

ESSAY: HEALTHCARE IN APPALACHIA AND THE ROLE OF THE FEDERAL GOVERNMENT

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Text

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I. Introduction

The United States government has long attempted to address the health issues facing underserved areas like Appalachia. In the 1940s, the Hill-Burton program provided federal funding for hospital construction. ¹ In the 1960s, the government made it easier for foreign medical professions to obtain visas to service rural regions. ² Although health in Appalachia has improved in many [*1002] areas, the region has not kept pace with the United States. ³ This widening health disparity merits an examination of the government's efforts to address the problems. This Essay explores programs at the Department of Veterans Affairs ("VA") and Medicare that target access to healthcare in Appalachia. Part II will describe the conceptual framework for this Essay, which is the method through which access to healthcare will be examined. Part III will describe the predisposing factors in Appalachia. Part IV will describe the need for healthcare in Appalachia. Sections V.A and V.B will describe governmental programs at the VA and through Medicare that address access to healthcare. In Section V.C, the VA and Medicare will be compared in approaches to two common issues: telehealth and opioid abuse.

II. Access to Healthcare: Conceptual Framework

¹ Jane Wishner et al., Kaiser Family Found., A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies 3 (2016), <http://files.kff.org/attachment/issue-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care>.

² See [8 U.S.C. § 1184\(l\)](#) (2012); Conrad 30 Waiver Program, U.S. Citizenship & Immigr. Servs., <https://www.uscis.gov/working-united-states/students-and-exchange-visitors/conrad-30-waiver-program> (last updated May 5, 2014).

³ Julie L. Marshall et al., Appalachian Regional Commission, Health Disparities in Appalachia 14 (2017), https://www.arc.gov/assets/research_reports/Health_Disparities_in_Appalachia_August_2017.pdf.

This Essay focuses on the boundaries of Appalachia that are described in the authorization of the Appalachian Regional Commission, which funds much of the research about the region. This region traces the Appalachian Mountains from southern New York to northern Mississippi and covers 205,000 square-miles, 420 counties, and 13 states.⁴

This Essay uses the Anderson Healthcare Utilization Model to frame its analysis. Under this model, access is defined as actual use of healthcare and the factors that facilitate or impede this usage.⁵ Under the Anderson model, three dynamics determine access to healthcare: predisposing factors, need, and enabling factors.⁶ Predisposing factors in Appalachia are the region's characteristics, i.e., its demographics, health beliefs, and social characteristics.⁷ Need is conceptualized as both objective and perceived and includes things like the physical environment.⁸ Enabling factors are supports such as programs aimed at improving access.⁹

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III. Predisposing Factors in the Appalachian Region

Using the U.S. Census Bureau's definition of rural,¹⁰ Appalachia is 42% rural, compared to 20% rurality for the entire United States.¹¹ Appalachia's rurality is linked to a lower supply of healthcare professionals.¹² The supply of primary care physicians per 100,000 people in Appalachia is 12% lower than the national average with the areas of lowest supply being rural Appalachia, central Appalachia, and distressed counties in Appalachia.¹³ There is also a shortage in specialty areas, with data showing that the supply of specialty physicians in Appalachia is 28% lower than the national average.¹⁴ The supply of mental health professionals in Appalachia is 35% lower than the national average, and the supply of dentists is 26% lower than the national average.¹⁵

The supply of hospitals in rural areas is also lowering. Since 2010, approximately 3% of rural non-specialty hospitals have closed.¹⁶ Generally, hospitals in such locations are at higher risk of closure, have lower operating margins, and are substantially more reliant on government funding.¹⁷ This increased reliance on government funding means that any change in policy by the government has a disproportionate impact.¹⁸

⁴ Id. at 25.

⁵ Ronald M. Andersen & Pamela L. Davidson, *Improving Access to Care in America: Individual and Contextual Indicators*, in *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management* 3 (Ronald M. Andersen et al. eds., 3d ed. 2007).

⁶ Id. at 4.

⁷ Id. at 4-6.

⁸ Id. at 6-7.

⁹ Id.

¹⁰ The U.S. Census Bureau defines rural as those areas with less than 50,000 people; anything more populated is considered urban. Michael Ratcliffe et al., U.S. Census Bureau, *Defining Rural at the U.S. Census Bureau: American Community Survey and Geography Brief* 3 (2016), https://www2.census.gov/geo/pdfs/reference/ua/Defining_Rural.pdf.

¹¹ Marshall et al., *supra* note 3, at 3.

¹² Id. at 11.

¹³ Id. at 217.

¹⁴ Id. at 229.

¹⁵ Id. at 223.

¹⁶ Diana J. Mason, *Rethinking Rural Hospitals*, 318 JAMA 114, 114 (2017).

¹⁷ Id.

Many of the hospitals in rural parts of Appalachia that do exist were the product of the Hill-Burton Act, which provided federal funding for hospital construction beginning in 1946.¹⁹ Financing for the Hill-Burton Act was discontinued in 1997, but the hospitals that received funding must still provide free or reduced care to those in need under the Act.²⁰ Thus, the obligations from [*1004] the Act continue without the benefits. Difficulty improving hospital infrastructure has contributed to a perception in rural areas that the local hospitals are inferior to more modern urban facilities and create an incentive to utilize more distant facilities.²¹

The lower supply of healthcare professionals in Appalachia may have a qualitative effect that exists beyond the effect of ease of access on utilization. A large majority of studies have shown evidence of distance decay in healthcare, i.e., evidence that patients living further from healthcare facilities have worse health outcomes than those who live closer.²² Despite fewer points of access and worse health (as discussed in further detail below), some data indicates that healthcare usage in Appalachia is roughly the same as in other parts of the country, which might be further evidence of distance decay.²³

Income is lower in Appalachia than the rest of the country, but there is a large difference in income within the region.²⁴ Median income is 19% lower than the national median, but 38% lower in central Appalachia.²⁵ The poverty rate in Appalachia is only slightly higher than the national rate of 15.6%, but areas of high rurality have a 23% poverty rate.²⁶ Appalachia also has a larger percentage of its population receiving disability benefits²⁷ and lower levels of average education than the rest of the country.²⁸ These differences are also more pronounced when rural Appalachia is compared to the entire nation.²⁹

In the past, industry in Appalachia has been dependent on mining, forestry, agriculture, chemical industry, and heavy industry.³⁰ Much of the work in Appalachia is physical and labor-intensive and has significant environmental [*1005] impact.³¹ From 2000 to 2011, about two-thirds of all U.S. jobs in coal mining production were in Appalachia,³² and about 176 of the 410 Appalachian counties are in the coal mining area.³³ In coal mining areas, hospital admissions are more likely to involve individuals with incomes below \$ 35,000.³⁴ Patients in coal mining

¹⁸ See, e.g., *id.* (discussing payment reductions caused by the Middle Class Tax Relief and Job Creation Act and the Budget Control Act of 2011); Jennifer Oliva, Access, Affordability, and the American Health Reform Dilemma Part III: How an ACA Repeal Would Devastate Appalachia, *Oxford Hum. Rts. Hub* (Mar. 29, 2017), <http://ohrh.law.ox.ac.uk/access-affordability-and-the-american-health-reform-dilemma-part-iii-how-an-aca-repeal-would-devastate-appalachia/>.

¹⁹ Wishner et al., *supra* note 1, at 3.

²⁰ John Henning Schumann, A Bygone Era: When Bipartisanship Led to Health Care Transformation, *NPR* (Oct. 2, 2016, 6:00 AM), <https://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation>; Hill-Burton Free and Reduced-Cost Health Care, *Health Resources & Servs. Admin.*, <https://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html> (last updated Apr. 2017).

²¹ Wishner et al., *supra* note 1, at 5.

