March 3, 2015

Kristen Cunningham
Director, Regulation Policy and Management (02REG)
Department of Veterans Affairs
810 Vermont Avenue, NW
Room 1068
Washington, D.C. 20420

REF: RIN 2900-AP24

Re: Expanded Access to Non-VA Care through the Veterans Choice Program

Dear Ms. Cunningham,

Catholic Health Initiatives appreciates the opportunity to provide comments to the Department of Veterans Affairs (VA) on the interim final rule adopting expanded access to non-VA care through the Veterans Choice Program. As one of the nation’s largest health systems, Colorado-based Catholic Health Initiatives (CHI) operates in 18 states and comprises 105 hospitals, including four academic medical centers and 30 critical access hospitals, as well as numerous community health-services organizations, accredited nursing colleges, home-health agencies, and other facilities that span the inpatient and outpatient continuum of care.

CHI’s highest advocacy priority for well over a decade has been access to health care for all, including those who honored their country in military service. We are pleased that the VA is taking steps to implement changes to improve access to health care for our veterans. We understand the importance of expanding health care choices to veterans who are unable to receive timely services in VA facilities, particularly those veterans living in rural areas. However, this interim final rule does little to improve the situation.
We appreciate that the VA is limited to promulgating rules that meet the requirements of the Veterans Access, Choice and Accountability Act of 2014. This law, which created the Veterans Choice Program, was passed quite hastily, and much of its language prevents the very things it was trying to accomplish (e.g. greater access to health care for veterans in rural areas, swifter access to health care for all veterans). The VA was given little latitude to truly overhaul an inefficient system, and was asked to make sweeping changes in only a few months. In addition, the Veterans Choice program will only be in effect through August 2017. Many of our comments reflect the problems in the law itself, rather than the VA’s regulations. Despite these limitations, we hope that our recommendations can be used in future decision-making as Congress and the VA work to improve access to health care for millions of veterans.

Mileage Requirement

In order to participate in the Veterans Choice Program, a veteran must satisfy a number of requirements to receive coverage, including that (generally) the veteran must reside more than 40 miles from the closest VA medical facility. The rule defines a VA medical facility as a VA hospital, VA community-based outpatient clinic (CBOC) or a VA health care center. Unfortunately, the 40-mile limit is in place regardless of whether the facility can provide the specific care that the veteran requires. (For example, if a veteran needs neurological services and the nearest VA hospital is 150 miles away, but the nearest VA outpatient clinic that provides only primary care is 30 miles away, the veteran is ineligible to receive care from a local non-VA hospital.) In its discussion of these interim final rules, the VA stated that it believes the statutory language authorizing the Veterans Choice Program precludes it from considering the type of care provided at a VA medical facility under the 40-mile limit.

We believe that the 40-mile distance limit unreasonably restricts many veterans’ ability to access health care services and significantly limits the ability of the VA to achieve the goals of the law. Therefore, we urge the VA to consider ways to improve access to care for veterans living in rural areas by modifying the 40-mile distance requirement to account for the level of services the veteran needs.

While the program’s statutory language may be clear that outpatient clinics must be included in the definition of “VA facility,” the VA has some latitude in its interpretation. For example, to access services through the Veterans Choice Program, the veterans may reside less than 40 miles from a VA medical facility if he or she faces geographical challenges that create an unusual or excessive burden in traveling to the facility. The VA has interpreted “geographical challenges” to mean that travel is impeded by a body of water or a geologic formation that
cannot be crossed by road. We urge the department to interpret this standard much more broadly to account for the extenuating circumstances some veterans face in accessing the health care they need.

**Prompt Pay**

As required, the VA establishes a nationwide claims processing system to receive requests for payment and to provide accurate and timely payments for claims received under the Choice Program. However, the rule does not set forth timeframes within which the VA must review claims and make payment. Our hospitals have repeatedly expressed frustration with their inability to obtain timely payment from the VA, which hinders access to care for veterans who need non-VA services. As an example, one of our hospitals resubmitted the same claim to the VA numerous times because the department kept losing it, and when the claim was eventually reimbursed, the payment was incorrect.

The problem is widespread. In March 2014, the Government Accountability Office (GAO) reported that one non-VA hospital often received no response after claims were sent to the VA, or experienced lengthy delays (in some cases years) before the claims were processed. Additionally, GAO testified at a June 18, 2014, House Committee on Veterans' Affairs hearing that these types of delays or denials create an environment where non-VA entities are hesitant to provide care for fear they will not be paid for their services.

If the VA intends to encourage non-VA facilities to participate in this program, it must make swift and significant changes to the claims processes currently in place. We urge the VA to commit to paying non-VA hospitals in a timely manner. Specifically, we ask the department to:

- Review claims as soon as practical to determine whether they are proper. When a claim is determined to be improper, the department should return the claim to the hospital within seven days after its initial receipt. The VA also should specify the reasons why the claim was deemed improper and request a corrected claim.
- Pay claims within 30 days of the receipt of a proper claim.
- Make interest payments to hospitals when claims are not paid according to the 30-day standard.

We are also concerned that the VA’s policy to calculate copays from veterans receiving care at non-VA facilities after the care is provided, essentially at the time the claim is processed,
creates a situation where hospitals will not get reimbursed appropriately. It is extremely difficult to recover copay funds from individuals after they have left the facility. Since all care provided at non-VA facilities must be pre-approved (excepting emergency services, which are not covered under this rule), and all non-VA providers must enter into an agreement with the VA ahead of providing care under this rule, we are unclear why the VA cannot calculate the veteran’s copay at the time service is rendered. **We urge the department to modify its existing rules to allow for copay calculations at the time of services at a non-VA facility.**

Thank you for your consideration of our comments on these very important issues. If you would like additional information, please contact me at 720-298-9100, or email Rachel Tanner, Director Regulatory Affairs, at racheltanner@catholichealth.net.

Thank you,

Colleen Scanlon, RN, JD  
Senior Vice President and Chief Advocacy Officer