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Submitted to via www.regulations.gov

RE: RIN 2900–AP24, Expanded Access to Non-VA Care through the Veterans Choice Program

The National Association of Community Health Centers (NACHC) appreciates the opportunity to comment on the Veterans' Administration's Interim Final Rule on the Veteran's Choice Program, published in the Federal Register on November 5, 2015 (79 Fed. Reg. 65571). NACHC is the national membership organization for federally qualified health centers (FQHCs.)

Health centers play a critical role in the health care system, serving as the health home to over 23 million people, including over a quarter million veterans. With over 9,000 sites, they provide affordable, high quality, comprehensive primary care to medically underserved individuals, regardless of their insurance status or ability to pay for services. For additional information on health centers, please see the attachment.

NACHC believes that the Veterans Choice Program is an important step forward in providing access to high quality, comprehensive, and timely health care for our nation's veterans. We applaud the VA staff for their diligent efforts to develop this national program under a very short timeline.

Health centers have a unique and important role in the Veterans Choice program (hereafter referred to as "the Program"), for two reasons:

- Federal Qualified Health Centers (FQHCs) are the only type of health care provider which is specifically named in the statute as eligible to care for participating veterans (See Section 101(a)(1)(B)(ii)). This special attention suggests that Congress intended for FQHCs to play a central role in assisting the VA to implement the Program successfully.
- Health centers are required to care for all individuals who come through their doors regardless of their ability to pay, and to charge them either no fee or a discounted fee if their annual income is at or below 200% of the Federal poverty line. This makes health centers unique among all other Medicare provider types, because they may not - and will not - turn a patient away even if they will receive no payment for the services they provide. In addition, while many health centers receive Federal grants to offset the costs of caring for uninsured and underinsured patients, Congress has clearly expressed its intention that these grant funds should not be used to cover shortfalls in the costs of

caring for publicly-insured patients. As will be discussed below, this places health centers in a particularly vulnerable position when logistical challenges (e.g., contracting, authorization, communication with veterans) impact a provider's ability to receive reimbursement.

The following comments reflect FQHCs' unique role in the Veterans' Choice program, their 50 years of experience serving medically underserved individuals, and the experiences of those FQHCs who have been participating in Veterans' Choice since its implementation in November 2014.

Summary of NACHC's Comments

Our comments and recommendations fall into five categories, as follows:

- Authorizations to receive non-VA care:
 - Establish a unique call-in number for contracted providers to receive expedited service;
 - Make authorizations retroactive to the date of an eligible request;
 - Alert veterans and their providers if their authorization will not be renewed at the end of the 60-day period;
 - For patients who are authorized to see a non-VA provider for the care of a chronic condition, expand the authorization to cover emerging primary care needs.
- Reimbursement under Veterans Choice Program:
 - Ensure that FQHCs will be reimbursed for their reasonable costs as recently calculated by Medicare;
 - Clarify that PC3 rates do not "trump" rates under Veterans Choice;
 - Make provider contracts retroactive to the start date of the Veterans Choice program;
 - Define "timely" payment in the IFR;
 - Refer to Medicare Part B for pharmaceutical rates.
- Access to Care:
 - Broaden language around credentialing and licensing to ensure that qualified non-physician practitioners (NPPs) are eligible providers in all states;
 - Determine distance to nearest facility using travel miles, not a straight line;
 - Base eligibility on distance to nearest facility that can provide the type of care the veteran needs.
- Third Party Administrators (TPAs):
 - Increase coordination and consistency between TPAs;
 - Require TPAs to clearly inform providers whether they are signing up for Veterans Choice or PC3;
 - Clarify which TPA is responsible for patients who live in states served by both TPAs.
- Sharing of Patient Records:
 - Develop a streamlined system for sharing patient records between VA and non-VA providers.

1. Authorizations to receive non-VA care

NACHC recognizes that the authorizations process is a necessary tool for achieving critical goals, including: ensuring that only eligible veterans participate in the Program; ensuring that eligible veterans go to VA providers whenever possible; and ensuring that care is coordinated between VA and non-VA providers.

However, the current authorization process often results in eligible veterans presenting themselves for care at non-VA providers without the necessary authorization. As discussed above, other provider types can choose not to care for these individuals until an authorization is received; however, health centers are required to care for these individuals without delay, and to provide this care for free or at a discounted rate if the veteran's annual income is at or below 200% FPL. As a result, health centers incur substantial costs in care for these individuals – costs which Congress has been clear that their Federal grant was not intended to cover.

In short, administrative delays and challenges in receiving authorization to care for eligible veterans create a substantial financial (and administrative) burden on health centers – which, by law, they cannot choose to avoid. By having to treat eligible veterans as if they are “uninsured” because prior authorization requirements have not been met due to administrative issues beyond their control, health centers are forced to use 330 funds in a manner that is inconsistent with Congressional intent, leaving less funds available for the truly uninsured. While Congress intended for health centers to play a special role in the Program, it is doubtful that this is the outcome it intended.