²² Charlotte Kelly et al., Are Differences in Travel Time or Distance to Healthcare for Adults in Global North Countries Associated with an Impact on Health Outcomes? A Systematic Review, *6 BMJ Open* 1, 1, 6 (2016).

²³ See, e.g., Zhiwei Zhang et al., An Analysis of Mental Health and Substance Abuse Disparities & Access to Treatment Services in the Appalachian Region 3 (2008), https://www.arc.gov/assets/research_reports/AnalysisofMentalHealthandSubstanceAbuseDisparities.pdf; Mark L. Francis et al., Rural-Urban Differences in Surgical Procedures for Medicare Beneficiaries, *146 JAMA Surgery* 579, 579 (2011).

²⁴ Marshall et al., *supra* note 3, at 3.

²⁵ *Id.* at 285.

²⁶ *Id.* at 292.

²⁷ *Id.* at 297.

²⁸ *Id.* at 297, 303.

areas are also significantly more likely to need treatment for opioid or synthetic drug usage.³⁵ Mining employment is expected to decline over the next few years, and jobs are expected to increase in areas like personal service, professional services, and health and education,³⁶ a change which should lead to different work-related health issues for the region.

Studies have also measured healthcare beliefs and attitudes in Appalachia, though most focus on segments of the region. A 2004 survey of Appalachian Virginia indicated that the value placed on medical care may be an important factor.³⁷ Nineteen percent of respondents to the survey indicated that they sought healthcare only as a last resort, with respondents writing that they choose to "suffer[] it out" instead of seeking care.³⁸ Most respondents indicated not filling prescriptions, not receiving standard preventative care, not having their vision or hearing test, and not seeing a dentist.³⁹ Indeed, respondents averaged 24 months since the last visit to a dentist, and 5% of respondents indicated that they had never been to a dentist.⁴⁰ A study of churchgoers in parts of Appalachia found that the major barriers to screening for colorectal cancer included the belief that screening was only necessary with symptoms and also a general lack of knowledge about the need for screening.⁴¹

Attitudes regarding privacy also recur in studies of the health behavior in Appalachia. One case study found that privacy issues and cultural or family barriers were barriers to accessing treatment for substance abuse and mental health treatment.⁴² A study of West Virginia women found that fear and [*1006] embarrassment were among the top barriers to screening for breast and cervical cancer.⁴³ The region's concerns for privacy may be exacerbated by a lack of local, familiar health professionals and create additional barriers to seeking care.⁴⁴ Although privacy toward non-family members appears to be of increased importance in Appalachia, there are indications of an increased familiarity among family members. For example, one survey of Appalachian Virginia revealed a large number of families who shared medications,⁴⁵ an issue that likely contributed to the opioid epidemic in the region.

Appalachia is less racially diverse than the United States.⁴⁶ Appalachia is 83.2% white compared to 63.3% for the entire United States.⁴⁷ Appalachia is 9.2% black alone and not Hispanic (compared to 12.2% for the United

²⁹ Id. at 298, 304.

³⁰ Appalachian Region Industry Report - 2014, Appalachian Regional Commission, https://www.arc.gov/assets/research_reports/AppalachianRegionIndustryReport2014.pdf (last visited Mar. 22, 2018).

³¹ See id.; Dan Hodge, Appalachian Coal Industry, Power Generation and Supply Chain 13-14 (2016), https://www.arc.gov/assets/research_reports/CoalIndustryPowerGenerationandSupplyChainReport.pdf.

³² Hodge, supra note 31, at 30.

³³ Zhang et al., supra note 23, at 17.

³⁴ Id. at 170.

³⁵ Id. at 3-4.

³⁶ Appalachian Region Industry Report - 2014, supra note 30.

³⁷ Kathleen Huttlinger et al., Health Care in Appalachia: A Population-Based Approach, 21 Pub. Health Nursing 103, 104 (2004).

³⁸ Id. at 107.

³⁹ Id.

⁴⁰ Id. at 106.

⁴¹ Irene Tessaro et al., Knowledge, Barriers, and Predictors of Colorectal Cancer Screening in an Appalachian Church Population, Preventing Chronic Disease, Oct. 2006, at 1, 1.

⁴² Zhang et al., supra note 23, at 4.

States) and 4.3% Hispanic or Latino (compared to 16.6% for the United States).⁴⁸ The percentage of Appalachians who are veterans is 10.1%, compared to 9% for the United States.⁴⁹ VA data has shown that a disproportionate number of veterans live in rural areas.⁵⁰

Other information demonstrates demographic factors relevant to understanding the health issues of Appalachia. A 2008 report measured the prevalence of substance use in Appalachia and found higher usage of cigarettes, opioids, and synthetic drugs in Appalachia, but lower usage of marijuana, cocaine, and methamphetamine.⁵¹ County level data from the University of Wisconsin's Population Health Institute indicates that Appalachia has significantly higher rates of physical inactivity and obesity.⁵²

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IV. Need

Appalachia trails the United States in most health measures. Studies have shown higher rates in various mortality measures.⁵³ Percentage of deaths by heart disease, cancer, Chronic Obstructive Pulmonary Disease ("COPD"), injury, stroke, diabetes, suicide, and poisoning are all higher in Appalachia.⁵⁴ Among this group, the most significant increases in mortality for Appalachia compared to the mortality rates in the United States are those for COPD (27% higher), injury (33% higher), and poisoning (37% higher).⁵⁵ The mortality rate for poisoning includes drug overdoses, such as those related to opioid addiction.⁵⁶ A recent study found that 25-44 year-old individuals in Appalachia had mortality rates that were 70% higher than the remainder of the United States.⁵⁷ Years of Potential Life Lost ("YPLL") is 25% higher in Appalachia than the nation as a whole.⁵⁸ This rate is 40% higher in rural Appalachia than the region's large metropolitan counties.⁵⁹ Infant mortality is also 16% higher in Appalachia.⁶⁰

Measures of morbidity are also increased for Appalachia. Appalachia has a higher rate of physically unhealthy days, mentally unhealthy days, diabetes, and obesity than the nation, though some of these increases are slight.⁶¹

⁴³ Nikki L. Lyttle & Kelly Stadelman, *Assessing Awareness and Knowledge of Breast and Cervical Cancer Among Appalachian Women*, *Preventing Chronic Disease*, Oct. 2006, at 1, 1.

⁴⁴ See Chaundel Presley, *Cultural Awareness: Enhancing Clinical Experiences in Rural Appalachia*, 38 *Nurse Educator* 223, 223 (2013) (describing preferences in rural Appalachia to establish a personal relationship prior to developing a trust relationship).

⁴⁵ See Huttlinger et al., *supra* note 37, at 107.

⁴⁶ Kevin Pollard & Linda A. Jacobsen, *The Appalachian Region: A Data Overview from the 2009-2013 American Community Survey* 14 (2015), https://www.arc.gov/assets/research_reports/DataOverviewfrom2009-2013ACS.pdf.

⁴⁷ *Id.* at 13.

⁴⁸ *Id.*

⁴⁹ *Id.* at 65.

⁵⁰ Dep't of Veterans Affs., *Strategic Plan Refresh FY 2011-2015*, at 13 (2011), https://permanent.access.gpo.gov/gpo3819/VA_2011-2015_Strategic_Plan_Refresh_wv.pdf (stating that in 2006, 36% of veterans enrolled in VA healthcare lived in rural areas, such as those in Appalachia, but that 20% of the overall US population at the time lived in rural areas).

⁵¹ Zhang et al., *supra* note 23, at 2-3.

⁵² See, e.g., Univ. Wis. Population Health Inst., *2017 County Health Rankings: West Virginia* 5 (2017), http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_WV.pdf (finding the nation's median for adult obesity to be 31% and physical inactivity to be 26%, compared to West Virginia, where adult obesity was 35% and physical inactivity was 29%). For a state or county analysis, see *County Health Rankings and Roadmaps*, Univ. of Wis. Population Health Inst., <http://www.countyhealthrankings.org/> (last visited Mar. 22, 2018).

