STATEMENT OF
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THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
"VA FEE BASIS: EXAMINING SOLUTIONS TO A FLAWED SYSTEM"

SEPTEMBER 14, 2012

Chairwoman Buerkle and distinguished Members of the Subcommittee on Health:

Thank you for this opportunity to submit The American Legion's views on the Department of Veterans Affairs (VA) Fee-Basis Program.

Title 38, United States Code (U.S.C.) Section 1703a states when VA facilities are not "capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Secretary may contract with non-Department facilities in order to furnish medical care.(1)"

According to the Veterans Health Administration (VHA), if a medical service or procedure cannot be provided in a timely manner by VHA due to capability, capacity or accessibility, the service may, with approval, be fee-based or contracted outside of the VA. Typically, VA will utilize fee-basis as a last resort and prefers to treat the veteran within their closest hospital, another hospital within Veteran Integrated Service Network (VISN), through a sharing arrangement with a Department of Defense (DOD) Military Treatment Facility before purchasing care in the community. However, VA utilizes fee-basis programs as a first resort when the VA Medical Center is short on staffing and needs to meet a performance measure for timeliness of appointments or care within the established wait time guidelines.

In a Senate Field Hearing on "Improving Access to Quality Healthcare for Rural Veterans" our American Legion Past National Vice Commander Merv Gunderson said, "The American Legion urges VA to reconsider its national non-VA purchased care policies to allow VA Medical Center Chiefs of Staff to use their best judgment and discretion to prevent veterans from being forced to drive hours to a facility for several routine and reoccurring appointments" (2).

There is a need for VA to develop and raise fee-basis care program policies and procedures with a patient-centered care strategy that takes veterans' interest and distance into account. The directive could clarify the roles and responsibilities of the Chief Business Office's Purchased Care Office, VISN, VA Medical Center, Business Office and clinical staff's policies and procedures for fee basis directives and policies to reduce variance and improve coordination

between National, VISN and VA Medical Centers. The new policy should be well-defined, explained to veteran patients and be consistent policy within all VA Medical Centers.

In the last four years, non-VA purchased care has doubled from $2.2 billion in FY 2007 to $4.5 billion in FY 2011 along with a corresponding increase of 615,768 veterans served in FY 2007 to 970,727 veterans served in FY 2011 (2). VA program leadership has stated the reasons for growth of non-VA usage are: the increase of unique veterans seeking VHA care; economic conditions; waiting times because of more veterans enrolling in the system; and growth of number of CBOCs and emergency medical needs in rural areas (2). During our System Worth Saving site visits, Directors and VA hospital finance staff have told us the fee-care is between 15-25 percent of their medical center budgets and continues to grow. The facilities struggle with what services they can provide in-house and whether they should hire a full-time specialist to balance the number of veterans requesting the specialty services or contract out this care.

Nowhere is this challenge more evident than with women veterans' gender specific specialty services. The majority of women veterans' gender-specific care and services are contracted out as VA does not currently have the numbers of women veteran staff and demand for services. Yet, as women veterans are the fastest growing demographic of veterans enrolling in VA, the hiring of women veteran providers within the VA to provide gender-specific services should be carefully considered.

In an effort to reduce the continued rise in fee-basis costs as well as to improve coordination of care between VA and non-VA purchased care, VA is developing a Patient Centered Community Care (PCCC) program. The PCCC program is defined as an "effort to create centrally supported health care contracts available throughout the VA. Additionally, "the goal is to provide veterans coordinated, timely access to high quality care from a comprehensive network of VA and non-VA providers." The PCCC is taking many of the lessons learned from Project Health Care Effectiveness through Resource Optimization (HERO), a five year pilot that recently was completed.

In a Chief Business Briefing in May 2012, VA stated that current individual fee program care concerns include: "veterans obtains an authorization, veterans chooses provider, services are provided (accreditation/credentialing status is unknown), no shows are not tracked/reported, VA Medical Centers pay the local fee schedule rate, provision of medical documentation is not always consistent or timely and access, timeliness, safety and complaints are not always a part of traditional fee requirements" (3).

VA's future plan through PCCC is to refer veterans to network provider, require accreditation and credentialing and VA Medical Center pays the national negotiated rate rather than the local fee schedule rate. By establishing national contracts for non-VA purchased care, VA can reduce these program costs by improving economies of scale and lowering of fee prices as well as ensuring VA's standards for timeliness and quality is tied to these contracts.

However, VA must be cognizant that not all fee-basis coordination can be managed nationally. Many rural areas do not have specialty or even primary care providers so some collaboration and coordination between the facility and local community providers should be leveraged and

encouraged to ensure small private practice providers, which may be the only option in a community, and especially rural areas, continue to be permitted to submit contracts.

Quality of Care Findings with Fee-Basis Programs

Along with the cost reduction and efficiencies the PCCC program is proposing, it is equally important that quality standards for contracting care must be the same or better than the care the veteran would otherwise have if they were treated in VA.

Since 2003, the System Worth Saving Task Force has conducted site visits to VA Medical Centers to assess the timeliness and quality of veterans health care programs and to provide feedback from veterans on their level of care. Across the country, we have heard from veterans that in many cases, the quality of care they have received from non-VA providers has been great and they were treated close to their home.

