REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (A-17)
Expansion of US Veterans' Health Care Choices
(Resolution 229-A-16)
(Reference Committee A)

EXECUTIVE SUMMARY

This report responds to referred Resolution 229-A-16, "Expansion of US Veterans' Health Care Choices," which asked the American Medical Association (AMA) to: (1) adopt policy that the Veterans Health Administration (VHA) expand all eligible veterans' health care choices by permitting them to use funds currently spent on them through the Veterans Affairs (VA) system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65 to use these funds to defray the costs of Medicare premiums and supplemental coverage; and (2) actively support federal legislation to achieve this reform of veterans' health care choices.

In 2014, it was discovered that thousands of veterans were waiting excessive amounts of time to access health care through the US Department of Veteran Affairs (VA). To address access issues, the Veterans Access, Choice and Accountability Act of 2014 created the Veterans Choice Program (VCP), which authorized the VA to contract with physicians in private practice to provide care to veterans who either live too far away from a VA facility or cannot access care in a VA facility in a timely manner. The VCP was set to expire in August 2017. Implementation of the VCP was challenging. The VA was given just 90 days to fully implement the nationwide program. The VA recognized continued access issues early in the implementation stage and has been working with stakeholders, including the American Medical Association (AMA), to make needed changes.

Suggesting premium support for veterans to purchase health care in the private sector is not a new concept. However, the VHA is not a health insurance plan with a tangible amount of money to give veterans to purchase private health care. The VHA is the largest integrated health care system in the US and provides highly specialized and comprehensive care that is not available to the same extent in the private sector. Importantly, feedback from veterans on the care they receive through the VHA is mostly positive and some veterans have expressed gratitude for the camaraderie they experience while receiving treatment alongside fellow veterans.

The Administration, Congress and the VA are now working together to reform the VCP rather than let it expire or privatize it. Recent legislation was enacted into law to extend the VCP beyond the sunset date of August 2017. The extension allows the program to use the remaining appropriated funds and give Congress and the VA time to work on a comprehensive reform plan.

This report provides background on the creation of the VCP; outlines efforts to redesign the VA health care delivery system; highlights stakeholder input; explains the difficulty of providing premium support to veterans; summarizes legislative activity; explains how to become a VA provider; summarizes AMA policy, advocacy and resources; discusses avenues to improve access to care for veterans; and proposes recommendations.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-17

Subject: Expansion of US Veterans' Health Care Choices (Resolution 229-A-16)

Presented by: Peter S. Lund, MD, Chair

Referred to: Reference Committee A (John Armstrong, MD, Chair)

At the 2016 Annual Meeting, the House of Delegates referred Resolution 229, "Expansion of US Veterans' Health Care Choices," which was sponsored by the Ohio Delegation. Resolution 229-A-16 asked the American Medical Association (AMA) to:

> (1) adopt policy that the Veterans Health Administration (VHA) expand all eligible veterans' health care choices by permitting them to use funds currently spent on them through the Veterans Affairs (VA) system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65, to use these funds to defray the costs of Medicare premiums and supplemental coverage; and (2) actively support federal legislation to achieve this reform of veterans' health care choices.

The majority of testimony on Resolution 229-A-16 requested referral for study to review the implications of allowing veterans to access health care outside of the VA through premium support, which was viewed as complicated and controversial with implications not only for the VA, but also for Medicare, the private health insurance market and the entire health care system.

This report provides background on the creation of the Veterans Choice Program (VCP); outlines efforts to redesign the veterans' health care delivery system; highlights stakeholder input; explains the difficulty of providing premium support to veterans; summarizes legislative activity; explains how to become a VA provider; summarizes AMA policy, advocacy and resources; discusses avenues to improve access to care for veterans; and proposes a series of recommendations.

BACKGROUND

In 2014, it was discovered that thousands of veterans were waiting excessive amounts of time to access health care through the VA. To address access issues, the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146, "Choice Act") created the VCP, which authorized the VA to contract with physicians in private practice to provide care to veterans who either live too far away from a VA facility or cannot access care in a VA facility in a timely manner. The VCP was set to expire in August 2017.

Implementation of the VCP was challenging. The VA was given just 90 days to fully implement the nationwide program. To achieve this short timeline, the VA modified existing purchased care contracts that were not designed to handle the scope of the VCP. In addition, the VA distributed nine million choice cards, mostly to veterans who were not immediately eligible for the VCP. The

VA recognized these problems early in the implementation stage and has been working with stakeholders, including the AMA, to make needed changes.

