



**CALIFORNIA  
HOSPITAL  
ASSOCIATION**

*Providing Leadership in  
Health Policy and Advocacy*

March 25, 2019

The Honorable Robert Wilkie  
Secretary  
Department of Veterans Affairs  
810 Vermont Ave, NW, Room 1068  
Washington, DC 20420

***Subject: RIN 2900–AQ46; Veterans Community Care Program; Proposed Rule, Federal Register (Vol. 84, No. 36), February 22, 2019***

Dear Secretary Wilkie:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to comment on the Department of Veterans Affairs (VA) proposed rule implementing provisions of the Veterans Community Care Program, as authorized by the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Network (MISSION) Act of 2018. California hospitals have long cared for our nation's veterans in collaboration with the VA under contracted programs, such as the Veterans Choice program, and in the provision of emergency care services. We look forward to strengthening this partnership as we work to provide high-quality care to veterans in communities throughout California.

We were pleased that the MISSION Act includes provisions to improve existing programs by simplifying administrative processes and outlining prompt payment policies for non-VA providers. These legislative provisions are particularly important to hospitals in rural communities across California, where many veterans live but VA facilities are few and far between.

The proposed rule builds upon this effort by outlining important components of the program's implementation, such as eligibility requirements and access standards for veterans, the process by which the VA would authorize community-based care for eligible veterans, and payment rates for non-VA entities and providers. However, CHA is concerned that the proposed rule does not implement the prompt payment provisions required by Section 111 of the MISSION Act and provides little information about additional administrative and operational requirements that would ensure the program operates the way Congress intended. Through our experience with the Veteran's Choice program, we have learned the importance of proactively clarifying policies and procedures with providers and contractors to ensure smooth claims processing for veterans' care. We look forward to our continued work with the agency and its contractors to meet our shared goals and offer the following comments for consideration. We urge the department to consider our comments, which seek to ensure that veterans are able to access the care they need without finding themselves in a complicated paperwork process.

#### **Prompt Payment**

Non-VA hospitals have, for some time, been challenged in receiving timely payment from the VA and its contractors, often due to a lack of clearly delineated policies and procedures, lack of an IT infrastructure,

and complexities inherent in our health care system. Some have experienced claim backlogs of several months or, in some cases, years. Congress took steps to address these longstanding issues by requiring the VA to establish a prompt payment process under which it must pay or deny payment for services within 30 calendar days of receiving a clean electronic claim or within 45 calendar days of receiving a clean paper claim. Congress also required that, in the case of a denial, the VA notify the provider with the reason for denial and what, if any, additional information would be required. Once received, the VA would have to reprocess the claim within 30 days of its receipt. Further, Congress established that any claim that has not been paid, denied, or made pending within the specified time periods would be considered overdue and subject to interest payment penalties. **CHA urges the VA to publish the required regulations to administer this section as soon as possible. We believe strongly that Congress intended these provisions to apply to non-VA hospitals that contract with the department as well as those that do not, and appreciate the department's commitment to timely and adequate reimbursement to all non-VA providers that care for our nation's veterans.**

**CHA urges the VA to consider publishing a comprehensive claims processing manual and other guidance that ensures providers and contractors share an understanding of policies and procedures for claims processing as this program is implemented.**

#### **Payment Rates**

Consistent with the MISSION Act, the VA proposes to limit payment rates for non-VA providers to the applicable Medicare fee schedule or prospective payment system amount. The VA would adjust this rate annually, corresponding with Medicare's annual payment update, but would not make any other adjustments that Medicare may make to its rates throughout the year. It is our understanding that these payment rates would accurately reflect the current rates paid to non-VA hospitals and physicians, as well as other providers such as durable medical equipment suppliers, and reflect the most current geographic adjustments to the fee schedules.

The VA also proposes to deviate from the payment parameters described above if it determines — based on patient needs, market analyses, health care provider qualifications, or other factors — that this limitation would not be practicable. However, the process by which the VA would notify non-VA providers is unclear; would this be a provider bulletin placed on a website or, for some providers, a contractual amendment?

While CHA is pleased that Congress clearly specified the reimbursement rates, it is important to note that the Medicare fee-for-service (FFS) payment schedule is not comprehensive — especially for the under-65 population, which includes a large number of veterans. Medicare FFS payment is also not comprehensive for services provided in urgent care settings, which the VA has proposed as a new benefit under the Veterans Community Care Program in a separate proposed rule. For services in provider-based settings that are recognized by Medicare FFS, we assume that the VA would pay at the appropriate rate. **However, we urge the VA to clarify payment rates for services that fall outside of established Medicare service rates and develop a transparent payment update process.**

#### **Eligibility and Authorization**

Certain aspects of previous arrangements with the VA and its contractors have been administratively burdensome for hospitals. Under the proposed rule, any covered veteran eligible for community care could choose between receiving care through the VA or through an eligible community provider. In non-emergency situations, veterans would be required to obtain prior VA authorization for care received

through the Community Care Program. However, it is unclear how hospitals would initially determine veteran eligibility and subsequently obtain authorization of medically necessary care — particularly for hospitals that are not contracted with the VA.

