American College of Physicians
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Robert Wilkie
VA Secretary
Department of Veterans Affairs
810 Vermont Avenue NW
Room 1063B
Washington, DC 20420

RE: Veterans Community Care Program (RIN 2900–AQ46)

Dear Secretary Wilkie:

The American College of Physicians (ACP) appreciates this opportunity to comment on the proposed rule "Veterans Community Care Program," which facilitates access to timely healthcare for eligible veterans. ACP is the largest physician medical specialty society, and the second largest physician-membership organization, in the United States. ACP members include 154,000 internal medical physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Many of ACP's physician members provide care within the Veteran's Health Administration (VHA), and many internists have received part of their training within the VHA. ACP strongly supports the Veterans Affairs' (VA) mission of providing high quality, comprehensive, and timely care to veterans in their time of need and throughout their lifetime.

The Veterans Community Care Program authorized by the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 to expand the availability of medical and hospital services from community, non-Veterans Health Administration (VHA) physicians and other healthcare professionals for veterans who qualify based on length of wait-list time or distance from VHA facilities. ACP recognizes the important healthcare services that the VHA provides to our nation's military veterans. Furthermore, the College supports the efforts of the Agency through the Veterans Community Care Program to meet the healthcare needs for the men and women who have admirably served our country. We believe the comments and recommendations offered below by the College in response to the proposed rule will assist the Agency towards this goal.

Funding for VHA and VA Services

Figures provided by the Paralyzed Veterans of America, Veterans of Foreign Wars, and DAV in *The Independent Budget*[1] place the total amount of funds required for VA, VHA Medical Community Care at $18.1 billion for FY 2020. **We are greatly concerned that absent increased and dedicated funding by Congress equal to the actual costs of the new Veterans Community Care Program, which may be**

[1] http://www.independentbudget.org/pdf/funding.pdf

grossly underestimated by the administration and CBO, funds may be diverted from traditional medical services within the VHA or other VA services. We believe this would jeopardize existing medical services for our veterans, compromise the current VHA structure, and even delay the implementation of the benefits within the VA Mission Act and its programs.

ACP believes the Congressional intent of the MISSION Act is to improve care furnished directly in VA facilities in a number of ways. Therefore, ACP strongly urges the administration to work with Congress to provide the necessary additional funding to existing VA facilities that have the capability to provide the required services veterans so desperately need. If patients cease going to the VA facilities, then there could be pressure to close the much needed facilities. These additional funds would allow VA facilities to remain open for extended hours, provide veterans medical services that meet their needs in a timely manner, and reinforce the trust that forms the basis for every interaction with the VA. This will further give veterans the opportunity to choose the health care clinicians that they know and trust.

Eligible Veterans

This proposed rule would provide eligibility for a covered veteran to access care and services through the Veteran Community Care Program if the VA determined that no VA facility within a specified area offers the hospital care, medical services, or extended care services needed. The VA would determine whether a VA facility does not offer the specific care and service that a covered veteran requires in relation to the residence of the covered veteran in consultation with the VA clinician or member of the VA care coordination team at the time when access to care in the community is determined.

Conditions such as residing in a state without a full-service VA medical facility, or qualifying under the grandfathering provision related to 40 mile eligibility and residence in one of the five states with the lowest population density (Alaska, Montana, North Dakota, South Dakota, or Wyoming) would qualify a veteran to receive any clinically necessary hospital care, medical service, or extended care services that is in accord with generally accepted standards.

Section 17.4010 of this proposed rule grandfathering eligibility would be carried forward indefinitely for only those covered veterans that reside in the 5 states. Any covered veterans that did not reside in one of these states would only be considered to have this grandfathered eligibility related to the 40-miles criterion for the first two years after the date of enactment of the MISSION act until June 6, 2020.

The newly proposed VA designated access standards consider both wait times and receipt of care or services as well as the average driving time from the covered veteran's residence to such care and services. There are existing standards in the Veteran Choice Program that measure timeliness of and distance from the patient's home to the service needed, whereas VA currently measures under the Veterans Choice Program, the distance from the patient's home to the nearest VA medical facility with a full-time primary care physician. Changing VA's distance-related measurement for community care to be the distance from the patient's home to the care or service needed would assist the VA in determining when covered veterans can be served directly by VA and when covered veterans can choose community care.

The College strongly recommends that the Agency, monitor this change in access standards of both wait times and receipt of care or services as well as the average driving time (this appears to be already in place), so that it is based on the proximity of a VA facility that has the capability to address the actual needs of the veteran.