The HIV rate for Appalachia is lower.⁶² Although Appalachia is not entirely rural, a study of surgical procedures for Medicare recipients in rural areas found that despite indications of access barriers, a broad array of surgical procedures were more likely in rural areas urban ones.⁶³

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V. Government Efforts to Address Healthcare Disparities in Appalachia

The government's role in healthcare is increasing. In 1990, one third of the \$ 600 billion spent on healthcare in the United States came directly or indirectly from the federal government.⁶⁴ In 2015, the federal government was responsible for 40% of health spending in the United States (and about \$ 1.3 trillion total).⁶⁵ Government spending is provided in partnership with state governments through Medicaid and through programs at the VA, Department of Health and Human Services, Department of Defense, and Department of Homeland Security.⁶⁶ This Essay focuses on the programs with the VA and Medicare and ends with a comparison of approaches on two specific issues.

A. Programs at the Department of Veterans Affairs

The Veterans Health Administration ("VHA") has been evolving in a way that offers increased access points for veterans, a change that has special impact in Appalachia given the frequent remoteness of healthcare. From the early 1900s until the mid-90s, the VA was largely a hospital, bed-based system.⁶⁷ This manner of care impacted on the utilization of VA care. In 1995, a GAO review found that veterans living within 5 miles of a VA facility were most likely to use the VA and that volume of services also diminished with increased distance.⁶⁸ At the time, approximately 89% of veterans lived more than 5 miles from a VA hospital, and approximately 83% of veterans lived more than 5 miles from a VA clinic.⁶⁹ About 50% of veterans lived more than 25 miles from a VA hospital and about one-third of veterans lived more than 25 miles from a VA outpatient clinic.⁷⁰

⁵³ See Marshall et al., *supra* note 3, at 5-8.

⁵⁴ *Id.* at 5. Some of this disparity may be due to the demographics of the region. The leading causes of death for white non-Hispanics are heart disease, cancer, and chronic lower respiratory disease, and, as stated above, Appalachia is predominantly white. See Health of White Non-Hispanic Population, CDC, <https://www.cdc.gov/nchs/fastats/white-health.htm> (last updated May 3, 2017).

⁵⁵ Marshall et al., *supra* note 3, at 5, 8.

⁵⁶ *Id.* at 8.

⁵⁷ Michael Meit et al., The Walsh Ctr. for Rural Health Analysis, *Appalachian Diseases of Despair* 18 (2017), https://www.arc.gov/assets/research_reports/AppalachianDiseasesofDespairAugust2017.pdf.

⁵⁸ Marshall et al., *supra* note 3, at 73.

⁵⁹ *Id.*

⁶⁰ *Id.* at 151.

⁶¹ *Id.* at 5-7.

⁶² *Id.* at 7.

⁶³ Francis et al., *supra* note 23, at 579.

⁶⁴ J. William Hollingsworth & Philip K. Bondy, *The Role of Veterans Affairs Hospitals in the Health Care System*, 322 *New Eng. J. Med.* 1851, 1851 (1990).

⁶⁵ Dhruv Khullar & Dave A. Chokshi, *Toward an Integrated Federal Health System*, 315 *JAMA* 2521, 2521 (2016).

⁶⁶ *Id.*

VA provision of care is still organized around full-service hospitals (called VA Medical Centers or VAMCs), but use of these hospitals as the [*1009] primary instrument of care has diminished.⁷¹ From 1980 to 1996, the VA closed 42% of its hospital beds.⁷² Over that same period, the VA increased its outpatient visits by 60%.⁷³ As part of this transition, the VA opened more satellite facilities, which do not offer a full array of services and may only offer a few services but create additional points of access.⁷⁴ One of the VA's most common clinics is the Vet Center, which offers social and psychological services.⁷⁵ In 1930, VA healthcare was provided through 54 hospitals.⁷⁶ Currently, the VA has approximately 152 hospitals, 800 community-based outpatient clinics, 126 nursing home care units, and 35 domiciliaries.⁷⁷

Despite the VA's efforts to decentralize care and increase access points, a veteran still might be remote from VA care. The 950 hospitals and clinics noted above means there is only one CBOC or VA hospital for every 3,000 square miles in the continental United States. In contrast, there are approximately 2,849 non-profit, non-governmental hospitals in the United States⁷⁸ and over 7,500 urgent care centers.⁷⁹ A veteran living in Boone, North Carolina, for example, would have to travel almost 40 miles to the nearest VA medical facility.⁸⁰ Additionally, every medical service is not offered at every VA facility. For two days a week, the VA operates a Rural Outreach Clinic in Jonesville, Virginia, but specialty referrals from this clinic are forwarded to a VAMC more than an hour away.⁸¹ The shortage of physicians in Appalachia means that the remoteness of care in the VA may be less of an issue when comparing VA care to private care in Appalachia.

When expanding its access points, the VA has traditionally used criteria that included objectives such as improved rural access and reduced distance and [*1010] travel time.⁸² The VA also requires that any new clinic offer both primary care and mental health services.⁸³ Under VHA policy, primary care services are defined to include a variety of services related to basic care and preventative care.⁸⁴ VHA policy also defines the mental health services that must be offered.⁸⁵

⁶⁷ Kenneth W. Kizer, Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System, U.S. Dep't Veterans Affs. (Mar. 1996), <https://va.gov/healthpolicyplanning/rxweb.pdf>.

⁶⁸ U.S. Gov't Accountability Office, GAO/HEHS-96-31, How Distance from VA Facilities Affects Veterans' Use of VA Services 2 (1995), <https://www.gao.gov/assets/230/221992.pdf>.

⁶⁹ *Id.* at 3.

⁷⁰ *Id.*

⁷¹ See, e.g., U.S. Dep't of Veterans Affairs, VHA Directive 1229, Planning and Operating Outpatient Sites of Care 1 (2017) [hereinafter VHA Directive 1229], https://www.va.gov/vhapublications/viewPublication.asp?pub_ID=5439.

⁷² Kizer, *supra* note 67.

⁷³ *Id.*

⁷⁴ See VHA Directive 1229, *supra* note 71, at 2-4.

⁷⁵ See Vet Center Program, U.S. Dep't Veterans Affs., <https://www.vetcenter.va.gov/> (last updated Jan. 17, 2018).

⁷⁶ History - VA History, U.S. Dep't Veterans Affs., https://www.va.gov/about_va/vahistory.asp (last updated Mar. 8, 2018).

⁷⁷ *Id.*

⁷⁸ Fast Facts on US Hospitals 2018, Am. Hosp. Ass'n, <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml> (last visited Feb. 28, 2018).

⁷⁹ Industry FAQs, Urgent Care Ass'n Am., <http://www.ucaoa.org/general/custom.asp?page=IndustryFAQs> (last visited Mar. 22, 2018).

