

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - A-03
(June 2003)

Subject: Veterans Health Administration Health Care System
(Resolutions 802, I-01, and 709, I-02)

Presented by: Cyril "Kim" Hetsko, MD, Chair

Referred to: Reference Committee G
(Lawrence A. Stone, MD, Chair)

1 At the 2001 Interim Meeting, the House of Delegates referred Resolution 802 to the Board of
2 Trustees. Introduced by the Organized Medical Staff Section (OMSS), the resolution calls for the
3 AMA “to study the policies and practices of the Veterans Health Administration (VHA) health care
4 delivery system, particularly as to how such policies impact the care and relationships between
5 private physicians and their patients who are veterans”; and to “work with the VHA to develop a
6 mechanism to facilitate the provision of timely communication and exchange of information
7 between VHA physicians and all other treating physicians.” The Board of Trustees referred the
8 requested study to the Council on Medical Service for a report back to the House at the 2002
9 Interim Meeting. However, due to a delay in receiving information from the VHA, the Council
10 deferred its report to the 2003 Annual Meeting.

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12 In its correspondence to the Council, the OMSS specified that the primary concern of the resolution
13 was the impact on continuity of care that results from the lack of communication between VHA
14 and private physicians. OMSS cited inappropriate substitution of medications, duplication of
15 services, and lack of access to laboratory results as examples of the negative results of poor
16 communication.

17
18 At the 2002 Interim Meeting, a second resolution related to the topic of patients cared for by both
19 VHA and private physicians, was referred to the Board of Trustees. Introduced by the Kansas
20 Delegation, Resolution 709 (I-02) calls for the AMA to “petition the VHA to change its policies to
21 allow beneficiaries to receive VA formulary-approved medications pursuant to an order from their
22 personal physician, without the necessity of seeing a VA practitioner,” and to “petition the
23 Veterans Administration to change their policies to require no more than annual written refill
24 prescriptions for maintenance medication.” In additional information received by the Council, the
25 Kansas Medical Society specified its appreciation of the mission of the VHA health system, the
26 need for the VHA to operate within tight budget constraints, and the lengthy delays in patient care
27 that could be somewhat alleviated through the implementation of changes to the VHA system that
28 recognize and utilize the clinical expertise of non-VHA physicians, in consideration of VHA
29 formulary restrictions.

30
31 This report summarizes recent VHA policies and events that led to the introduction of Resolutions
32 802 (I-01) and 709 (I-02); presents the key findings and related observations of the Council as to
33 the various causes of and potential solutions to the problems cited in the resolutions; and presents
34 several recommendations.

1 HISTORICAL DEVELOPMENT OF CURRENT CIRCUMSTANCES

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3 VHA Mission

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5 The VHA is the nation's largest direct care delivery system. It employs approximately 180,000
6 health care professionals at 163 hospitals, more than 800 community and facility-based clinics, 135
7 nursing homes, 43 domiciliaries, 206 readjustment counseling centers, and various other facilities.
8 In addition to its medical care mission, the veterans health care system is the nation's largest
9 provider of graduate medical education and a major contributor to medical and scientific research.

10
11 The mission of the VHA is to serve the needs of America's veterans by providing primary care,
12 specialized care, and related medical and social support services. Once enrolled in the VHA
13 system, a veteran is entitled to all the appropriate services. Enrollment in the VHA system depends
14 on several factors related to VHA enrollment priorities, as well as the amount of funding available
15 for VHA operations. There are eight separate enrollment priority groups, and these are defined
16 according to the status of the veteran with respect to degree of service-connectedness disability,
17 degree of disability, prisoner of war, income, wealth, and type of military service (i.e., time and
18 place). Depending on the enrollment priority group to which a veteran belongs, various levels of
19 cost sharing apply.

20
21 New Market-Based Enrollment Strategy

22
23 Due to the decrease in the number of American veterans of World War II and the Korean War, the
24 VHA found itself as a very large direct provider of care to a rapidly declining patient base. These
25 circumstances led Congress and the VHA to consider how to optimize the use of current VHA
26 resources while maintaining the system's productive capacity. In order to obtain the patient
27 volumes required to sustain the productive capacity of the VHA, Congress passed the Veterans'
28 Health Care Eligibility Reform Act of 1996 (VHCER), which mandated VA to establish and
29 implement a national enrollment system to manage the delivery of health care services. This
30 legislation led the way for the creation of a Medical Benefits Package to provide a standard health
31 plan to most enrolled veterans and to certain groups of veterans who do not need to enroll. The law
32 mandated that the enrollment system be effective October 1, 1998. After that date, most veterans
33 must be enrolled to receive care. The net effect of the new enrollment policy was to make a much
34 larger number of veterans eligible for VHA care, pending their enrollment and the limitations of
35 VHA capacity. In general, VHCER shifted the emphasis from what care a patient may be eligible
36 to receive to what care an enrolled patient may need. For some veterans, the VHA maintained the
37 character of an entitlement program, as the following veterans do not need to enroll:

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39 • Veterans who need treatment for a VA-rated service-connected disability.
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41 • Veterans who are VA-rated service-connected disabled 50% or more.
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43 • Veterans who were released from active duty within the previous 12 months for a disability
44 incurred or aggravated in the line of duty.

