United States Senate

COMMITTEE ON VETERANS' AFFAIRS

WASHINGTON, DC 20510

April 15, 2010

Director, Regulations Management (00REG1)
Department of Veterans Affairs
810 Vermont Avenue, NW
Room 1068
Washington, DC 20420

Re: Response to RIM 2900-AN37
"Payment for Inpatient and Outpatient Health Care Professional Services at Non-Departmental Facilities and Other Medical Charges Associated With Non-VA Outpatient Care"

Dear Director:

I am writing to comment on the proposed rule, 2900-AN37, which would adjust the reimbursement methodology in 38 CFR Part 17, for several health care services provided as part of the Fee Basis Program. The Department has proposed to adopt Medicare payment methodology for all non-VA inpatient and outpatient health care professional services and other outpatient services, in the absence of an amount negotiated between VA and the provider under the Federal Acquisition Regulation.

I applaud VA's efforts to address the current inconsistent and unpredictable fee-basis reimbursement rates, and to reduce costs for this care. I urge VA to consider carefully, though, the complexities and potential future impact that such efforts to contain costs too swiftly could have on immediate access to care for veterans residing in rural or otherwise underserved communities where VA care may be unavailable, especially for those veterans receiving laboratory and dialysis services. Of primary concern are VA's proposed payment rate reductions for laboratory services by 75 percent, dialysis services by 39 percent, Ambulatory Surgery Center services by 11 percent, and all other outpatient services by 25 percent.

I am concerned that VA has proposed to adopt Medicare payment rates without also adopting Medicare's complementary payment policies that protect vulnerable medical services and provider types from sharp payment rate reductions. Such complementary payment protections include end-of-year settlements and cost reporting adjustments. Furthermore, the Medicare payment system will undergo significant change in 2011, as it moves to a so-called bundled payment structure. The new rate will include adjustments for patient case mix, high-cost patients, and low-volume facilities. It concerns me that the Department believes it is unable to implement these rate adjustments or a similar structure.

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VA recognizes that this proposed rule will economically impact the health care community and references the historical precedent of other Federal payers utilizing a phased-in approach to implementing such procedures. I urge VA to closely examine and consider a variety of such phased-in approaches.

Although VA has stated in its proposed rule that it believes the impact of its proposal in the local health care market to be minimal, the table that VA has presented to illustrate this impact reflects the volume and percentage of total veterans who use the VA health care system as a percentage of the total population in each state. I would suggest that a more accurate forecast of the impact in the local health care market necessitates a more local analysis of the number of veterans for whom VHA preauthorized non-VA inpatient and outpatient services, stratified by geographic provider types (i.e., urban, suburban, and rural), as opposed to rolling up the analysis to the overall state totals. Since a significant portion of veterans receiving non-VA medical care reside in rural communities where VA care is unavailable, I am concerned that rural health care providers may be impacted disproportionately.

I am also concerned that VA's proposed rule oversimplifies a complicated and rapidly changing payment system and fails to identify how to address the issue for which Medicare's policy protections were designed. Also, merely replicating the system designed by Centers for Medicare and Medicaid Services (CMS) does not account for the significant differences in patient populations served by VA as compared to CMS, nor does it account for the differences in provider reimbursement operations.

A VA Office of Inspector General report from August of 2009 found that 37 percent of claims from the VA Fee Basis Program for many different services were improperly paid. The reality is that VA has improperly reimbursed dialysis providers in the Fee Basis Program under the simpler current rule requiring payment under the 75th percentile methodology. VA has acknowledged these repeated errors and now must reimburse providers for these underpayments. This causes me serious concern regarding how VA would accurately pay providers under the evolving and significantly more complex Medicare payment methodology.

I believe it would behoove the Department to conduct a more thorough analysis of the potential impact of its proposed rule on access to medical care for veterans, especially those residing in rural communities and receiving laboratory and dialysis services. As part of this analysis, VA should carefully consider a variety of phased-in approaches. Additionally, I believe that VA should document how it will ensure providers receive accurate and timely reimbursement under the new rule. Finally, the Department should evaluate the possibility of employing a gradual approach to changing reimbursement levels and demonstrate to the Committee that VA's proposed rule will not lead to a harmful impact on access to care, especially in rural and underserved areas.

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Thank you in advance for considering these comments.

Sincerely,

Daniel K. Akaka
Chairman

Mark Begich
Senator