Other efforts by the VA to increase care have maintained a similar focus on primary care and mental health. VA mobile care units focus on preventative healthcare screening, mental health outreach, influenza/pneumonia vaccinations and routine primary care. ⁸⁶ To address the physician health shortage and the stigma that can be related to mental healthcare, the VA has also engaged chaplains as mental health providers. ⁸⁷

In addition to traditional factors such as the impact of convenience on demand for care, the VA's expansion has been guided by conceptions regarding the VA's expertise. VHA policy states that veterans are entitled to timely access to mental healthcare and creates an impetus for increasing the supply of mental health professionals. ⁸⁸ Cultural competency in serving veterans is also a key factor in VA care. Indeed, VA policy directly states that mental health must be provided with cultural competence and states that "all staff who are not veterans must have training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country." ⁸⁹ In line with focusing its facility expansion on those issues where the VA offers something unique, the VHA's recent revision to its directive on planning outpatient care states that expansion should not occur if community care, i.e., care paid for by the VA at an outside facility, is appropriate to meet the demand. ⁹⁰ Community care might not be appropriate in areas where the VA **[*1011]** offers special expertise such as the treatment of Post-Traumatic Stress Disorder. ⁹¹

Community Care is a term used by the VA to describe payment for care at non-VA facilities. VA community care began in 1945 in response to high demand among veterans returning from World War II ⁹² and is currently enabled through Contracts for Non-VA Care ⁹³ and through the Veterans Access, Choice and Accountability Act of 2014. ⁹⁴ The provisions of [38 U.S.C. § 1703](#) give the VA broad discretion to contract with non-VA facilities when the VA is "not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or [is] not capable of furnishing the care or services required." ⁹⁵

From 2012 to 2015, claims processed for community care increased approximately 81%. ⁹⁶ In 2014, the VA paid for approximately \$ 5.6 billion in care from community providers. ⁹⁷ For 2019, the VA anticipates spending \$ 14.2

⁸⁰ Find Locations, U.S. Dep't Veterans Affs., <https://va.gov/directory/guide/home.asp> (search address field for "Boone, NC" and select facility field for "Medical Facilities (ALL)").

⁸¹ See Mountain Home VA Healthcare System, Dep't Veterans Affs., <https://www.mountainhome.va.gov/locations/Jonesville.asp> (last updated Nov. 22, 2016).

⁸² U.S. Dep't of Veterans Affairs, VHA Handbook 1006.1 (2004) (Rescinded); VHA Directive 1229, *supra* note 71; see also Hans Petersen, Reaching Out to Three Million Rural Veterans, U.S. Dep't Veterans Affs. (Aug. 19, 2013), <https://www.va.gov/health/NewsFeatures/2013/August/Reaching-Out-to-Three-Million-Rural-Veterans.asp>.

⁸³ VHA Directive 1229, *supra* note 71, at 2.

⁸⁴ See *id.* at 3-4.

⁸⁵ *Id.* at 13.

⁸⁶ See Megan Tyson, Mobile Vet Centers: Reaching Out in Rural Areas, U.S. Dep't Veterans Affs., <https://www.va.gov/health/newsfeatures/20091116a.asp> (last updated Nov. 16, 2009).

⁸⁷ [38 C.F.R. § 17.655 \(2018\)](#); Patient Care Services: Community Clergy Training Program, U.S. Dep't Veterans Affs., <https://www.patientcare.va.gov/chaplain/clergytraining/index.asp> (updated Nov. 20, 2017).

⁸⁸ See U.S. Gov't Accountability Office, GAO 16-24, VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed 9-10 (2015) [hereinafter VA Mental Health].

⁸⁹ U.S. Dep't of Veterans Affairs, VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics 6 (2015).

⁹⁰ VHA Directive 1229, *supra* note 71, at 1.

billion on community care.⁹⁸ Consistent with this increased emphasis, the VA is currently undergoing a process to consolidate its external care programs into a single section: the Office of Community Care, which currently pays for care when a veteran is faced with a medical emergency or needs a service unavailable at the VA.⁹⁹

The VA's program for paying for community care for veterans faced with a medical emergency does not require prior approval. Nevertheless, it does require that the health issue causing the emergency meet requirements as to its relation to military service or alternatively, that the veteran enrolled for VA care within 24 months prior to the emergency.¹⁰⁰ The VA also requires that the [*1012] medical emergency be one in which a prudent layperson would reasonably expect that delay would be hazardous to life or health and that other federal care is not available.¹⁰¹

Care can then be provided through an individual authorization, through the VA's Patient-Centered Community Care or PC3 program, or through the Choice Act.¹⁰² Both individual authorizations and referrals through the PC3 program require prior approval and provide access to care from non-VA providers for services that are not readily available at a local VAMC.¹⁰³ Eligibility for care can be determined by geographic accessibility, general capability of the VA, or timeliness,¹⁰⁴ but these measures are vaguely defined by the law. The VA contracted with HealthNet Federal Services LLC (HealthNet) and TriWest Healthcare Alliance Corp. (TriWest) to administer PC3 and establish networks of contractors.¹⁰⁵ Generally, providers under both programs are paid in accordance with a contracted amount or an amount linked to Medicare's fee schedule or prospective payment amount.¹⁰⁶

In 2014, after a wait-time scandal at the Phoenix VA hospital, Congress authorized the Veterans Choice Program ("Choice Program") under the Veterans Access, Choice, and Accountability Act of 2014 ("Choice Act"),¹⁰⁷ as amended by the Department of Veterans Affairs Expiring Authorities Act of 2014.¹⁰⁸ The Choice Program is intended to temporarily supplement PC3 by allowing coverage for more services for eligible Veterans and providing

⁹¹ See, e.g., Miriam Reisman, PTSD Treatment for Veterans: What's Working, What's New, and What's Next, 41 *Pharmacy & Therapeutics* 623, 627, 632 (2016).

⁹² Dep't of Veterans Affairs, VA History in Brief 15, https://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf (last visited Feb. 28, 2018).

⁹³ [38 U.S.C. § 1703](#) (2012).

⁹⁴ Veterans Access, Choice and Accountability Act of 2014, Pub. L. No. 113-146, **128 Stat. 1754**.

⁹⁵ [38 U.S.C. § 1703\(a\)](#).

⁹⁶ U.S. Gov't Accountability Office, GAO 16-353, Veterans Health Care: Proper Plan Needed to Modernize System for Paying Community Providers 2 (2016) [hereinafter *Veterans Health*].

⁹⁷ *Id.* at 49.

⁹⁸ VA 2019 Budget Request: Fast Facts, U.S. Dep't of Veterans Affs., <https://www.va.gov/budget/docs/summary/fy2019VAsBudgetFastFacts.pdf> (last visited Mar. 22, 2018).

⁹⁹ See VHA Office of Community Care, U.S. Dep't of Veterans Affairs, <https://www.va.gov/communitycare/> (last updated Feb. 12, 2018).

¹⁰⁰ [38 U.S.C. § 1728](#) (2012); [38 U.S.C. § 1725](#) (2012).

¹⁰¹ [38 U.S.C. § 1728](#).

¹⁰² *Veterans Health*, *supra* note 96, at 11-12.

Veterans more flexibility in their choice of care. ¹⁰⁹ The VA uses the same contractors it used for PC3 to handle the Choice Program. ¹¹⁰

[*1013] Unlike PC3, the Choice Program has explicit criteria for determining the distance or wait time that triggers eligibility for external care. A Veteran is eligible to seek non-VA care under the Choice Program if the Veteran must drive more than 40 miles to the nearest VA medical facility with a full time primary care physician or if the Veteran must wait more than 30 days for an appointment at the nearest VA medical facility. ¹¹¹ Veterans eligible for the Choice Program because they reside more than 40 miles from a VA facility do not need a referral from a VAMC but do need a referral from the appropriate Contractor. ¹¹² A Veteran may also be eligible for the Choice Program if traveling to the closest VA medical facility, regardless of distance, would create an excessive burden due to geographic challenges, environmental factors, or a medical condition. ¹¹³

Initially the distance for eligibility was calculated based on the straight-line distance between the Veteran's home and the VA medical facility. ¹¹⁴ In April 2015, the VA announced that it would determine eligibility for the Veterans Choice Program based on the distance between a Veteran's place of residence and the nearest VA medical facility using driving distance rather than straight-line distance. ¹¹⁵ This change roughly doubled the number of Veterans eligible for the Choice Program ¹¹⁶ and likely had a significant impact on eligibility in rural Appalachia.

