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March 1, 2019

Robert Wilkie
VA Secretary
Department of Veterans Affairs,
810 Vermont Avenue, North West,
Room 1063B,
Washington, DC 20420

Dear Mr. Wilkie:

On behalf of the American College of Physicians (ACP), I am pleased to provide feedback and recommendations regarding the Urgent Care proposed rule which seeks to amend title 38 of the United States Code (U.S.C.) intended to offer eligible veterans convenient care for specific, limited, non-emergent health care needs. Many of ACP's physician members provide care within the Veteran's Health Administration (VHA) and we strongly support the Veterans Affairs' (VA) mission of providing high quality, comprehensive, and timely care to veterans in their time of need and throughout their lifetime.

The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP recognizes the vital health care services that the VHA provides to this nation's military veterans. We support maintaining the integrity of this system of care and also ensuring adequate funding to allow the VHA to provide timely and high-quality health care services. Furthermore, in the past, the College has supported the efforts of the Agency to better meet the growing health care needs of veterans through the Veterans Choice Program, which expanded the availability of medical and hospital services from the community, non-VHA physicians and other health care professionals for veterans who qualify.

Funding for VHA and VA Services

The Congressional Office Budget (CBO) has estimated that the cost of urgent care over the next five years will be over \$1.4 billion based on 2.7 million claims, which are about \$200 per visit. Currently, the VHA Medical Community Care is funded at \$9.39 billion, which is \$443.59 million less than fiscal year 2018.

ACP Comment:

We are greatly concerned that absent increased and dedicated funding by Congress equal to the actual costs of the new urgent care program, which may be grossly underestimated by the administration and CBO, funds may be diverted from traditional medical services within the VHA or other VA services. We believe this would jeopardize existing medical services for our veterans,

compromise the current VHA structure, and even delay the implementation of the VA Mission Act and its programs.

ACP strongly urges the administration to work with Congress to provide the necessary additional funding to existing VA facilities that have the capability to provide urgent care services. If patients cease going to the VA urgent care clinics and emergency departments, then there could be pressure to close them. These additional funds would allow for those facilities to remain open for extended hours, providing veterans medical services that meet their needs and reinforce the trust that forms the basis for every interaction with the VA. This will further give veterans the opportunity to choose the health care clinicians that they know and trust.

Training programs

One of the most important programs within the VA system is training of Residents; funding for the Resident program must remain in place. A large number of physicians benefit from the training programs provided by and directed through the VA, and these programs rely on the number of Veterans treated at VA facilities. **Jeopardizing these training programs for Residents learning and working opportunities could have a far-reaching downstream effect, not only on the nation’s veterans but on the nation as a whole.**

Definitions of Urgent and Episodic Care

In this proposed rule, this benefit is termed “urgent care instead of walk-in-care.” To be consistent with the current industry practice, “urgent care” would include care provided at walk-in retail health clinics as well as urgent care facilities. The Secretary is directed to establish procedures for accessing urgent care from non-VA providers or entities that meet the requirements by the rulemaking while maintaining consistency with sections 1725A(a) and (g) based on the eligibility of the veteran.

The VA believes that defining urgent care to include services that are furnished by walk-in retail health clinics or urgent care facilities, as designated by the Centers for Medicare and Medicaid Services, would be in alignment with public expectations of the types of urgent care services that are otherwise available under other health care plans. Any care that is provided to an eligible veteran that does not meet this definition, whether it be that the care was provided by a non-qualifying entity or provider or that the care provided was beyond the scope of urgent care as defined in the section, will not be covered by VA. In these situations, the eligible veteran would be liable for the cost of such care.

The proposed definition for “episodic care” is defined as care or services provided to an eligible veteran for a particular health condition, or a limited set of particular health conditions, without an ongoing relationship being established between the eligible veteran and qualifying non-VA entities or providers. Only certain health conditions would be considered as “episodic care (or a flu shot)” or a limited set of particular health conditions, to be addressed in a single visit. For example, an eligible veteran could seek episodic care for a sore throat, an ankle sprain, or both in a single visit. There would be no further relationship between the qualifying non-VA entity or provider and the eligible veteran for the treatment of those health conditions. VA believes that flu shots, as well as therapeutic vaccines that are furnished in the course of treatment of another condition, would be clinically appropriate because the risk of an adverse reaction would be minimal for a flu shot, and therapeutic vaccines would be necessary for the treatment of certain conditions. For example, a veteran seeking treatment for a wound caused by a rusted

metal requires treatment for the wound and may require a tetanus vaccine as part of the course of treatment.