For these reasons, NACHC recommends the following adjustments to the current authorization process:

- *Establish a unique call-in number for contracted providers to receive expedited service:* Since the first batch of Choice cards were mailed out in November 2014, an increasing number of veterans are presenting at health centers, expecting to receive VA-funded care there. Health centers recognize that many of these veterans are not eligible for the Program, as they do not meet the distance or wait time requirements; however, many of them are eligible but have yet to complete the authorization process, or have authorizations that require them to see a different provider. To assist with these situations, NACHC recommends that HealthNet and TriWest (the VA's Third Party Administrators for the Program) each establish a unique call-in number for contracted providers, and that these lines provide expedited service for time-sensitive requests. This strategy will benefit eligible veterans, as the ability to get immediate authorization will prevent non-health-center providers from turning them away; it will also benefit health centers, as they will not be forced to incur uncompensated costs for caring for these individuals.
- *Make authorizations retroactive to the date of an eligible request:* In cases where the TPAs are not able to provide an authorization at the time of the veteran's or provider's request, NACHC recommends that the authorization be made retroactive to the date that an eligible request was received. This will have similar benefits to having a unique call number for providers – fewer non-health-center providers refusing to care for unauthorized veterans, and fewer uncompensated care costs for health centers.

- Alert veterans and their providers if their authorization will **not** be renewed at the end of the 60-day period. The IFR states that the VA will alert the veteran if their current authorization will be renewed at the end of the 60-day period. NACHC recommends that the VA also alert veterans, and their providers, if the authorization will not be renewed. Individuals who are actively receiving non-VA care are likely dealing with physical and/or cognitive challenges, and watching the calendar to make sure they adhere to the 60-day deadline is unlikely to be a priority. As a result, these individuals could easily present at their non-VA provider after Day 60. In the case of most non-VA providers, the veteran could be denied care or forced to pay out-of-pocket; if the non-VA provider is a health center, it would be forced to absorb the cost of care.
- For patients who are authorized to see a non-VA provider for the care of a chronic condition, expand the authorization to cover emerging primary care needs. If a veteran has a current authorization to see a non-VA provider for a chronic condition, and they develop a primary care need, they must return to the VA to have that need addressed. A member health center recently told us about a veteran who had an authorization to go to the health center for diabetes care and management. During his 60-day authorization period, he broke his arm, and returned to the doctor who was actively caring for him – his health center doctor – for treatment; however, the health center was not reimbursed for this visit, because treating his broken arm was not considered diabetes care. This restriction is confusing for the veteran, costly for the health center, and – most importantly – contrary to national goals of coordinating care and creating medical homes for patients.

2. Reimbursement under Veterans Choice Program

- Ensure that FQHCs will be reimbursed for their reasonable costs, as recently calculated by Medicare: As stated above, Congress did not intend for health centers' Federal grant funds to be used to help pay for individuals with federally-supported coverage. In the fall of 2014, the Centers for Medicare and Medicaid Services (CMS) began implementing a new Medicare payment system for FQHCs, called the Medicare Prospective Payment System (PPS). This system was designed to meet the statutory requirement – contained at Section 1834(o)(2)(B)(i) of the Social Security Act -- that FQHCs be reimbursed at 100% of their reasonable costs as determined by CMS. As you are aware, the statute and IFR state that Medicare rates are a ceiling for provider reimbursements under the Program; however, given the unique status of FQHCs – including the requirement that their Federal grant funds not be used to pay for Federally-insured patients, and that their PPS rate has recently been demonstrated as covering their reasonable costs (but no more) – NACHC thinks it is appropriate for the regulations to specify that FQHCs should be reimbursed their PPS rate (as opposed to having this rate function only as a ceiling on reimbursement.) We also request that this rate be applied, regardless of the FQHC's participation in other VA projects.
- Clarify that PC3 rates do not “trump” rates under Veterans Choice: It is our understanding that a health center, or other eligible provider, will receive their Medicare rate under the Program, as long as that provider is not already participating in the VA's Patient Centered Community Care Program (PC3). We understand that in these instances, the PC3 contract rates override the Choice Program rates, which we believe is contrary to the law. We can find no instance where it is stated that the Medicare rates apply under the Choice Program, as long as the provider is not already participating in

the PC3 program. Thus, we request that the VA clarify that if a provider chooses to participate in both programs, the Medicare PPS rate should apply for those patients cared for under the Choice Program.