As noted above, community care at the VA is increasing. Much of this increase has been channeled into the Choice Program. The VHA has issued policy memoranda instructing VA medical centers to offer care through the Choice Program before authorizing care through any of the other VA community care programs. ¹¹⁷ For this reason, it would be a mistake to discuss the VA's community care programs without discussing problems related to the administration of these programs, which affect both veterans and healthcare providers.

As noted above, VA authorization for external care is tailored to an individual's circumstances using detailed rules that are administered through a prior approval process. This prior approval process involves multiple layers of

¹⁰³ Id.

¹⁰⁴ See [38 C.F.R. § 17.52 \(2018\)](#).

¹⁰⁵ Veterans Health, *supra* note 96, at 11.

¹⁰⁶ [38 C.F.R. § 17.56 \(2018\)](#); Veterans Health, *supra* note 96, at 11-12. The Medicare payments to Health Professional Shortage Areas that are described in Section B below are applied separately from the amounts utilized by the VA Office of Community Care. See [38 C.F.R. § 17.56](#). Thus, these bonuses to rural providers are not incorporated in Choice.

¹⁰⁷ Veterans Access, Choice and Accountability Act of 2014, Pub. L. No. 113-146, **128 Stat. 1754**.

¹⁰⁸ Department of Veterans Affairs Expiring Authorities Act of 2014, Pub. L. No. 113-175, [128 Stat. 1901](#); see also Ashton Habighurst, Note, Enhancing Accountability at the Department of Veterans Affairs: The Legality of the Veterans Access, Choice, and Accountability Act of 2014 Under the Due Process Clause, [64 Cath. U. L. Rev. 1045, 1045-46 \(2015\)](#).

¹⁰⁹ See Fact Sheet: Veterans Access, Choice, and Accountability Act of 2014, U.S. Dep't Veterans Affs., <https://www.va.gov/opa/choiceact/documents/Choice-Program-Fact-Sheet-Final.pdf> (last visited Mar. 29, 2018).

¹¹⁰ Veterans Health, *supra* note 96, at 13.

¹¹¹ Id.

¹¹² Id.

¹¹³ Id.

¹¹⁴ See VA Expands Choice Program Eligibility, Effective Immediately, VAntage Point: Official Blog U.S. Dep't Veterans Affs. (Apr. 24, 2015, 8:36 AM), <https://www.blogs.va.gov/VAntage/19424/va-expands-choice-program-eligibility-effective-immediately/>.

¹¹⁵ Id.

independent judgment and multiple steps where a claim may freeze while **[*1014]** awaiting documentation for funds. ¹¹⁸ Additionally, because the VA's authorization is narrowly tailored, there is a risk that a veteran who unknowingly exceeds the parameters of the authorization will have a claim denied. ¹¹⁹ The VA does allow a physician to issue a secondary authorization for such bills, ¹²⁰ but the risks of harm to a veteran through community care placement still exist. ¹²¹

Despite a contractual requirement that appointments be scheduled within 30 days, the GAO determined that a veteran could wait up to 81 days for care under the Choice Program if the VAMC and Contractors take the maximum amount of time allowed by the VA for the scheduling process. ¹²² A GAO review of 108 individual Choice Program referrals found overall wait times significantly exceeded the contractual limits. ¹²³ Those who are unable to find a placement through the Choice Program risk being sent back to the VA. ¹²⁴

In November 2015, the VA responded to these issues by allowing Contractor staff to be co-located at VAMCs in an effort to improve communication and reduce the number of referrals that were rejected due to inadequate information. ¹²⁵ The VA is also looking to technology in the form of automated Choice Program referrals and web-based communications for VAMCs and Contractors to speed up the preparation of referrals and address problems with referrals ¹²⁶ and plans to reduce delays in accepting and scheduling appointments by requiring Contractors to return referrals if appointments are not scheduled within required timeframes. ¹²⁷

A GAO study also found that VHA claims processing was significantly less timely than those through TriCare (which insures military retirees and their families) and Medicare. These issues relate to an underdeveloped claim filing system and failure to incentivize timely processing. Some providers have **[*1015]** stopped taking Choice based on the processing difficulty. Some providers have hired staff just to deal with Choice.

On January 3, 2018, the VA responded to increasing public pressure related to delayed payments by announcing long-and short-term actions to improve payments. ¹²⁸ The VA's short-term measures included the creation of rapid

¹¹⁶ Id.

¹¹⁷ Sidath Viranga Panangala, Cong. Research Serv., The Veterans Choice Program (VCP): Program Implementation 2 (2018), <https://fas.org/sqp/crs/misc/R44562.pdf>.

¹¹⁸ See Veterans Health, *supra* note 96, at 47.

¹¹⁹ Id.

¹²⁰ Id.

¹²¹ See, e.g., U.S. Dep't of Veterans Affairs, VHA Directive 2009-033, Resolving Adverse Credit History Reports for Veterans Receiving Late Payments for Purchase Non-VA Care (2009).

¹²² U.S. Gov't Accountability Office, GAO-17-397T, Veterans' Health Care: Preliminary Observations on Veterans' Access to Choice Program Care (2017).

¹²³ Id.

¹²⁴ In addition, due to a lack of data, it may not be possible to determine the average overall wait times veterans have experienced under the Choice Program. Id. Specifically, the VA does not capture the time that it takes for a VAMC to prepare a referral and send it to a contractor nor does it capture the time spent by the contractor in accepting a referral and contacting the veteran to opt in. Id.

¹²⁵ Id. at 25.

¹²⁶ Id.

¹²⁷ Id.

¹²⁸ VA to Take Immediate Actions on Timely Payments to Community Providers, U.S. Dep't Veterans Affs. (Jan. 3, 2018, 3:58 PM), <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=3993>.

response teams to work with the providers with the largest amount of unpaid claims, goals for the claims processed by vendors, and the establishment of multiple entry points for providers to check claim status.¹²⁹ The VA's long-term measures included IT improvements, incentive measures to promote payment of claims, publication of claims processing information, and legislative work to consolidate and simplify community care programs.¹³⁰

Although Community Care clearly targets providing access to isolated regions such as rural Appalachia, the VA's problems with community care strike at vulnerabilities in those same regions. Procedural burdens and a failure to make timely appointments is discouraging to those who already view healthcare as a last resort.¹³¹ The risk of having to pay for care you thought was covered or being billed for care that the VA should pay is significant for anyone. Additionally, VA delays in processing payments diminish provider choice and provide financial strain in areas where the margin for error is already slim.

B. The Department of Health and Human Services: Medicare

Medicare was signed into law on July 30, 1965, and covers individuals who have been disabled for more than 29 months and have enough work credits for the program, individuals 65 or older who select coverage under the program, and certain individuals with end-stage renal disease.¹³² Approximately 80% of the individuals on Medicare receive the program based on age.¹³³ Unlike coverage from the VA, Medicare does not provide direct medical care but is, instead, a governmental insurance program. Thus, Medicare's primary impact on Appalachia is its approach to funding.

[*1016] As noted above, rural hospitals are more reliant on government funding and can be dramatically affected by funding changes. In 1983, Congress initiated measures to decrease Medicare spending on hospital care.¹³⁴ These changes led to continued rural hospital closures and subsequent attempts to redress the financial strain by increasing Medicare payments to rural areas.

The basis for many of Medicare's subsidies is an area's designation as a Health Professional Shortage Area ("HPSA"), which indicate shortages in healthcare providers for primary care, dental health, or mental health.¹³⁵ These shortages can be determined with respect to the entire population for geographic area or specific population groups, such as migrant farmworkers or low-income groups.¹³⁶ Additionally, certain kinds of facilities are statutorily defined to be serving a Health Professional Shortage Area; this group includes certified Rural Health Centers ("RHCs").¹³⁷

¹²⁹ Id.

¹³⁰ Id.