However, a few concerns were identified during our System Worth Saving site visit interviews with VA Medical Center leadership, staff and by local veterans. These concerns include: lack of training and education program for non-VA providers; making sure veterans receive list of comprehensive network of VA and non-VA providers; lack of integration of VA's Computer Patient Record System (CPRS) with non-VA providers' computer systems/delay in contractors submitting appointment documentation; and the lapsing of Martha's Vineyard Fee Basis/Contract.

Lack of Training and Education Program for Non-VA Providers

In the System Worth Saving Report on Rural Health it stated, "In a recent article published in the Journal of American Medical Association in February 2012, Dr. Kenneth Kizer, former Under Secretary for Health for VA said, "Physicians in private practice may not be prepared to treat conditions prevalent among veterans – for example, the Reaching Rural Veterans Initiative in Pennsylvania found that primary care clinicians lacked knowledge of PTSD, and other mental health disorders prevalent among veterans, and were unfamiliar with VA treatment resources for such conditions." (5)

There is a need for development of military culture and awareness training for non-VA providers to educate and certify them on specific veterans' injuries/illnesses such as blast induced TBI, PTSD, and suicide prevention prior to contracting any veterans to them for care. The VA is a leader in mental health treatment and development of evidence-based therapies for PTSD. In addition, the majority of women veterans' gender specific care in VA is contracted out to the community. Non-VA clinicians need women veterans' specific training on the unique challenges women veterans face through injuries/illnesses they incurred during their military service.

If non-VA providers had a formal training and education program for military injuries/illnesses, it would ensure they are held to the same quality of care standards and treatments as VA providers.

Make sure veterans receive list of comprehensive network of VA and non-VA providers.

VA is developing a national database of local community providers that they have fee-based/purchased care from in the community. If this effort is expanded, veterans ultimately would receive a list of community providers for fee-basis or contracted care so they can determine the best provider for them.

Lack of Integration of VA's Computer Patient Record System with Non-VA Providers Computer Systems/ Delay in contractors submitting appointment documentation

Non-VA providers do not have full access to VA's Computer Patient Record System (CPRS) to ensure the veteran receives the same or higher quality of care. First, access to the veterans' medical record will allow the contracted community provider to review the patient's full record and history in order to make a proper diagnosis and treatment plan. Currently, VA makes copies of the veteran's record for any relative injuries/illnesses relating to the appointment but the provider does not have the full record in order to understand the patient's medical record and any co-occurring medical conditions. Second, sharing of the medical record will help the community provider to meet all of the quality of care measures tracked in CPRS as well as promote screening for TBI, PTSD, depression, substance use and suicide or other quality of care measures tracked in CPRS. Thirdly, allowing the non-VA provider access to the medical record will speed up receipt and documentation from the encounter instead of VA having to wait weeks or months to receive documentation back from a non-VA provider.

With emergence and development of the Lifetime Virtual Electronic Record (LVER) and Nationwide Health Information Exchanges across the United States, federal agencies will be integrated with private hospitals and companies to improve the interoperability of medical records if a veteran is contracted into the community for care.

Martha's Vineyard Fee-Basis/Contract

The American Legion conducted a site visit to Martha's Vineyard last year for our report on Rural Health Care. In 2000, a contract was signed between the Providence VA Medical Center and Martha's Vineyard Hospital. Through the contract, veterans living on Martha's Vineyard were able to receive care at Martha's Vineyard Hospital through fee basis instead of having to travel off of the island. The contract lapsed around 2004 which the VA did not realize until 2008 when the hospital acquired new management. Veterans who were being treated under the original contract found out the contract lapsed when Martha's Vineyard Hospital sent collection bill notices to those veterans for medical expenses previously covered under the contract.

Since 2008, VA has been negotiating a new contract between Providence VA and veterans are forced to take a ferry from Martha's Vineyard and drive two hours for care at the Providence VA Medical Center. Veterans on the island continue to be promised that VA is working on the contract but coordination and the processing of the contract between VA Central Office, VA's Purchasing Care Office, VISN and the Providence VA Medical Center has continued to be delayed.

While there are only a few veterans that live on the island, this delay illustrates the frustrations that veterans living in rural and isolated locations or other areas across the country experience in waiting for contracts and receiving assurances from VA that the contract will be resolved. VA should develop and implement a process to ensure all VA and non-VA purchased care contracts are inputted into a tracking system to ensure they remain current and do not lapse. If there are instances with a contract lapsing, such as in Martha's Vineyard, VA should make every effort to hold stakeholder meetings with veterans from those communities to solicit input and keep veterans enrolled in these contracts/services informed.

In order to improve situations like Martha's Vineyard, VA must strive to create a tracking database of all non-VA purchased care contracts to ensure contracts do not lapse and veterans are involved as stakeholders and VA regularly communicate with veterans on the status of contracts.

Madame Chairwoman, thank you for allowing The American Legion to testify today. I look forward to answering any questions you may have.

References:

(1) Title 38, United States Code (U.S.C.) Section 1703a

(2) Chief Business Office Purchased Care VSO Briefing to Veteran Service Organizations. May 2, 2012. PowerPoint Presentation.

(3) Chief Business Office Purchased Care VSO Briefing to Veteran Service Organizations. May 2, 2012. PowerPoint Presentation.

(4) Senate Field Hearing on "Improving Access to Quality Healthcare for Rural Veterans."

(5) Wong, Fang. National Commander of The American Legion. 2012 System Worth Saving Report on Rural Healthcare. May 2012.