Patient and Clinician Education

ACP Comment:

ACP strongly encourages patient and clinician education regarding aspects of this proposed rule. There is confusion regarding how continuity of care will be managed under episodic care. The challenge with these definitions is who determines the extent of services provided to the veteran outside of a VA facility that may ultimately result in a surprise bill, leading to financial hardship to the VA patient. This has been a real concern for decades as a recurring problem for patients who sought emergency care that the VA subsequently refused to cover because patients had not obtained advance authorization. Moreover, some less informed urgent care clinicians may unintentionally provide care outside the scope of urgent care as defined in this rule for which the veteran would ultimately be financially responsible. Also, if urgent visits in the community turn out to be serious, it would likely result in hospital admissions to community hospitals rather than VA hospitals.

Exchange of Information and Transparency

ACP Comment:

ACP strongly urge the VA to address non-VA physicians' writing prescriptions for veterans eligible for non-VHA care; those Veterans should be allowed to have those prescriptions filled by pharmacy services within the VHA system. Such processes should also allow for coverage of prescriptions filled by pharmacy services outside the VHA system in urgent or emergently needed situations. **Non-VA physicians should have ready access to and make use of VHA formularies when providing care to eligible veterans, and access to processes to petition for the use of non-VHA formulary drugs for selected patients.**

ACP encourages the administration to implement processes to ensure the timely, bidirectional exchange of patient clinical information necessary for effective patient care between VHA and non-VHA physicians, other healthcare professionals, and facilities regarding patients that receive healthcare services from both sources. There is concern that without proper communication or knowledge of the patients' history, the treating non-VA physician could unintentionally prescribe medication to a veteran that may lead to unintended consequences. There needs to be a mechanism for managing bidirectional electronic communication between the external facilities and the primary care physician (PCP). With a lack of communication, there is a high probability of error in care. If a patient visits a facility outside their PCP and there is a delay in sending information back to their PCP at the VA, the responsibility may rest on the VA physician. Electronic medical record (EMR) communication is vital; if information is not communicated promptly and a patient seeks care with their PCP at the VA after visiting a non-VA urgent care facility, then many things can go wrong such as testing, diagnosis, and unnecessary medication administration.

There must be a mechanism to generate data to assess quality improvements and cost savings and accountability for the \$1.4 billion in spending. Non-VA entities contracting with the VA to provide urgent care services to veterans should be required to use clinical performance measures consistent with those used within the VHA or other evidence-based measures endorsed through a national multi-stakeholder consensus process (e.g., National Quality Forum) and employed by other federal (e.g.,

Medicare) and private sector healthcare programs. All clinical performance measures and results should be transparent and readily available to the public.

ACP is supportive of the principle to provide urgent care in the community but urges the administration to establish a clear and transparent way to inform veterans (a hotline, for example) and require that community clinicians transmit records of any care provided back to the VA. This new program must be carefully implemented; if not, it could fragment care, impede continuity of care, undermine team-based care, and potentially lead to medical errors—especially if veterans receiving care from clinicians working for urgent care centers outside the traditional VHA do not have the care they receive communicated and coordinated effectively with clinicians working and responsible for their care within the VHA. Additionally, this program raises concerns of transferring scarce VA resources into the community and the potential of cannibalizing other vital VA programs.

We appreciate this opportunity to provide input on this very important matter and hope to continue to provide the clinician perspective on VA health care reforms, as appropriate. Please contact Brian Outland, PhD, Director, Regulatory Affairs, at 202-2614544 or boutland@acponline.org with questions or for additional information. We look forward to working with you going forward.

Sincerely,



Ana María López, MD, MPH, MACP
President
American College of Physicians