are perceived to currently to exist, and not have those duplicated in the non-VA settings, the Act mandates that the Secretary establish quality and access standards. On the quality front, consideration is mandated of the existing measures generally used, with the purpose of providing “relevant comparative information to make informed decisions” for the Veterans. This, of course, will be a major undertaking with datasets to include elements related to timely care, effective care, safety (including complications, readmissions and deaths) and efficiency. While there is not a specific definition of each of these terms—how “effective care” or “efficiency” is to be measured, the development process is to be a consultative one, involving the private sector and other non-governmental agencies. One goal of note, within a year of establishing the quality standards, the Secretary is to publish the quality rating of medical facilities in the Hospital Compare website.

With respect to access, of particular note is the mandate to develop an ability for Veterans to access walk-in care, i.e. care that is non-emergent and made available by entities or providers that furnish episodic care and non-longitudinal management of conditions, i.e. urgent care centers, and the like. This care, however, must also be integrated in such a fashion that there is continuity of care through the provider system.

One element of access and quality will also be competency. The Secretary is directed to establish standards and requirements for the provision of care in areas of special expertise, including PTSD, sexual trauma related conditions and traumatic brain injuries. This will involve the receipts of special training on the delivery of evidence based care in this areas.

All covered providers will be required to review and certify that they have reviewed the opioid evidence based guidelines for prescribing opioids. In addition, the document authorizing a Veteran’s care must include the relevant medical history and a list of all prescriptions. Providers who prescribe opioids must also include records of such prescriptions in the records provided to the Secretary.

The Act also addresses telemedicine, fully endorsing the potential. More specifically, the Act provides that “notwithstanding any provision of law regarding licensure” 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. This ability will apply to any professional authorized to provide care under the Act, provided they have an “active, current, full and unrestricted license”. The Act even goes further by providing that it supersedes inconsistent State laws, and further provides that a State with an inconsistent state law cannot take any action to deny or revoke a practitioner’s license on the basis that providing telemedicine services in a state where the practitioner is not licensed or otherwise in compliance with state law as a result of the telemedicine activity. Whether such a provision, wherein the Federal rules
directly intervene into traditional state medical professional licensing provisions will be subject to challenge, will be one of the interesting issues that may play out in the future.

Finally, 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. If the changes in Veteran’s care contemplated by the Mission Act are funded, there may be a substantial opportunity for non-VA providers to provide health care services for Veterans. To do so, they will need to assure themselves that they are qualified to treat this population and, in general, that the Medicare rates of payment will be sufficient to allow them to do so given the population and the administrative requirements that may place additional requirements on their systems.

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National Law Review, Volume VIII, Number 158