With respect to emergency care, the proposed rule continues the requirement that care provided to a covered veteran be authorized by the VA within 72 hours. Under previous programs, this timing has proven difficult. We hope that, under this new program, performance metrics and contractor response time will be considered and evaluated on a regular basis.

**While we understand the community care networks will be administered by a private sector contractor, we urge the VA to continually monitor and evaluate its ability to ensure eligibility and authorization questions can be addressed quickly and without significant burden to providers. This is particularly important for non-scheduled emergency or urgent care visits, which continue to be of significance to our member hospitals — both contracted and non-contracted VA providers.**

Under previous contracting arrangements, third-party administrators have been responsible for preauthorizing care, processing and paying claims, collecting medical records from the hospital and transmitting them to the VA, coordinating care, and serving as a resource for providers and veterans. Yet, hospitals have experienced incredible difficulty getting in touch with these entities, receiving answers to their questions about the program, and interpreting communications, particularly pre-authorizations. Absent clear communications channels, we are concerned that these problems will persist.

**For this program to run smoothly, hospitals need one electronic eligibility system that is available 24 hours a day, seven days a week. Ideally, such a system would be integrated with the VA electronic medical records system so that information could be accessed appropriately. In addition, hospitals and other providers need a single, accountable point-of-contact for addressing eligibility and authorization questions. We urge the VA to issue clear guidance on how hospitals can obtain eligibility and authorization information from the VA or its contractors in a timely and coordinated manner. Further, we urge the VA to describe how it will hold its contractors accountable for timely and accurate responses.**

### **Health Information Exchange**

CHA shares the administration's commitment to improving the exchange of health information to support seamless, high-quality care for all patients. To advance these goals, CHA urges the VA to participate in each of California's regional health information exchanges (HIEs) to share medical record information with non-VA hospitals and other community providers. Unlike some states that have one statewide HIE, California's diverse population and geography is served by more than 15 HIEs in 39 of California's 58 counties. Hospitals must already allocate significant resources to connecting to these HIEs, and many community-based HIEs operate on small budgets to keep costs for hospitals and providers down. We urge the VA to leverage its resources to connect with California's HIEs and support the exchange of veterans' health information with community providers.

### **Appeals**

Medicare, Medicaid and commercial health plans all have a transparent and comprehensive payment appeals process. The MISSION Act does not include a detailed provider appeals process, which is needed to ensure that all interests are represented. **CHA urges the VA to clearly articulate and adopt a**

**comprehensive appeals process that adequately represents patients, providers, and the VA.** This process could be managed by a contractor, but enlist a third-party entity — with appropriate clinical staff to determine medical necessity — to independently review medical records to determine payment. Absent such a process — which we believe would be used infrequently, assuming the VA develops an effective eligibility and authorization process — the VA must articulate and adhere to a timeline for moving a claim to an appeals process.

Hospitals have provided examples of when an appeals process would be necessary to properly address denied claims. For example, an authorization for an episode of care could specify an agreed-upon date of service. However, if the otherwise eligible veteran calls to reschedule their appointment for the following day, the claim could be denied when the date of service does not match the authorization provided by the contractor. An appeals process could ensure hospitals are reimbursed for services without a duplicative re-authorization process. Similarly, a hospital could provide service to a homeless veteran whose eligibility is challenged during claims processing due to a lack of a home address. California is home to 25 percent of the nation's homeless veterans, and hospitals are committed to providing care to this vulnerable population. There are countless examples of gaps in process for paying claims that necessitate an appeals process.

### **Credentialing**

Similarly, hospitals have described issues with credentialing under previous arrangements in which both the VA and the contractor separately ask for clinician credentialing information, duplicating burdensome processes and delaying payment. CHA urges the VA to clearly articulate and implement a process for “simultaneous credentialing” or, preferably, rely on one entity for this important task.

### **Transition to Veterans Community Care Program**

Finally, CHA urges the VA to clarify how non-VA hospitals may continue to partner with TriWest Healthcare Alliance under existing Veterans Choice Program agreements during the transition to the Veterans Community Care Program. As of today, a contractor for California's community care network region has not yet been named; establishing these networks following the selection of a contractor will take significant time. Because the Veterans Choice Program is scheduled to sunset on June 6, 2019, we expect a significant gap between full implementation of the community care network and the end of the Veterans Choice Program contracts — all while veterans will continue to seek care in their communities.

CHA appreciates the opportunity to provide comments on this proposed rule, and we stand ready to assist in supporting the implementation of this important program. If you have any questions, please do not hesitate to contact Megan Howard, CHA senior policy analyst, at (202) 488-3742 or [mhoward@calhospital.org](mailto:mhoward@calhospital.org), or me at (202) 488-4688 or [akeefe@calhospital.org](mailto:akeefe@calhospital.org).

Sincerely,

/s/

Alyssa Keefe

Vice President, Federal Regulatory Affairs