¹³¹ This issue is not isolated to VA Community Care, of course. See, e.g., VA Mental Health, *supra* note 88 (describing issues with timely appointments at internal VA facilities).

¹³² History, Ctrs. for Medicare & Medicare Servs., <https://www.cms.gov/About-CMS/Agency-information/History/> (last updated Sept. 14, 2017).

¹³³ 2014 CMS Statistics, U.S. Dep't Health & Hum. Servs., https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf (last visited Mar. 22, 2018).

¹³⁴ Wishner et al., *supra* note 1.

¹³⁵ Donna O. Farley et al., Medicare Rural Payment Issues: Primary Care Services and Geographic Definitions 5 (2002), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/Farley3_2002_3.pdf.

¹³⁶ Id.

¹³⁷ Id.

Unless an area is automatically qualified as a HPSA, it must go through a designation process that evaluates whether it is a rational area for the delivery of services, meets criteria as to the ratio of population to provider, and cannot be served by health professionals in contiguous areas.¹³⁸ HPSAs can be as small as a census tract, but can also be county-sized and cannot overlap.¹³⁹

Physicians serving HPSAs are eligible for a ten percent increase on Medicare's standard payment for a service.¹⁴⁰ These payments are administered based on the location where the services are provided.¹⁴¹ Facilities in HPSAs can also seek approval for programs that provide recruitment and retention funding, such as loan repayment assistance.¹⁴²

The effectiveness of these bonuses at improving access has been criticized.¹⁴³ Physician bonuses represent a low percentage of Medicare payments.¹⁴⁴ Additionally, a GAO review of the physician payments found that **[*1017]** many of the issues the payments were created to address have been addressed by other action.¹⁴⁵ The GAO report concluded that physician unavailability is less of a barrier to accessing healthcare than issues such as the patient share of cost.¹⁴⁶ The GAO also concluded that the amounts of the payments were unlikely to play a significant role in recruiting professionals to rural areas and noted regulatory and administrative shortcomings in the program, such as the failure to link incentives to treatment of individuals with access problems or include other performance measures.¹⁴⁷

In order to address the healthcare professional shortage, Medicare also pays higher rates to certain health centers that focus on outpatient care.¹⁴⁸ Rural Health Centers can be for-profit, non-profit, or governmental, but must be in a non-urbanized area using census definitions.¹⁴⁹ Federally Qualified Health Centers can come in a variety of forms and are not defined as restrictively as Rural Health Centers.¹⁵⁰ Federally Qualified Health Centers are intended to be safety net providers for outpatient services.¹⁵¹ In total, Federal Health Centers serve one in three

¹³⁸ [42 C.F.R. §§5.1-5.4 \(2018\)](#).

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² National Health Service Corps Site Reference Guide, Nat'l Health Serv. Corps 1 (2017), <https://www.nhsc.hrsa.gov/downloads/sitereference.pdf>.

¹⁴³ See U.S. Gov't Accountability Office, GAO/HEHS-99-36, Physician Shortage Areas: Medicare Incentive Payments Not an Effective Approach to Improve Access (1999) [hereinafter Physician Shortage].

¹⁴⁴ Lisa R. Shugarman & Donna O. Farley, Shortcomings in Medicare Bonus Payments for Physicians in Underserved Areas, 22 Health Aff. 173, 173 (2003).

¹⁴⁵ See Physician Shortage, *supra* note 143.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ Rural Health Clinics, Rural Health Info. Hub, <https://www.ruralhealthinfo.org/topics/rural-health-clinics> (last visited Feb. 8, 2018).

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*; see also [42 U.S.C. § 254b](#) (2012).

¹⁵¹ *Id.*

people living in poverty nationwide, one in six people living in rural communities, and more than 330,000 veterans.¹⁵²

Some hospitals also qualify for larger payments from Medicare and likewise focus on areas where there is a healthcare shortage.¹⁵³ Designations that qualify under these criteria include sole community hospitals, Medicare-dependent hospitals, and rural referral centers.¹⁵⁴ In addition to these generally available payments, Medicare also provides grants to support critical access hospitals.¹⁵⁵ These grants target quality and financial and operational improvement¹⁵⁶ and in this way attempt to address the slim margins rural hospitals work under and issues that have led to the perception that rural hospitals may be worse.

As a financial assistance to stabilize rural healthcare, these programs may be important. As noted above, profit margins in rural areas are slim. The **[*1018]** closure rate of rural hospitals has recently declined, though the number of financially struggling hospitals has increased.¹⁵⁷

C. Program Comparisons

Medicare and the programs at the Department of Veterans Affairs largely work in isolation from each other. Nevertheless, a comparison of their approaches to similar health issues illustrates each program's impact on Appalachia and how government programs impact health in the region. This Section will compare Medicare and the Department of Veterans Affairs with respect to telehealth and opioid management.

1. Telehealth

Telehealth¹⁵⁸ is the "use of electronic information and telecommunications technologies to support remote clinical healthcare, patient and professional health-related education, public health, and other healthcare delivery functions."¹⁵⁹ Telehealth is increasingly being utilized to overcome time and geographic barriers to healthcare access.¹⁶⁰ Studies indicate that telehealth is effective for treating certain chronic conditions such as mental health, diabetes and heart disease and can lead to improved health outcomes and reductions in healthcare costs.¹⁶¹ The VA and Medicare have taken different approaches to telehealth. While the VA quickly embraced the program, Medicare has been slower to encourage its usage.

¹⁵² Health Center Program, Health Res. & Servs. Admin. <https://www.bphc.hrsa.gov/about/healthcenterfactsheet.pdf> (last visited Feb. 8, 2018).

¹⁵³ Farley et al., *supra* note 135.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ Mason, *supra* note 16.

¹⁵⁸ Telehealth and telemedicine are sometimes used interchangeably, but they can have different definitions. See Bernice Reyes-Akinbileje, Telehealth and Telemedicine: Description and Issues, Cong. Research Serv. (Mar. 29, 2016), [https://congressional.proquest.com/profiles/gis/result/pqpresultpage.gispdfhitspanel.pdflink/\\$2fapp-bin\\$2fgis-congresearch\\$2f7\\$2fb\\$2f9\\$2f1\\$2fcrs-2016-dsp-0127_from_1_to_32.pdf/entitlementkeys=1234%7Capp-gis%7Ccongresearch%7Ccrs-2016-dsp-0127](https://congressional.proquest.com/profiles/gis/result/pqpresultpage.gispdfhitspanel.pdflink/$2fapp-bin$2fgis-congresearch$2f7$2fb$2f9$2f1$2fcrs-2016-dsp-0127_from_1_to_32.pdf/entitlementkeys=1234%7Capp-gis%7Ccongresearch%7Ccrs-2016-dsp-0127).

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

The VA first instituted guidance on the usage of telehealth on March 9, 2004.¹⁶² After first focusing on guidance regarding the clinical aspects of telehealth, the VA issued guidance to standardize procedures regarding telehealth equipment in 2008.¹⁶³ The VA views telehealth as significant for its **[*1019]** clients because it allows increased access to rural and remote populations.¹⁶⁴ Indeed, nearly half of the users of telehealth at the VA in 2016 lived in rural areas.¹⁶⁵ The VA has made specific focus on the use of telehealth to treat PTSD,¹⁶⁶ an area where the VA offers specialized expertise that is not likely to be matched in the private sector.¹⁶⁷ Despite the maturity of its telehealth program, the VA continues to remove barriers to telehealth and to seek increases in utilization.¹⁶⁸

Medicare has traditionally placed significant limitations on telehealth. Although most states require that commercial insurers reimburse telehealth visits, Medicare limits reimbursement in a variety of ways, including geographic limitations linked to rurality and HPSAs, the type of practitioner, and the service offered.¹⁶⁹ Unlike the VA, Medicare generally does not allow for "store and forward" telehealth,¹⁷⁰ a method in which communication is not made to a provider in real time, but rather is made by captured data.¹⁷¹

Utilization of telehealth in Medicare is increasing,¹⁷² but still significantly trails utilization through the VA. In 2013, less than 1% of rural Medicare beneficiaries were treated through telehealth.¹⁷³ Over that same period, 12% of VA beneficiaries received telehealth.¹⁷⁴ In fiscal year 2015, the VA conducted more than 2.1 million telehealth visits, compared to 192,692 for contract year 2015 in Medicare.¹⁷⁵

[*1020] This contrast has direct impact on healthcare in rural communities but also affects each program's development of infrastructure and technology in ways less direct and more difficult to measure but no less important.¹⁷⁶ For example, one common issue with telehealth in rural areas is inadequate broadband infrastructure to support the technology.¹⁷⁷ Additional funding through Medicare provides additional incentive to develop this infrastructure.

