



March 7, 2018

David J. Shulkin, MD
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Avenue NW, Room 1068
Washington, DC 20420

Dear Secretary Shulkin:

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to the [proposed rule](#) titled "Civilian Health and Medical Program of the Department of Veterans Affairs" as made available by the Department of Veterans Affairs (VA) in the January 17, 2018, *Federal Register*.

The AAFP appreciates that the VA is amending regulations governing the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). We offer the following comments and suggestions to selected portions of this proposed rule.

CHAMPVA rates must equal Medicare

Summary

The proposed rule states that authorized non-VA providers may provide medical services and supplies that are covered by CHAMPVA. CHAMPVA-covered services and supplies are those provided by authorized non-VA providers who agree to provide covered services and supplies to CHAMPVA beneficiaries in exchange for payment of the CHAMPVA determined allowable amount. The VA defines these accepted assignments as the action of an authorized non-VA provider who accepts responsibility for the care of a CHAMPVA beneficiary and thereby agrees to accept the CHAMPVA determined allowable amount as full payment for services and supplies rendered to the beneficiary. This extinguishes the beneficiary's payment liability to the provider but for applicable cost sharing and deductibles.

AAFP Response

The AAFP strongly believes that CHAMPVA payment must be at or above Medicare levels to be effective in promoting access to primary care services for veterans, spouses, children, survivors, and certain caregivers of veterans who meet eligibility criteria. Primary care for any population is critical to ensuring continuity of care, as well as providing necessary preventive care, which improves overall health and can reduce total health care costs. The Medicare payment rate is widely used as a benchmark by other public and private payers. Any public or private payer health plan contract that does not at least meet the Medicare payment rate will create an unmanageable financial drain for most medical practices that already operate on extremely thin margins. If the VA offers contracts at less than the Medicare rate, the AAFP is concerned that most practices will not be able to participate in the program, which undermines the goal of expanding access to these important

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services. The VA should offer contracts at least at the Medicare rate, so family physicians and other non-VA entities can afford to treat veterans.

Definition of “authorized non-VA provider”

Summary

This regulation defines “authorized non-VA provider” to mean an individual or institutional non-VA provider of CHAMPVA-covered medical services and supplies who is licensed or certified by a state to provide the covered medical services and supplies, or is otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider. This requirement for state licensure or other certification would be like TRICARE, which requires that its providers be either licensed or certified by a state, or, where states do not offer licensure or certification, be otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider.

AAFP Response

The AAFP appreciates the VA recognizing and respecting state licensure and certification requirements. As articulated in the AAFP’s July 13, 2016, comment [letter](#) to the VA, we maintain our concern with policies that grant full practice authority for non-physician providers without regard for state practice acts. **We therefore strongly oppose the option of “otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider.”** The VA should not supersede state laws and regulations regarding the authority of non-physician providers. The determination of a health professional’s ability to practice must follow appropriate standards as determined by state governments and states are divided regarding independent practice authority. In fact, most states do not believe it to be in the best interest of their citizens and do not allow it, citing concerns for patient safety.

The AAFP continues to consider the VA to be a leading and innovative health system in exploring the efficiencies of integrated care teams. The AAFP believes that health professionals should work collaboratively as clinically integrated teams in the best interest of patients. Physician-led, team-based care addresses patients’ needs for high quality, accessible health care and reflects the skills, training, and abilities of all health care team members to the full extent of their state-based licenses. Family physicians are particularly qualified to lead the health care team, because they possess distinctive skills, training, experience, and knowledge that trains them to provide comprehensive medical care, health maintenance, and preventive services for a range of biological and behavioral problems.

Expanded access to preventive services

Summary

The VA proposes to expand the list of CHAMPVA-covered preventive services and supplies for which cost-share amounts and deductibles would not apply. As proposed, CHAMPVA beneficiaries, like their TRICARE counterparts, would pay no associated costs for colorectal cancer screening, breast cancer screening, cervical cancer screening, prostate cancer screening, annual physical exams, and immunizations. The proposed rule discusses the VA’s authority to extend the waiver of beneficiary costs to other preventive services, meaning the current list of services is not all-inclusive, enabling the VA to add supplemental items to the list in the future, if needed. The VA proposes to make clear that there will be no associated cost share for CHAMPVA beneficiaries for such services.

AAFP Response

We applaud the VA for expanding CHAMPVA covered preventive services while eliminating the cost-share amounts and deductibles for these services. The AAFP fully supports the VA's authority to add additional services in the future if needed. **We strongly encourage all VA health plans to cover all preventive services with Grade "A" or "B" [recommendations](#) from the U.S. Preventive Services Task Force (USPSTF).** Health promotion and prevention of disease are critical and foundational components of primary care and family medicine. The AAFP encourages all its members to practice evidence-based, cost-effective preventive medicine in the delivery of health care. In support of its members, the AAFP advocates for policies and payment that advance, stimulate, and facilitate preventive services.

