CENTER FOR
HEALTHCARE
QUALITY &
PAYMENT REFORM

320 Ft. Duquesne Boulevard
Suite 20-J
Pittsburgh, PA 15222
(412) 803-3650
www.CHQPR.org

Statement for the Record

U.S. House of Representatives
Committee on Veterans' Affairs
Oversight Hearing:
"Rural Access: Is VA Meeting All Veterans Where They Live?"
January 11, 2024

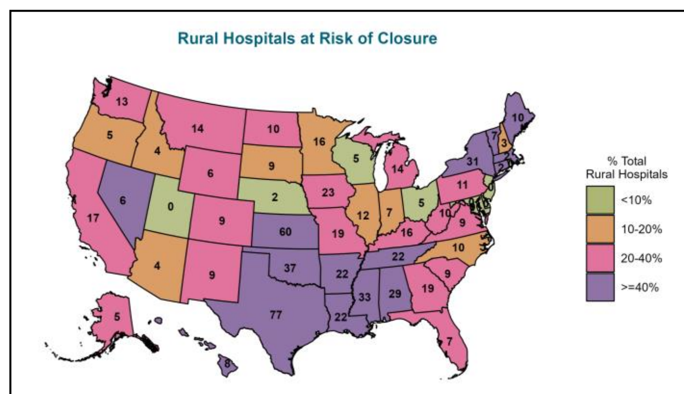
by
Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

Chairman Bost, Ranking Member Takano, and distinguished members of the Committee on Veterans' Affairs, thank you for inviting me to provide input on ways that Congress can improve access to health care services for veterans living in rural areas of the country. Hundreds of rural communities are at risk of losing essential health care services over the next several years, and there are important steps Congress can and should take to address this problem in order to preserve and strengthen access to health care services both for veterans and other residents of small rural communities.

The Growing Crisis in Rural Healthcare

Congress has clearly recognized the importance of enabling veterans living in rural areas to obtain healthcare services without having to travel long distances to do so. The Veterans Community Care Program (VCCP), created under the VA MISSION Act in 2018, enables veterans to receive healthcare services from community hospitals and clinics when the nearest VA facility is at least 30-60 minutes away.

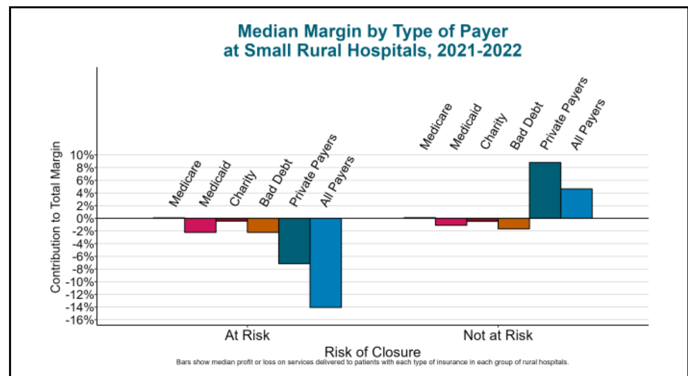
However, the ability of a rural veteran to benefit from VCCP depends on whether there are healthcare services in the community where the veteran lives. Over the past decade, more than 100 rural communities across the country have lost access to essential healthcare services, such as emergency care, maternity care, inpatient care, and primary care, because their local hospital has closed. **Hundreds more small rural communities, and the veterans who live in them, are at risk of losing essential healthcare services over the next several years because of the serious financial problems currently facing rural hospitals and clinics.** As described in more detail in our report *Rural Hospitals at Risk of Closing*, more than 600 rural hospitals – 30% of all rural hospitals in the country – are at risk of closing in the near future, and over 300 of these hospitals are at *immediate risk* of closing.



Why Rural Hospitals and Clinics Are Closing

Our research has found that **the primary cause of the financial problems facing most small rural hospitals and clinics is the way private health insurance companies pay them for services**.

- Whereas insurance companies typically pay large hospitals more than Medicare rates, those same companies pay small rural hospitals *less* than Medicare rates.
- In many cases, the insurance companies do not pay *at all* for services the hospital or clinic delivers to patients by requiring prior authorization for services, rejecting claims inappropriately, and refusing to contract. These problematic tactics are being used by Medicare Advantage (MA) plans and Medicaid Managed Care Organizations (MCOs) as well as by employer-sponsored insurance plans and plans that individuals purchase on the health insurance exchanges.