¹⁶² U.S. Dep't of Veterans Affairs, VHA Handbook 1173.17, Home Telehealth Equipment Management Procedures 1 (2008).

¹⁶³ Id.

¹⁶⁴ Reyes-Akinbileje, supra note 158, at 6.

¹⁶⁵ David Shulkin, VA Removes Burdensome Red Tape to Increase Access to Care, InsideSources (Aug. 24, 2017), <http://www.insidesources.com/va-removes-burdensome-red-tape-increase-access-care/>.

¹⁶⁶ Reyes-Akinbileje, supra note 158, at 6.

¹⁶⁷ See Grant R. Martsolf, Behavioral Health Workforce and Private Sector Solutions to Addressing Veterans' Access to Care Issues, 73 JAMA Psychiatry 1213-14 (2016).

¹⁶⁸ Shulkin, supra note 165.

¹⁶⁹ Reyes-Akinbileje, supra note 158, at 12.

¹⁷⁰ Ctrs. for Medicare & Medicaid Servs., Telehealth Services 4 (Feb. 2018), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsh.pdf> (explaining that store and forward is only permitted in Hawaii and Alaska).

¹⁷¹ Compare id. (explaining that store and forward is only permitted in Hawaii and Alaska), with Store-and-Forward Telehealth, U.S. Dep't Veterans Affs., <https://www.telehealth.va.gov/sft/> (last visited Mar. 22, 2018) (explaining store and forward telehealth is becoming commonplace in areas of healthcare within the VA).

¹⁷² Ateev Mehrotra et al., Utilization of Telemedicine Among Rural Medicare Beneficiaries, 315 JAMA 2015-16 (2016).

¹⁷³ Id. at 2015.

¹⁷⁴ Id.

¹⁷⁵ Reyes-Akinbileje, supra note 158, at 1.

2. Opioid Management

Opioid addiction and abuse is a significant issue in Appalachia. The VA has been criticized for both its role in contributing to opioid addiction and its response to over-prescription of opioids.¹⁷⁸ Medicare is more integrated with the larger public healthcare system and has a less distinguishable programmatic effect. Nevertheless, its role is also instructive.

The VA purchases drugs directly and dispenses them to veterans at VA facilities.¹⁷⁹ Veterans are provided drugs for service-connected conditions at no cost.¹⁸⁰ Some veterans also do not have to pay for prescriptions to treat conditions that are not related to service.¹⁸¹ Others pay \$ 10 or less per prescription each month, up to an annual copay of less than \$ 1000.¹⁸² Thus, at most, an individual veteran will pay a low, standardized cost regardless of the cost of a medication.¹⁸³ Even at cost, the potential for illegal resale in opioids is significant,¹⁸⁴ but many times the VA will be providing a drug to a veteran at a significant loss.¹⁸⁵

[*1021] Medicare primarily assists with medication through a drug benefit known as Part D.¹⁸⁶ Participation in Part D is optional for Medicare enrollees and requires the payment of a premium and the selection of a plan.¹⁸⁷ Part D plans are administered by non-governmental insurance companies (referred to as "plan sponsors"). Subject to certain requirements, these plan sponsors negotiate their own prices for prescriptions, which means that a drug's cost can vary significantly according to the plan selected by the individual.

Medicare Part D was instituted in 2006 and has been the largest payer for opioids.¹⁸⁸ Consumer out-of-pocket spending on opioids declined from \$ 4.40 per morphine milligram equivalent in 2001 to \$ 0.90 in 2012,¹⁸⁹ though some of that decrease reflects a shift toward less expensive drugs.¹⁹⁰ Medicare pays approximately 20% to 30% of the cost of opioids.¹⁹¹ Drugs designed to resist tampering and manipulation can be more expensive than generic alternatives,¹⁹² and have seen their coverage through Medicare Part D plans decline more than these

¹⁷⁶ There have been proposals to reduce some of Medicare's limitations. See, e.g., Evidence-Based Telehealth Expansion Act of 2017, H.R. 3482, 115th Cong. (2017).

¹⁷⁷ See, e.g., Mica Soellner & Trevor Hook, Telehealth Gives Rural Missouri More Access to Health Care, U.S. News (Jan. 12, 2018, 1:02 AM), <https://www.usnews.com/news/best-states/missouri/articles/2018-01-12/telehealth-gives-rural-missouri-more-access-to-health-care>.

¹⁷⁸ See, e.g., Art Levine, How the VA Fueled the National Opioid Crisis and Is Killing Thousands of Veterans, Newsweek (Oct. 20, 2017, 3:30 AM), <http://www.newsweek.com/2017/10/20/va-fueled-opioid-crisis-killing-veterans-681552.html>.

¹⁷⁹ U.S. Gov't Accountability Office, GAO-13-358, Comparison of DOD and VA Direct Purchase Prices 1-2 (2013).

¹⁸⁰ Determine Cost of Care, U.S. Dep't Veterans Affs., <https://www.va.gov/HEALTHBENEFITS/cost/index.asp> (last visited Mar. 22, 2018).

¹⁸¹ Health Benefits Copay, U.S. Dep't Veterans Affs., <https://www.va.gov/HEALTHBENEFITS/cost/copays.asp> (last visited Mar. 29, 2018).

¹⁸² Id.

¹⁸³ Id.

¹⁸⁴ See Dep't of Health and Human Servs., OEI-02-17-00250, Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing (2017) [hereinafter Opioids in Medicare].

¹⁸⁵ See Pharmaceutical Prices, U.S. Dep't Veterans Affs., <https://www.va.gov/oal/business/fss/pharmPrices.asp> (last visited Feb. 8, 2018).

generic alternatives in response to growing public awareness of abuse.¹⁹³ Thus, the effect of the government's share of price on the epidemic is complex.

The role of the VA in the spread of opioids is also complex. Veterans have high incidences of chronic pain and often suffer from mental health issues such as PTSD that can lead to substance abuse.¹⁹⁴ The balance between treatment and addiction has proven difficult.

[*1022] The VA prides itself on a patient-centered approach to medical care¹⁹⁵ but also often acts as a national program implementing national strategies. In 1998, the VA established pain management as a national priority.¹⁹⁶ The goals for the program included "the provision of a system-wide VHA standard of care for pain management to reduce suffering from preventable pain ... assurance that clinicians practicing in the VA healthcare system are adequately prepared to assess and manage pain effectively," and a variety of other measures that emphasized the role of pain management in patient care.¹⁹⁷ This was in part a reaction to the under-treatment of pain as a medical condition.¹⁹⁸ A Newsweek article indicates that the manufacturer of OxyContin also played a role in convincing the VA (and other providers) to emphasize the treatment of pain with opioids.¹⁹⁹

VHA policy described the risk of painkiller addiction but emphasized pain as the "[fifth] vital sign" to be attended as part of holistic care.²⁰⁰ By 2012, one in four veterans receiving outpatient care in the VA were receiving an opioid.²⁰¹ At this time, veterans were also substantially more likely to die from an accidental opioid overdose than non-veterans.²⁰² As national awareness of opioid addiction increased, VHA policy changed. In 2013, VHA launched the opioid safety initiative,²⁰³ which attained reduction in opioid usage that has been criticized as too aggressive given the symptoms that can accompany withdrawal.²⁰⁴

VHA policy continues to evolve. VHA now offers a tool designed to assist its doctors in tapering opioid use and advises a general dosage reduction **[*1023]** of 5 to 20% every 4 weeks.²⁰⁵ The VA has begun integrating with

¹⁸⁶ Medicare's general coverage program (Part B) pays for drugs provided as part of hospital care or at a physician's office. What Part B Covers, Medicare.gov, <https://www.medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html> (last visited Mar. 29, 2018).