In addition, the AAFP is increasingly concerned with patients' inability to afford medically necessary care. Most urgently, the escalation in deductibles is limiting access to care. Higher deductibles create a financial disconnect between individuals, their primary care physician, and the broader health care system. Therefore, to maximize the proven benefits of health care coverage and a continuous relationship with a primary care physician, the AAFP [proposes](#) the establishment of a standard primary care benefit for individuals and families with high-deductible health plans (HDHP). Under our proposal, individuals would be able to connect with the health care system through visits with their primary care physician or their primary care team. These visits would be exempt from cost-sharing requirements such as deductibles and co-payments. The establishment of a standard primary care benefit would guarantee connectivity to the health care system and serve as a guardrail against disease progression that leads to more costly care. We would welcome the opportunity to discuss the AAFP's proposal (currently limited to high deductible plans) further with the VA and its potential application within the context of the CHAMPVA program.

Preauthorization

Summary

The VA proposes to revise preauthorization requirements to indicate that, when a beneficiary has other health insurance (OHI) that provides primary coverage for the benefit, preauthorization requirements will not apply. The VA would waive any requirement for preauthorization where OHI covers the benefit. The VA would not require preauthorization for durable medical equipment (DME) as a covered service or supply. Since CHAMPVA is a secondary payer when the beneficiary has OHI, the VA would be required to perform reviews of medical necessity on a retrospective basis. If, during the coordination of benefits process, it is determined that CHAMPVA would be the responsible payer for the services and supplies but CHAMPVA preauthorization was not obtained before delivery of the services or supplies, the VA would obtain the necessary information and perform a retrospective medical necessity review. The VA would also propose that any claims where a retrospective review occurs are filed within the appropriate one-year period.

AAFP Response

The AAFP is encouraged that the VA is taking steps to update and minimize preauthorization requirements. Physicians strive to deliver high-quality medical care in an efficient manner. The frequent phone calls, faxes, and forms physicians and their staff must manage to obtain prior authorizations (PAs) from prescription drug plans, DME suppliers, and others impede this effort.

We encourage the VA to apply the following PA principles to CHAMPVA and other health plans under the VA's purview:

- Activities requiring PA must be justified in terms of financial recovery, cost of administration, workflow burden, and lack of another feasible method of utilization control.
- Rules and criteria for PA determination must be transparent and available to the prescribing physician at the point of care. If a service or medication is denied, the reviewing entity should provide the physician with the reasons for denial. For medications, it should provide alternative choices.
- PA should be eliminated for physicians with aligned financial incentives (e.g. shared savings, etc.) and proven successful stewardship.
- The VA should eliminate PA for DME, imaging, supplies, and generic drugs.

Transitional steps the VA should take include:

- Limit and reduce the number of products and services requiring PA.
- Adopt a standardized form and process for PA among all VA contractors.
- Require VA contractors, including pharmacy benefit managers (PBMs), that design PA specifically to save the VA or PBM money rather than benefit the patient to pay physicians for their time, as decided by the 2008 *Merck-Medco v. Gibson* court case.
- Pay physicians for PAs that exceed a specified number or are not resolved within a set time-period.
- Prohibit VA contractors from requiring repeated PAs for effective medication management for patients with chronic disease and PA for standard and inexpensive drugs.

Smoking cessation pharmaceutical supplies through Medications by Mail

Summary

This regulation proposes to provide outpatient, prescription smoking cessation pharmaceutical supplies only through Medications by Mail (MbM).

AAFP Response

In general, the AAFP supports expanded access to these products through MbM, however smoking cessation pharmaceutical supplies should not be limited to distribution through MbM. Patients should still have access to smoking cessation pharmaceutical supplies, including over-the-counter medications, at traditional outlets like pharmacies and hospitals. Smoking cessation supplies are much more effective when accompanied by counseling, a point noted in the U.S. Public Health Service guidelines. **The AAFP therefore calls on the VA to increase opportunities for family physicians and other healthcare clinicians to counsel patients about tobacco cessation. The VA could play an important role to that end, including expansion of access to quit-line services, pharmacy-based counseling, and improved payment for primary care cessation counseling.** Counseling reinforces pharmacotherapy use in the treatment of tobacco dependence and is an [effective method](#) to reduce smoking rates. The AAFP strongly encourages the VA to work with other federal agencies through existing collaborations such as the Surgeon General's Interagency Committee on Smoking and Health to discuss these issues.

Allowing drug maintenance programs to substitute one addictive drug for another

Summary

Current CHAMPVA policy excludes from coverage drug maintenance programs where one addictive drug is substituted for another (such as methadone substituted for heroin.) The VA removed this restriction from TRICARE regulations, and proposes to similarly remove this restriction in CHAMPVA,

noting that the current restriction fails to recognize the accumulated medical evidence supporting certain maintenance programs as one component of the continuum of care necessary for the effective treatment of substance use disorders.

AAFP Response

The AAFP fully agrees with removing this restriction from the CHAMPVA program and applauds the VA for recognizing the accumulated medical evidence supporting such a change. Recognizing the current epidemic, late in 2016, the AAFP updated our "Chronic Pain Management and Opioid Misuse: A Public Health Concern" [position paper](#) to better equip members to combat the opioid abuse crisis while continuing to treat chronic pain. This position paper explicitly supports the use of naloxone and buprenorphine as medication assisted treatments.

We appreciate the opportunity to provide these comments. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org with any questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "John Meigs, Jr.", with a small "MD" written below the signature.

John Meigs, Jr., MD, FFAFP
Board Chair

About Family Medicine

Family physicians conduct approximately one in five of the total medical office visits in the United States per year – more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.

CC: Joseph Duran