These tactics create problems for both patients and the hospitals/clinics. The hospital or clinic may not be able to afford to deliver a service if the patient's insurance will not pay for it, and if the hospital or clinic delivers services to patients without adequate payment, the hospital or clinic could be forced to close.

For most small hospitals, the majority of their patients are affected by these problematic payment practices. Large hospitals can afford to hire staff and consulting firms to challenge inappropriate prior authorization denials and to resubmit rejected claims until they are paid. Small rural hospitals do not have the resources to do those things, so the small hospitals end up with large financial losses for a large portion of their patients. (More information on the causes of the financial problems at rural hospitals is available in CHQPR's report *The Two Different Types of Hospitals in the U.S.*)

Problems VCCP Creates for Veterans and Healthcare Providers in Rural Areas

These same kinds of problems exist in the Veterans Community Care Program (VCCP). The companies used by the VA to administer VCCP (Tri-West Healthcare Services and Optum Serve) often fail to contract with small rural hospitals and clinics. Even if the hospitals and clinics have a contract, the companies may fail to pay them for services, and the hospitals/clinics often cannot receive authorizations for services to veterans in a timely fashion. A small rural hospital or clinic may be unable to deliver the services that a local veteran needs if they do not know whether or when they will be paid.

We contacted several small rural hospitals to ask about the experiences they have had providing healthcare services to veterans, and they described serious problems both in delivering care to veterans and getting paid for it. These are examples of the comments they made:

> *"[The staff at the VA's network contracting organizations] are horrible to work with and have no follow through. On two occasions, we negotiated and agreed on new contracts with them, we signed and submitted the contract, and then they never executed it. We then have claims denied because we are "out of network," which makes the patient responsible for the full payment. When we try to contact the VA contractor to resolve the problem, they typically do not follow up."*

> *"One of the hurdles we face is that even if a veteran is referred to us for primary care (because they no longer have a PCP at the VA), we still have to request authorizations to send patients for specialty consults and this delays care. It can take a long time to get*

> *those authorizations. This also goes for veterans utilizing their benefits in our ED. If the ED provider believes the patient needs specialty care, we have to wait for the ED authorization to come through before requesting an authorization to refer out. I feel like patients using their VA benefits have to wait much longer than our average patient for access to specialty care."*

These problems are not new. In November 2022, the United States Government Accountability Office reviewed the adequacy of the networks established under VCCP and reported that there were problems with veterans' access to care due to gaps in the networks established by the VA contractors and failures by the VA to identify and correct these problems (*VA Needs to Strengthen Its Oversight and Improve Data on Its Community Care Network Providers*, GAO-23-105290). A 2021 study of the VCCP ("Understanding VA's Use of and Relationships With Community Care Providers Under the MISSION Act," *Medical Care* 59(6 Suppl 3)) found that community providers had problems with timely reimbursement and confusing rules related to prior authorizations. The study included these quotes from VA facility directors:

> *"The biggest challenge that has affected establishment of new relationships with community providers has been the VA's historically slow reimbursement process and the convoluted authorization and claims submission process. Many community providers became frustrated with the various payment methodologies which were often very confusing."*
>
> *"The biggest obstacle we face to maintaining current relationships with community partners is related to claims and payment issues. Many of our partners had services authorized … and were not paid. Therefore, they are very hesitant to continue to accept referrals from us."*
>
> *"Our TPA performance with referrals, secondary authorizations and payments has limited community providers' willingness to provide care to Veterans. The VA payment timeliness has also been a problem. The reimbursement rates (Medicare) also severely limit our ability to attract new community providers to our network."*

It is important to note that for most small rural hospitals, the problem is not the *amount* of payment. Medicare payment rates for services delivered to veterans would be sufficient to cover the costs of the services at these hospitals. But the hospitals are either not being paid at all by the VA contractors, or they have to incur significant administrative costs and delays in order to get paid.