REDESIGNING THE VETERANS' HEALTH CARE DELIVERY SYSTEM

Blueprint for Excellence

In 2014, the VA issued a "Blueprint for Excellence," which identified strategies to improve the performance of VHA health care, develop a positive service culture, transition from a focus on "sick care" to "health care," and develop business systems and management processes that are efficient, transparent and accountable.[1] In addition to the VCP, the VA maintains the following community care programs: Emergency Care, Preauthorized Care, Patient-Centered Community Care, State Veterans Home, Indian Health Services/Tribal Health Program and other benefits and services.

The Blueprint for Excellence includes a recommendation to consolidate all of the community care programs into one streamlined program and make improvements to information and billing systems. The VA has decided that maintaining all of the community care programs is unsustainable given the following challenges: varied eligibility criteria; multiple referral and authorization requirements; lack of standard care coordination model; multiple local provider contracting approaches; variable payment rates and structures; and multiple programs that result in confusion for veterans and providers. In 2015, the VA submitted a plan to Congress to consolidate the community care programs into a community care network, which is expected to be fully operational in June 2018.[2]

Veterans Choice Act Independent Assessment

The Choice Act called for an independent assessment of 12 areas of the VA's health care delivery system and management processes. The "Veterans Choice Act Independent Assessment," issued in 2015, identified the following four systemic problems: a disconnect in the alignment of demand, resources and authorities; uneven bureaucratic operations and processes; non-integrated variations in clinical and business data and tools; and leaders not fully empowered due to a lack of clear authority, priorities and goals. To address these issues, the independent assessment developed recommendations to improve the VHA system.[3] A subsequent review found that the VHA is making progress on implementing the suggested changes.[4]

Commission on Care

In accordance with the Choice Act, a "Commission on Care" (the Commission) was also established to evaluate the health care that veterans had been receiving. Released in 2016, the Commission's final report concluded that although care delivered by the VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility. The Commission outlined a series of recommendations, many of which are already being implemented as part of the ongoing "MyVA initiative." [5,6]

MyVA Initiative

The "MyVA initiative" is considered the largest department-wide transformation in the VA's history and has reportedly been very successful. In 2016, the VHA scheduled about 58 million appointments, which accounts for 1.2 million more than were scheduled in 2015 and almost 3.2 million more than in 2014. In September 2016, about 96 percent of appointments were completed

within 30 days of the clinically indicated or veteran's preferred date. About 91 percent of these appointments were scheduled within 14 days, about 85 percent within 7 days and about 22 percent on the same day. The average wait time for primary care appointments was reportedly about five days, for specialty care about six days and for mental health care about two days.[7]

VHA and VCP contractors authorized appointments for more than 3 million veterans to receive care in the private sector from February 1, 2015, through January 31, 2016. The number of authorized appointments represents a 12 percent increase compared to the same time period a year earlier.[8]

STAKEHOLDER INPUT

Many veterans' organizations (i.e., Disabled American Veterans, The American Legion, Military Order of the Purple Heart, Vietnam Veterans of America, Veterans of Foreign Wars, Paralyzed Veterans of America, AMVETS, and Iraq and Afghanistan Veterans of America) have emphasized that reform efforts should focus on strengthening the VA health care system, not dismantling it. These organizations specifically called for reform efforts to be based on veterans' health care needs and preferences, and have voiced concerns about coordination of care, the quality of medical services and the health outcomes for veterans receiving health care in the private sector. The organizations concluded in a statement that "we are confident that any objective, unbiased analysis of all the relevant data and evidence about the VA health care system compared to private sector health care will demonstrate the benefits of maintaining and strengthening a dedicated veterans' health care system."[9]

PREMIUM SUPPORT FOR VETERANS

Suggesting premium support for veterans to purchase health care in the private sector is not a new concept. Proponents have suggested providing veterans with a choice of accessing private health care regardless of the distance from their residence to the nearest VA facility or how long it takes to make an appointment within the VA. Opponents have argued that premium support for veterans would essentially be a voucher and may not cover all necessary services. One proposal has suggested privatizing health care for all veterans by phasing out VA health care facilities over the next 20 years.[10]

The VHA is not a health insurance plan with a tangible amount of money to give veterans to purchase private health care. The VHA is the largest integrated health care system in the US, consisting of 150 medical centers, and approximately 1,400 community-based outpatient clinics, community living centers, vet centers and domiciliaries. The VHA medical centers provide a wide range of services including traditional hospital-based services, medical and surgical specialty services, and advanced services such as organ transplants and plastic surgery.

In addition, the VHA provides unique, highly specialized care for many medical conditions, such as spinal cord and traumatic brain injuries, which are not available to the same extent outside of the VHA. The VHA provides a comprehensive, multidisciplinary approach that allows providers to address the full spectrum of veteran needs beyond physical medical care, such as behavioral health care, rehabilitation, vocational training and educational assistance. Some veterans have expressed gratitude for the camaraderie they experience while receiving treatment alongside fellow veterans.