¹⁸⁷ In 2015, approximately 72% of eligible Medicare recipients also selected Part D. Jack Hoadley et al., The Henry J. Kaiser Family Found., Medicare Part D at 10 Years: The 2015 Marketplace and Key Trends, 2006-2015, 1 (2015), <http://files.kff.org/attachment/report-medicare-part-d-at-ten-years-the-2015-marketplace-and-key-trends-2006-2015>.

¹⁸⁸ Chao Zhou et al., Payments for Opioids Shifted Substantially to Public and Private Insurers While Consumer Spending Declined 1999-2012, 35 Health Aff. 824, 824 (2016).

¹⁸⁹ Id.

¹⁹⁰ Denise-Marie Ordway, Prescription Opioid Drugs: What They Cost and Who Pays, Journalist's Resource, <https://journalistsresource.org/studies/society/public-health/opioid-overdose-drug-prescription-cost-research> (last visited Mar. 29, 2018).

¹⁹¹ Zhou et al., *supra* note 188, at 827.

¹⁹² Caroline F. Pearson, Medicare Drug Plans Favor Generic Opioids that Lack Abuse Deterrent Properties, Avalere Health (June 9, 2015), <http://avalere.com/expertise/managed-care/insights/medicare-drug-plans-favor-generic-opioids-that-lack-abuse-deterrent-propert>.

¹⁹³ Michelle Andrews, Medicare Drug Plans Favor Generic Opioids over Those Designed to Avoid Abuse, Study Finds, Kaiser Health News (June 12, 2015), <https://khn.org/news/medicare-drug-plans-favor-generic-opioids-over-those-designed-to-avoid-abuse-study-finds/>.

¹⁹⁴ Walid F. Gellad et al., Addressing the Opioid Epidemic in the United States: Lessons from the Department of Veterans Affairs, 177 JAMA Internal Med. 611-12 (2017).

state opiate databases to prevent doctor shopping²⁰⁶ and now requires its doctors to check state registries before prescribing opioids.²⁰⁷

As noted above, Medicare functions as insurance and not through the direct provision of services. In 2011, the GAO examined Medicare expenditures for signs of doctor shopping and found that about 2% of those obtaining drugs that fall within 14 categories of frequently abused drugs obtained those drugs from five or more practitioners in 2008.²⁰⁸ Although abusers were identifiable, CMS did not believe they were authorized by federal law to restrict access.²⁰⁹

A recent report of the DHHS OIG notes continuing issues. In 2016, one in three Part D beneficiaries received a prescription opioid.²¹⁰ This report also found evidence of doctor shopping, receipt of extreme amounts of opioids, and problematic prescribers. As with the VA, policy changes to address the issue are being implemented. In July 2016, federal legislation enabled Part D sponsors to establish programs limiting the access of beneficiaries who are at risk for prescription drug abuse.²¹¹

DHHS's changes in policy enable action by Part D sponsors but do not require action. Part D sponsors are not required to identify beneficiaries at risk for prescription drug abuse or with records that indicate doctor shopping. Likewise, DHHS encourages prescribers to check state monitoring databases but does not make this a requirement for reimbursement.²¹²

VI. Conclusion

Health disparities between Appalachia and the remainder of the country are increasing. The region faces challenges related to its rurality, economy, and the characteristics of its population. Rural hospitals are closing and those that remain face substantial financial strain. In 1946, the Hill-Burton Act established **[*1024]** the foundation for our present healthcare system.²¹³ With proper consideration, there is an opportunity to do the same again. The

¹⁹⁵ See, e.g., Baligh Yehia et al., The Role of VA Community Care in Addressing Health and Health Care Disparities, 55 Med. Care S4-S5 (2017).

¹⁹⁶ Mark Helfand & Michele Freeman, Dep't Veterans Affairs, Assessment and Management of Acute Pain in Adult Medical Patients: A Systematic Review 2 (2008), https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0009028/pdf/PubMedHealth_PMH0009028.pdf/.

¹⁹⁷ Id.

¹⁹⁸ Id.

¹⁹⁹ Levine, supra note 178; see also Allen Frances, Pharma Corruption Started the Opioid Epidemic, HuffPost (Oct. 4, 2017, 11:57 AM), https://www.huffingtonpost.com/entry/pharma-corruption-started-the-opioid-epidemic_us_59d4f8c7e4b0da85e7f5ed58.

²⁰⁰ See, e.g., U.S. Dep't of Veterans Affairs, VHA Directive 2009-053, Pain Management (2009).

²⁰¹ Gellad et al., supra note 194, at 611.

²⁰² Levine, supra note 178.

²⁰³ Gellad et al., supra note 194, at 611.

²⁰⁴ Levine, supra note 178.

²⁰⁵ U.S. Dep't of Veterans Affairs, Opioid Taper Decision Tool 6 (2016), https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf.

continuing evolution of government programs that address these challenges must have a foundation in the realities of the region and an understanding of the impact of government intervention.

Government work has often focused on increasing points of access for the region. The VA has dramatically transformed from utilizing large hospitals as a central point of access to a more accommodating system that includes clinics and increasingly emphasizes funding non-VA care, while still acknowledging areas of unique VA expertise. Medicare has increased payments to rural providers and established clinics and centers to ameliorate healthcare shortages. The effectiveness of some of these incentives may merit a closer look, as might the impact of locality in certain kinds of healthcare treatment.

Technology such as telehealth is changing the provision of healthcare in rural areas by offering convenient service from a distance. Increasing implementation will require care. Studies on elements of distance decay and understanding the ways in which technology can make care remote are necessary. Programs that account for privacy concerns and the need for familiarity with a provider may be particularly important in Appalachia.

For systems that work on broad level, care is necessary to avoid unintended consequences. The impact of pain on a patient is an important factor in patient-centered care. Nevertheless, access to pain treatment becomes a hazard when it is tempered by an understanding of the particular patient and the risks of addiction. Medicare's incentives in areas such as prescription payments may require additional oversight regarding the impact of these payments.

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²⁰⁶ See U.S. Dep't of Veterans Affairs, VHA Directive 1005, Informed Consent For Long-Term Opioid Therapy for Pain (2014); see also U.S. Dep't of Veterans Affairs, VHA Directive 1306, Querying State Prescription Drug Monitoring Programs (PDMP) (2016) [hereinafter VHA Directive 1306].

²⁰⁷ See VHA Directive 1306, *supra* note 206.

²⁰⁸ U.S. Gov't Accountability Office, GAO-11-699, Instances of Questionable Access to Prescription Drugs (2011).

²⁰⁹ *Id.*

²¹⁰ Opioids in Medicare, *supra* note 184.

²¹¹ Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198 § 704, **130 Stat. 696**. This program contains elements suggested by the GAO in 2011.

²¹² Opioids in Medicare, *supra* note 184.

²¹³ See John Henning Schumann, A Bygone Era: When Bipartisanship Led to Health Care Transformation, NPR (Oct. 2, 2016), <https://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation>.