- *Make provider contracts retroactive to the start date of the Veterans Choice program:*
At present, providers are not eligible to be reimbursed for care provided to eligible veterans until they have signed a Veterans Choice provider agreement with the TPA. As you are aware, the Veterans Choice cards began being mailed out in November, and increasing numbers of veterans presented themselves to health centers soon afterwards. While many health centers sought to sign provider agreements starting in November, the TPAs were not prepared to offer and finalize agreements. Similar to the situation with authorizations, this meant that administrative issues forced health centers to absorb the cost of care provided to eligible veterans who presented for care prior to the agreements being signed.

This situation could be mitigated by making the agreements retroactive to the date that veterans began coming to providers with their Veterans Choice cards. This retroactivity should be contingent on the provider verifying that it complied with all program requirements (e.g., licensing) at that time. If this date is not possible, a less preferable option would be to make the agreements retroactive to the date that the provider initially contacted the TPA to express interest in being a network provider.

- *Define “timely” payment in the IFR:* Section 17.1540(c) states that “The claims processing system will provide accurate, timely payments for claims received”. To assure consistent and appropriate timelines across the country, NACHC recommends that the VA codify the maximum length of time that is considered “timely” between the receipt of a claim and the issuance of a payment (assuming that the claim is “clean.”) The VA could consider adopting Medicare’s “prompt payment standards”, which are contained in Section 1842 of the Social Security Act. Under this standard, Medicare’s TPAs must pay all “clean” claims within 30 days, or else pay interest on them.
- *Refer to Medicare Part B for pharmaceutical rates:* NACHC supports the VA’s interpretation of Section 101 permitting prescription drugs to be furnished through the Program, as this will make it easier for eligible veterans to access medications and comply with their medication regimens. NACHC also wishes to alert the VA that Medicare Part B establishes standardized reimbursement rates for over 700 pharmaceutical items. While Medicare Part D pays for a much larger volume of pharmaceuticals than Part B, Part D rates are negotiated directly between drug plans and manufacturers; therefore, there is not a standard “Medicare rate” under Part D. In contrast, Part B establishes consistent national rates for over 700 pharmaceutical products; therefore, we recommend that the VA refer to the Part B rates when determining maximum reimbursement to non-VA providers for pharmaceuticals. More information on Part B pharmaceutical rates is available at http://aspe.hhs.gov/sp/reports/2014/medicarepart/ib_mprpd.cfm

3. Access to Care

- Broaden language around credentialing and licensing to ensure that qualified non-physician practitioners (NPPs) are eligible providers in all states: Section 17.1530(d) states that eligible providers under the Program “must maintain at least the same or similar credentials and licenses as those required of VA’s health care providers.” In some states, the official approval process for some categories of NPPs is referred to neither as “licensing” nor “credentialing”; rather, terms such as “accrediting” or “certifying” may be used. To ensure that no qualified NPPs are unintentionally excluded from participation, NACHC recommends that this language be broadened to reflect the full range of approval processes. For example, section 17.1530(d) could be modified so that providers under the Program “must maintain at least the same or similar professional qualifications pursuant to applicable State law as those required of VA’s health care providers.”
- Determine distance to nearest facility using travel miles, not a straight line: Similar to many other groups, NACHC is concerned about the proposal to measure a veteran’s distance from the nearest VA facility “as the crow flies.” This interpretation creates a significant burden on veterans who live in rural and frontier areas, where the distances required to travel between two locations are often much greater than the straight-line distance between them. Given that the purpose of the Program is to increase access for veterans who do not live near a VA facility, this interpretation appears contrary to the intention of the law.
- Base eligibility on distance to nearest facility that can provide the type of care the veteran needs: The preamble also notes that the “nearest VA facility” is defined by the nearest facility, regardless of whether or not that facility can actually provide the care that the veteran needs. The example in the preamble is one of a veteran who lives within 10 miles of a VA cardiac center, but the veteran needs primary care and the closest primary care facility is 50 miles away. Under the IFR, this veteran would not be eligible, because he or she lives less than 40 miles from the nearest facility. NACHC recommends that a veteran’s eligibility for the Program be based on their distance from the nearest VA facility that can provide the appropriate type of care, not simply the closest VA facility.

4. Third Party Administrators (TPAs)

While the role of TPAs is not addressed directly in the IFR, NACHC would like to take this opportunity to provide observations and suggestions on this aspect of the Program, based on health centers’ experiences to date interacting with HealthNet and TriWest.

- Increase coordination and consistency between TPAs: NACHC recognizes that the VA faced extremely tight timelines to implement the Veterans Choice Program, and has worked diligently with their Third Party Administrators (TPAs) to ensure that this program improves access to care for eligible veterans. Nonetheless, the program would

benefit from increased coordination, consistency and streamlining between the two TPAs.