Veterans provided input on privatizing the VHA during the Commission's evaluation. The majority opposed privatizing the VHA, with a minority wanting more access to non-VA providers. The Disabled American Veterans shared with the Commission a compilation of more than 4,000

verbatim comments on veterans' health care experiences, which indicated that approximately 82 percent reported overall positive experiences.[11]

LEGISLATIVE ACTIVITY

The Administration, Congress and the VA are working together to reform the VCP rather than let it expire or privatize it. Recent legislation was enacted into law to extend the VCP beyond the sunset date of August 2017. The extension allows the program to use the remaining appropriated funds and give Congress and the VA time to work on a comprehensive reform plan.

BECOMING A VA PROVIDER

The AMA encourages physicians to become VA providers. Physicians can sign up on the following website: https://www.hnfs.com/content/hnfs/home/va/provider/options-for-providers.html Interested physicians can register to become a provider for just the VCP or for all the community care programs. Physicians can download a non-VA provider fact sheet at https://www.ama-assn.org/sites/default/files/media-browser/public/washington/veterans-affairs-fact-sheet-for-non-va-medical-care-program_1.pdf for a summary of the conditions of participation and other requirements that are included in the VCP application process.

Adequate and prompt payments by the VA have been long-standing problems, which can deter physicians from providing services to veterans. The VCP pays Medicare rates, but the other community care programs pay less. To address payment delays, in 2012 the Veterans Benefits Administration created a new electronic claims processing system, the Veterans Benefits Management System, to process claims faster, more efficiently and more accurately. From 2013-2016, the new system allowed the VA to reduce the backlog of disability claims by 87 percent.[12]

RELEVANT AMA POLICY

The AMA supports providing full health benefits to eligible veterans to ensure they can access the medical care they need outside the VA in a timely manner (Policy H-510.986[2,3]). AMA Policy H-510.990 encourages the VA to continue exploring alternative mechanisms for providing quality health care coverage for veterans.

The AMA supports approaches that increase the flexibility of the VA to provide all veterans with improved access to health care services (Policy H-510.991). Policy H-510.985[1] calls on the AMA to continue advocating for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the VA health care system. Policy H-510.985[2] calls on the AMA to monitor implementation of and support necessary changes to the VCP "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the VA health care system.

The AMA urges all physicians to participate, when needed, in providing health care to veterans (Policy H-510.986). AMA Policy H-510.985[4] advocates that the VA pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician. The AMA has long advocated that payers should pay for

clean claims submitted electronically within 14 days and paper claims within 30 days (Policy H-190.981).

The AMA urges the VA to hire additional primary and specialty physicians as needed and to enhance its loan forgiveness efforts to help with physician recruitment and retention, and to improve patient access in VA facilities (Policies H-510.985[5] and D-510.990).

The AMA supports improved access to health care for veterans, including in the civilian sector, for returning military personnel when their needs are not being met by locally available resources through the Department of Defense or the VA (Policies H-510.985, H-510.990, H-510.991 and D-510.994). Policy H-510.986 encourages state and local medical societies to create a registry of physicians who are willing to provide health care to veterans in their community.

AMA ADVOCACY AND RESOURCES

The AMA strongly supported passage of the Choice Act, which created the VCP, and supports bipartisan efforts to make the VCP permanent, and to streamline the registration process for non-VA providers. The AMA has been actively involved in helping to shape and monitor implementation of the VCP. For example, the AMA sent a letter to the VA in March 2015, urging it to change the way it calculated the 40 mile distance criteria from a straight line to the time it takes for a veteran to travel to the nearest VA medical facility.[13] AMA advocacy efforts were instrumental in influencing the VA to change the distance criteria in April 2015, which expanded eligibility for the VCP.[14]

In addition to meetings and other communications with VA officials, the AMA submitted statements on proposed legislation to improve the VCP to the Senate Committee on Veterans' Affairs in March 2016, and to the House Committee on Veterans' Affairs in May 2016.[15,16] The AMA continues to work with the Committees on Veterans' Affairs to streamline programs, improve access to care and encourage participation by non-VA physicians and other providers. The AMA has communicated the following to the committees:

Consolidation of Programs: The AMA strongly supports the improvement and consolidation of the VCP to streamline and eliminate confusion and duplication between community care programs. The AMA believes that creating efficiencies and reducing administrative costs will benefit both veterans and physicians and encourage greater participation.