1 Prescription Drug Benefit

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3 The VHA has sought to become the preferred provider of care by veterans, and in one area in
4 particular, it has succeeded far beyond its expectations. By including prescription drugs, at little or
5 no cost to the beneficiary, in its standard benefit package, the VHA has attracted a very large
6 number of veterans to its system. Many of these are veterans who normally obtain all or most of
7 their medical care through alternative systems of delivery or finance, including Medicare.
8 Accordingly, a large number of veterans, particularly those of low income or means, are drawn to
9 enroll in the VHA system primarily or exclusively because of its prescription drug benefit. In fact,
10 VHA spending on prescription drugs increased by approximately 50% from 1999 to 2002, rising
11 from \$2 billion to \$3 billion.

12
13 Budget Constraints

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15 In the course of adapting its capacity to meet the medical needs of veterans in consideration of their
16 geographical distribution and in anticipation of their increased enrollment, the VHA implemented a
17 strategy to increase the number and types of access points for services. This included increasing
18 the number of community-based outpatient clinics (CBOCs), mobile clinics, and contracting with
19 community providers. Combined with the expansion of enrollment eligibility criteria, this resulted
20 in VHA enrollment nearly doubling from 3,421,393 in 1998 to 6,788,780 in 2002, an increase of
21 98%. In comparison, VHA funding increased from \$17.4 billion to just over \$23 billion over the
22 same period, a cumulative increase of only 32%.

23
24 Given the failure of revenues to keep pace with expanding enrollment, the VHA has recently
25 revised some of its policies. For example, in August 2002, with 280,000 patients waiting for first
26 appointments or follow-up care, the VHA suspended its enrollment marketing efforts, citing the
27 well documented need to provide quicker service to those veterans already enrolled. In January
28 2003, the VHA suspended future enrollment of veterans who would otherwise qualify as Priority
29 Group 8 enrollees. Negotiations between the VHA and the Department of Health and Human
30 Services are currently underway to devise a partial fix, in the case of those veterans who are
31 eligible for Medicare, by having their VHA care funded, in part, by Medicare, through HMO-like
32 arrangements. The program, known tentatively as VHA + Choice Medicare, could help an
33 estimated 164,000 veterans currently locked out of enrollment in the VHA system due to the recent
34 revision to eligibility policy.

35
36 RELEVANT AMA POLICY

37
38 The AMA has established several policies that are relevant to the issues raised in Resolutions 802
39 (I-01) and 709 (I-02). For example, policy H-510.991 (AMA Policy Database) supports
40 approaches that increase the flexibility of the Veterans Health Administration to provide all
41 veterans with improved access to health care services. Further, Policy H-510.999 states that the
42 provision of care for non-service-connected disabilities is not the proper business of the Veterans
43 Administration.

44
45 DISCUSSION

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47 At its January 2003 meeting, the Council met with a representative of the VHA who provided the
48 Council with a wealth of information regarding the historical development of the strategy,

1 structure, priorities, and policies of the VHA, as they relate to the issues raised by Resolutions 802
2 (I-01) and 709 (I-02). In consideration of the helpful insights provided by VHA staff, as well as
3 the information provided to the Council by the sponsors of the resolutions, the Council made the
4 following observations regarding the nature and causes of, as well as possible solutions to, the
5 issues raised by the resolutions.

6
7 Prescription Drugs
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9 It is apparent that many veterans are experiencing significant delays in access to VHA physicians
10 and other health care providers. It is also apparent that this stems in large part from “benefit
11 cherry-picking” by many of these patients, who seek to obtain their medications at low cost from
12 the VHA, while obtaining the rest of their care through their normal channels of access, such as
13 private physicians. Resolution 709 (I-02) asks the VHA to amend its policies in order to permit
14 veterans to have their prescriptions filled by the VHA on the authority of private physicians.
15