Authorizing Non-VA Care

Section 17.4020 of this proposed rule perpetuates a program built on a system of authorizations. For example, authorization is required for an eligible veteran to receive an episode of care from an approved non-VHA clinician, for the non-VHA clinician to provide care to that veteran for that episode for more than 60 days, and for the veteran to receive additional care from another community specialty/subspecialty clinician deemed necessary by the treating clinician to address the episode. These authorization requirements can easily become a burden to the treating clinician and their staff, as well as the veteran. In order to minimize this potential administrative burden and to help facilitate the Program's goal towards the delivery of timely care, **the College recommends that all authorization forms be standardized (this appears to be already in place), that required clinical information for authorization be the minimum possible, and that processes be in effect to respond to the request in a rapid manner. In addition, it is recommended that the Agency consider reducing or eliminating authorization for treatment provided to eligible veterans from approved non-VHA clinicians who have already established a record of effective and efficient care within the Veterans Choice program.**

Payment Rates and Methodologies

Section 17.4035 of the rule addresses payment rates and payment methodologies. It continues the default payment rule established in the VA Choice Program that reimbursement rates under the Program will not exceed the applicable Medicare rate and further states that rates will be negotiated and set forth in an agreement between the Agency and an eligible entity or clinician. The College appreciates the Agency not rescinding the Veterans Choice Program regulations at this time, and to continue paying claims under such regulations for a period of time after the authority for the Veterans Choice Program expires in order not to create any confusion as to how those claims should be processed or adjudicated. **However, the College strongly recommends that in order to encourage participation by non-VHA physicians and other healthcare professionals in the Program, payment rates should be no lower than those provided under the Medicare program.** This is particularly true for primary care physicians and certain other specialty/subspecialty clinicians whose services are already undervalued under the Medicare payment system. Payment below the Medicare rate will serve as a significant barrier to participation.

This proposed rule also holds in place that claims processing for the Program fall under the responsibility of the Chief Business Office of the Veterans Health Administrations. **In order to encourage (and maintain) participation within the Program from the non-VHA healthcare professional community, claims submission procedures need to be clear and minimally burdensome, clean claims should be processed under prompt payment requirements, and related appeal processes should ensure a timely response.**

Bidirectional Availability of Clinical Information

It is the College's understanding that while processes are in effect within the Program to ensure that clinical documentation for services provided to veterans by non-VHA physicians and other healthcare professionals are added into the VA medical record system, the routine availability of critical medical information from the VA medical record system to the treating non-VHA clinician to address an episode

of care is less certain. Necessary previous clinical information regarding the veteran is too often not initially available to the treating non-VHA clinician and must be requested. This leads to unnecessary delays in care to obtain the needed medical information, and promotes lower quality and less efficient care delivery.

ACP encourages the administration to implement processes to ensure the timely, bidirectional exchange of patient clinical information necessary for effective patient care between VHA and non-VHA physicians, other healthcare professionals, and facilities regarding patients that receive healthcare services from both sources. There is concern that without proper communication or knowledge of the patients' history, the treating non-VA physician could unintentionally prescribe medication to a veteran that may lead to unintended consequences. There needs to be a mechanism for managing bidirectional electronic communication between the external facilities and the primary care physician (PCP). With a lack of communication, there is a high probability of error in care. If a patient visits a facility outside their PCP and there is a delay in sending information back to their PCP at the VA, the responsibility may rest on the VA physician. Electronic medical record (EMR) communication is vital; if information is not communicated promptly and a patient seeks care with their PCP at the VA after visiting a non-VA urgent care facility, then many things can go wrong such as testing, diagnosis, and unnecessary medication administration.

Dissemination of Veterans Community Care Information to Non-VHA Clinicians

The College commends the Agency for the excellent clinician-focused information displayed on its website[2] regarding the Veterans Choice Program and non-VHA clinician participation and encourage the Agency to follow through with the same quality information for the Veterans Community Care program. **The College strongly recommends that the Agency work with the various medical societies, including the College, to better disseminate information about the Program to non-VHA physicians and other healthcare professionals who could potentially participate.**

Please contact Brian E. Outland, Ph.D. on our staff at boutland@acponline.org or 202-261-4544 if you have any questions regarding the above comments and recommendations.

Respectfully,

Ana María López, MD, MPH, MACP
President
American College of Physicians

[2] https://www.hnfs.com/content/dam/hnfs/va/pccc/VeteransChoice/Choice_Program_Provider_Requirements.pdf