Access to Specialty Care: The AMA recognizes that a lack of access to specialty care in VA-based facilities is further complicated by provisions that require a minimum 40 mile driving distance, in addition to the lack of necessary specialists at VA community-based outpatient clinics.

Agreements/Contracts with Providers: The AMA supports using provider agreements between the VA and private physicians, similar to those for Medicare and Medicaid, which could help alleviate some of the burdensome compliance issues associated with federal contractors.

Billing and Payment: The AMA supports efforts to reform billing and reimbursement, such as to standardize provider payment rates using Medicare rates as a "floor" and not a "ceiling" (especially in regions with high demand and low supply of care specialists). Improving the VA's reimbursement processes would alleviate complaints that physicians and other providers have tied to the VCP in terms of administrative hassles and payment delays.

Electronic Billing: The AMA does not advocate for the strict mandate that all claims should be submitted electronically. Rather, it encourages a system similar to Medicare that allows certain exceptions, especially for smaller practices.

Tiered Networks: The AMA is very concerned about proposed plans to create tiered networks, especially in the absence of clear guidelines about differentiations in "high-value care." The AMA urges extreme caution that the VCP doesn't experience problems similar to those sometimes resulting from the Affordable Care Act, in which tiering narrowed networks and reduced access.

Value-Based Payment Modifier: The AMA is strongly opposed to the use of a value-based payment modifier (VBM). Because the VBM was developed to measure hospital populations, it may be inadequate for accurately measuring services provided by physicians' offices. Reports suggest that practices with the sickest patients fare poorly under the VBM. The AMA believes that more analysis of the VBM and its results are needed before it is applied to programs like the VCP.

The AMA has resources and advocacy materials located at: https://www.ama-assn.org/search/ama-assn/veterans. The AMA also has veterans' health resources for medical professionals located at: https://www.ama-assn.org/delivering-care/veterans-health-resources-medical-professionals.

DISCUSSION

Since the access issues in 2014, the VA has made concerted efforts to improve the care it provides to veterans and has made substantial strides, but improvements are still necessary. Given the extensive input the AMA has been providing, and the progress that is being made by the VA, the Council recommends that the AMA continue to work with the VA to provide quality care, support efforts to improve the VCP, and make it a permanent program.

The VA is aware that veterans need to be able to access medical care in the private sector when it is not available through the VHA. The Council suggests reaffirming Policy H-510.985, which supports necessary changes to the VCP to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the VA health care system. In addition, the Council believes the AMA should encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care.

The Council suggests supporting consolidation of all the VA community care programs to streamline and eliminate confusion and duplication. Creating efficiencies and reducing administrative costs will benefit both veterans and physicians and encourage greater participation.

The VCP has been reviewed by numerous external agencies since implementation. The Council suggests the VA use external assessments as necessary to identify and address systemic barriers to care. The Council also suggests that the AMA support interventions to mitigate barriers to the VA from being able to achieve its mission.

The lack of adequate and prompt payments by the VA has been a long-standing problem that can deter physician participation. The VCP pays Medicare rates, but lower payment rates have been negotiated for the other community care programs by third party administrators based on regional/local trends. Other local contracts between VA medical centers and individual practices have also been negotiated at lower rates. The Council's recommended reaffirmation of Policy H-510.985 reiterates AMA support for the VA to pay private physicians a minimum of 100 percent of Medicare rates.

While the VA has demonstrated progress in making prompt payments, there is room for improvement. The AMA has long advocated that payers should pay for clean claims submitted electronically within 14 days and paper claims within 30 days (Policy H-190.981). The Council recommends that the VA provide payments within the same timeframe.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 229-A-16 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to work with the Veterans Administration (VA) to provide quality care to veterans. (New HOD Policy)

2. That our AMA continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program. (New HOD Policy)

3. That our AMA reaffirm Policy H-510.985, which supports changes to the VCP to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the VA health care system and advocates that the VA pay private physicians a minimum of 100 percent of Medicare rates. (Reaffirm HOD Policy)

4. That our AMA encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways. (New HOD Policy)

5. That our AMA support consolidation of all the VA community care programs. (New HOD Policy)

6. That our AMA encourage the VA to use external assessments as necessary to identify and address systemic barriers to care. (New HOD Policy)

7. That our AMA support interventions to mitigate barriers to the VA from being able to achieve its mission. (New HOD Policy)

8. That our AMA advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days. (New HOD Policy)

9. That our AMA encourage the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care. (New HOD Policy)

10. That our AMA encourage the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans. (New HOD Policy)

11. That our AMA advocate for new funding to support expansion of the VCP. (New HOD Policy)

Fiscal Note: Less than $500.

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