16 There are several difficulties with achieving this objective. First, the VHA considers patient
17 referrals as transfers of care, not as referrals for specialized care or services. Second, as a principle
18 of implied statutory limitation, the VHA cannot provide medical services, including the filling of
19 drug prescriptions, to ineligible or unenrolled veterans, as these veterans are not in the VHA’s care.
20 In support of this point, the VHA’s General Counsel concluded that, under the existing federal
21 statutes, the VHA lacks the authority to fill prescriptions by private physicians, and that
22 Congressional action would be required to authorize the VHA to fill drug prescriptions ordered by
23 the private physicians of veterans who are not otherwise under the care of the VHA. Third, the
24 VHA is constrained in its ability to provide services by the limitations of its budget. Proposals that
25 effectively would increase the VHA’s costs by increasing the size of its beneficiary population,
26 absent new sources of revenue to fund those cost increases, are not financially realistic, as they
27 only add strain to a budget already under severe stress.
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29 Continuity of Care Issues
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31 Resolution 802 (I-01) cited insufficient communication between the VHA and private physicians
32 treating veterans. In subsequent correspondence with the sponsor of the resolution, the aspects of
33 clinical practice around which communication problems between practitioners were found to be
34 particularly prevalent were the inappropriate substitution of medications, the general duplication of
35 diagnostic services, and the reporting of lab results. Based on its study, the Council does not
36 believe that these are national problems endemic to the VHA system, but rather, the prevalence of
37 these problems varies across regions and even facilities.
38

39 The Council believes that the coordination of patient care is the responsibility of all those who
40 provide care to a given patient, and not merely the responsibility of either the referring physician or
41 the provider to whom the patient is referred. Therefore, any efforts to resolve communication
42 problems and coordination of care issues between the providers of care to veterans, must involve a
43 collaborative effort between those providers. And while some issues, such as the improvement of
44 veterans’ access to low-cost prescription drugs, could be largely resolved through broad changes to
45 federal policy (i.e., a prescription drug benefit for Medicare beneficiaries), the Council was guided
46 by the principles of collaboration and localization in its exploration of remedial strategies for
47 addressing the issues raised by Resolutions 802 (I-01) and 709 (I-02).

1 Potential Remedial Strategies

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3 Problems with coordination of patient care between two systems of care may arise when patients
4 have the option to choose the system from which they obtain care on a service-by-service basis.
5 This tendency can be eliminated or mitigated by confining the patient to a single system of care
6 through a system of cost incentives and/or rules and regulations, albeit at a potential cost to the
7 patient of lost access to any benefits provided only by the system not chosen by the patient.

8
9 If veterans are to continue to have the option to enroll in more than one system of care, then
10 measures to improve the coordination of care among all providers will be necessary. Tactics to
11 achieve improved coordination of care may include:

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- 13 • Promotion of awareness among private physicians of the nature of the VHA health care
14 system, specifically in regard to the VHA's view of patient referrals as transfers of care
15 between systems, rather than as, for example, requests to fill drug prescriptions.
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 - 17 • Patient acceptance and execution of the responsibility to convey information back and forth
18 between all providers of care, especially through the physical conveyance of relevant medical
19 records, such as radiographic images and interpretations, lab results, and drug prescriptions.
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 - 21 • Physician acceptance and execution of the responsibility to convey information back and forth
22 between all providers of care, especially through the acts of informing veteran patients of the
23 importance of the sharing of clinical information among all providers of care, and of the
24 importance of the patient serving as the facilitator and, as appropriate, conduit of that flow of
25 information.
 - 26
 - 27 • Development of single points of access for referral of private veteran patients to any of the
28 VHA's 22 geographically based groups of hospitals or regions, also known as Veterans
29 Integrated Service Networks (VISN). This can be accomplished through development and
30 distribution of regional VISN lists of contacts who would be responsible for reporting patient
31 information, subject to statutory privacy restrictions, to private physicians, at the direction of
32 the patient or on the request of the veteran patient's private physician.

33
34 RECOMMENDATIONS

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36 The Council on Medical Service recommends that the following be adopted in lieu of Resolutions
37 802 (I-01) and 709 (I-02), and the remainder of this report be filed:

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- 39 1. That the AMA urge state medical associations to encourage their members to advise patients
40 who qualify for Veterans Health Administration (VHA) care of the importance of facilitating
41 the flow of clinical information among all of the patient's health care providers, both within
42 and outside the VHA system. (Directive to Take Action)
 - 43
 - 44 2. That the AMA facilitate collaborative processes between state medical associations and
45 Veterans Health Administration (VHA) regional authorities, aimed at generating regional and
46 institutional contacts to serve as single points of access to clinical information about veterans
47 receiving care from both private physicians and VHA providers. (Directive to Take Action)

- 1 3. That the AMA continue discussions at the national level with the Veterans Health
2 Administration (VHA) and the Center for Medicare and Medicaid Services (CMS), to explore
3 the need for the feasibility of legislation to address VHA's payment for prescriptions written by
4 physicians who have no formal affiliation with the VHA. (Directive to Take Action)