How Congress Can Preserve and Strengthen Access to Healthcare for Rural Veterans

Clearly, actions are needed to ensure that veterans living in small rural communities can obtain services from the hospital and clinics located in their community and to ensure that the hospital/clinic will be paid for delivering services in a timely way.

Improving Contracting and Payment in VCCP

At a minimum, we recommend the following two steps be taken to improve contracting and payment in the Veterans Community Care Program:

- **Require Contracts With Small Rural Hospitals.** The VA contractors that administer VCCP (currently Tri-West Healthcare Alliance and Optum Serve) should be required to have a signed contract at all times with any Critical Access Hospital or Sole Community Hospital that is located more than 30 minutes away from a VA facility if the rural hospital agrees to accept Medicare payment rates for services to veterans, unless there is documented evidence of problems with the quality of care delivered by the hospital or its clinics. These facilities are, by definition, the only hospital in their community, and in many cases, they are the only source of primary care, behavioral health services, maternity care, and other specialty services. Consequently, if they are more than 30 minutes away from a VA facility, they need to be included in the network in order

to ensure access to care for veterans living in the community. Requiring that they be automatically included in the network if they agree to a standard contract would make it easier for veterans to know where they can obtain care, make it easier for the rural hospital to know that it will be paid for delivering the care veterans need, and simplify what the VA has to do to monitor this aspect of network adequacy.

- **Require Prompt Payment of Claims.** The VCCP contractors should be required to process and pay claims from small rural hospitals and clinics within a maximum period of time (e.g., no more than 30 days). The contractors should also be required to publicly report on their claims processing times and claims denial rates.

Preventing Closures of Community Hospitals That Rural Veterans Rely on for Services

Although these changes in the Veterans Community Care Program will facilitate better access to services for rural veterans and appropriate payment for the rural hospitals that deliver those services, these changes alone will not ensure that there will continue to be a hospital and clinic in the rural community to deliver services to veterans. Small rural hospitals will only survive if *all* payers pay them adequately for their services. In order to solve the problems caused by other health plans, we urge that Congress enact legislation that includes the following provisions:

- **Require Medicare Advantage (MA) Plans to Contract With Hospitals and Clinics in Small Rural Communities.** MA plans should be required to contract for services with any Critical Access Hospital, Sole Community Hospital, or Rural Health Clinic that is willing to provide services to Medicare beneficiaries enrolled in the MA plan in return for the same payment that the hospital or clinic would receive if the beneficiaries were enrolled in Original Medicare.
- **Require Adequate, Timely Payment by Medicare Advantage Plans.** Medicare Advantage (MA) plans should be required to pay Critical Access Hospitals, other small rural hospitals, and Rural Health Clinics at least as much as Original Medicare pays the hospitals and clinics for the same services, and the plans should be required to pay claims from small rural hospitals and clinics in a timely fashion.
- **Require Qualified Health Plans to Contract With Hospitals and Clinics in Small Rural Communities.** A Qualified Health Plan sold on a health insurance exchange should be required to include any small rural hospital or rural health clinic in its provider network if the hospital or clinic is willing to accept payments for services from the insurance plan equivalent to what it would receive for the same services from Medicare.
- **Require Approval of State Medicaid Plan Amendments (SPAs) Designed to Provide Adequate Medicaid Payments to Small Rural Hospitals and Clinics.** The Centers for Medicare and Medicaid Services (CMS) should be required to promptly approve a State Plan Amendment submitted by a state Medicaid agency that would require Medicaid Managed Care Organizations (MCOs) to pay small rural hospitals and clinics at least as much as those hospitals and clinics are paid by Medicare.

None of these requirements would require any increase in federal spending, yet they would help prevent many rural hospital closures and preserve access to essential healthcare services for rural veterans and other rural residents. For example, the requirements for Medicare Advantage plans would simply ensure that the large amounts of money CMS is already paying to these plans on behalf of rural Medicare beneficiaries are used to provide adequate payments to rural hospitals and clinics rather than to increase profits for the health insurance companies. Similarly, the requirements for commercial insurance policies would ensure that the premiums rural residents are paying for these policies and the federal subsidies for those premiums are used to pay adequately for the services those rural citizens need.

Thank you again for the opportunity to provide these recommendations. I would be happy to answer any questions you have about them or to provide additional detail on the problems facing rural hospitals.