- Require TPAs to clearly inform providers whether they are signing up for Veterans Choice or PC3: NACHC has heard numerous reports of health centers being steered, often without their knowledge, away from the Veterans Choice program and into PC3. For example, HealthNet’s main Veterans Choice website has a box prominently featured in the upper right corner labeled “Information for Providers.” The second link in that box is entitled “Becoming a Participating Provider.” However, that link goes to the “Join Our Network Form” for PC3, rather than Veterans Choice. This misleading link was brought to the VA’s attention over 3 months ago, but has yet to be fixed. Similarly, if a person searches for “Become a Veterans Choice Participating Provider” on the HealthNet webpage, and then clicks on “Register Today”, it takes you to a form that has “PC3” (and not Veterans Choice) in the URL. Health centers have also reported TPA customer service representatives telling them that they were only permitted to sign up for PC3.

This difficulty in registering for Veterans Choice is concerning for two reasons. First, there is significant confusion about whether a provider who has registered for PC3 is eligible to participate in Veterans Choice. Health centers have frequently been told that PC3 participation automatically makes them ineligible for Veterans Choice -- even if their PC3 registration pre-dates the Choice program, or was done by accident (due to misleading information such as the examples above.) However, a recent fact sheet (available at <http://www.va.gov/opa/choiceact/documents/FactSheets/Fact-Sheet-For-VACAA-Providers.pdf>) suggests otherwise. Second, there are significant differences in provider responsibilities, administrative rules, and payment rates between the two programs. A provider’s decision to participate in a program was based on the parameters established for that program, and forcing them into a different program makes it unlikely that they will be able to participate successfully for the long term.

- Clarify which TPA is responsible for patients who live in states served by both TPAs: Many eligible veterans live in states served by both TPAs, meaning that their home address falls under the jurisdiction of one TPA, but the nearest no-VA provider falls under the other TPA. At this time, it is unclear which TPA is responsible for coordinating care for these veterans – the TPA for the veteran’s home area, or the TPA for the provider’s area. NACHC would appreciate timely clarification on this issue, as veterans and health centers in numerous states are in this situation.

5. Sharing of Patient Information

- Develop a streamlined system for sharing patient information between VA and non-VA providers: The IFR preamble states that participating providers should “to the extent possible... submit medical records back to VA in an electronic format.” Health centers have long been a national leader in implementing Electronic Medical Records, and generally will send records to the VA electronically; however, to ensure appropriate and coordinated care for veterans, it is critical that patient information flow is simplified so

that the VA and the health center get the information they both need without creating unnecessary burden. NACHC feels that there is room for improvement in the current information exchange system, and would like to see a simplified system that is less labor-intensive for non-VA providers while also ensuring that they receive timely information about care provided by the VA. NACHC understands that this information exchange must be done in a manner that protects the integrity of the patient information to be shared.

* * *

Thank you for the opportunity to comment on this Interim Final Rule and related issues from the early months of implementation of the Veterans Choice program. NACHC staff, and our member health centers, would be happy to provide the VA with any further information that would be beneficial. To initiate a discussion, please contact me at 202-296-0158 or cmeiman@nachc.org.

Sincerely,

A handwritten signature in cursive script, appearing to read "Colleen P. Meiman".

Colleen P. Meiman, MPPA
Director, Regulatory Affairs
National Association of Community Health Centers

Attachment: Overview of Section 330 Health Centers

For 50 years, Health Centers have provided access to quality and affordable primary and preventive healthcare services to millions of uninsured and medically underserved people nationwide, regardless of their ability to pay. At present there are almost 1,300 health centers with more than 9,300 sites. Together, they serve **over 22 million patients**, including nearly seven million children and more than a quarter million veterans.

Health centers provide care to all individuals, regardless of their ability to pay. All health centers provide a full range of primary and preventive services, as well as services that enable patients to access health care appropriately (e.g., translation, health education, transportation.) A growing number of Health Centers also provide dental, behavioral health, pharmacy, and other important supplemental services.

To be approved by the Federal government as a Health Center, an organization must meet requirements outlined in Section 330 of the Public Health Service Act. These requirements include, but are not limited to:

- Serve a federally-designated medically underserved area or a medically underserved population. Some Health Centers serve an entire community, while other target specific populations, such as persons experiencing homelessness or migrant farmworkers.
- Offer services to all persons, regardless of the person's ability to pay.
- Charge no more than a nominal fee to patients whose incomes are at or below the Federal Poverty Level (FPL)
- Charge persons whose incomes are between 101% and 200% FPL based on a sliding fee scale
- **Be governed by a board of directors, of whom a majority of members must be patients of the health center.**

Most Section 330 Health Centers receive Federal grants from the Bureau of Primary Health Care (BPHC) within HRSA. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing care to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients who are not indigent or who have insurance, whether public or private, are expected to pay for the services rendered. In 2013, on average, the insurance status of Health Center patients is as follows:

- 41% are Medicaid recipients
- 35% are uninsured
- 14% are privately insured
- 8% are Medicare recipients.

No two health centers are alike, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed care to uninsured and medically underserved people.