

Via Electronic Submission (www.regulations.gov)

July 30, 2018

Robert Wilkie, Secretary
Department of Veteran Affairs
810 Vermont Ave NW
Washington, DC 20420

Re: VA Request for Information Regarding Health Care Access Standards

Dear Secretary Wilkie:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Department of Veterans Affairs' (VA's) Request for Information Regarding Health Care Access Standards. The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 151 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals, and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Partnerships with Academic Medicine

The AAMC strongly supports the VA in their efforts to reorganize the community care programs and commends the consolidation of the previous seven programs into one program through the MISSION Act, as we feel this will increase access for veterans and decrease administrative burden on VA and community-based physicians. Through the changes legislated in the MISSION Act and coming regulations, we encourage the VA to continue to partner with academic medical centers and their physicians, and actively recruit them to join VA community care networks.

Academic medical centers have long-standing relationships with the VA and extensive experience treating veterans. They function as health systems and integrated delivery systems, with robust networks and a strong presence in the community. Academic medical centers (AMCs) also have expertise in providing highly specialized care such as treatment for severe burns or neuro-ophthalmology services and treat some of the most complex and vulnerable patients. Academic medical centers are hubs of integration, resulting in expanded services and more coordinated care across the spectrum. The VA's traditional preferred partnership relationships with academic medicine can offer even more comprehensive and coordinated services to veterans who choose to be seen in those settings, and additionally include the benefits of cutting-edge medical education and research. As such, we encourage the VA to continue to recognize the importance and high value of academic medicine affiliates in any potential network tiers and maintain flexibility at the local level to allow VA medical centers to consider education and research missions in referrals.

Administrative Burden and Patient Access

To ensure that regulations that are developed in the future provide adequate access to care for veterans, the AAMC encourages the VA to continue to consult outside stakeholders. The Association strongly recommends that the VA reduce the complexity of the program's administrative burden on providers to ensure participation in community-based VA programs. We recommend aligning the VA's administrative practices with industry best practices and considering the typical workflow of providers

when developing policies. For example, the VA should consult with providers (specifically the large academic medical centers and faculty practice plans) on systems they currently use for scheduling patients, for submitting claims, and for documenting and submitting prescriptions. In a similar vein, we encourage the VA to develop an electronic health record and portal system that is interoperable with those of community-based providers. This will increase the quality of care received by veterans who go outside the VA system to receive care and reduce the burden on providers who treat them.

Some academic medical centers have chosen not to contract with the VA Choice program or have terminated contracts with the VA due to extreme challenges, such as insufficient communication about processes and policies, lack of or major delays in reimbursement, credentialing issues, and confusion about the relationships and differing responsibilities between community-based providers, the VA, and third-party administrators. We encourage the VA to develop schematics, graphs, or other resources as they revise the VA community care program so that providers can understand the process and participate as fully as possible.

Access Standards and Network Adequacy

The AAMC recommends the VA review a variety of methods to evaluate and establish network adequacy and access standards in their community care program. Private health insurers often establish their own standards for network adequacy, determining a patient to provider ratio and provider panel. For example, one primary care provider per 2,000 patients may be considered an adequate network in certain areas. Three insurers in a defined geographic area may have the same access standard of one primary care provider per 2,000 patients, but because the providers are in the networks of multiple insurers, there is the potential that a single provider could be responsible for 6,000 patients. This would be considered an inadequate network and insufficient patient access, as well as a huge burden on the provider. We recommend that the VA work with insurers and third-party administrators when developing network adequacy and access standards to avoid this problem, and to look at standards beyond just patient and provider density.

In determining network adequacy, the VA should also consider veteran health status. Veterans tend to have complex medical challenges and therefore the ratio of providers per patient may need to be different than ratios for other populations. Access to specialists that are not available within the VA system, or to specialties within the VA that do not have the capacity to treat more patients, also are important considerations. Models looking at network adequacy should address the location regions, the population, and veteran health status.

Additionally, we recommend that the VA assess the providers that are available to veterans within the VA system in determining network adequacy. For example, there may be an inadequate number of physicians from certain specialties in the VA system and therefore a need to ensure inclusion of a sufficient number in the community care networks.

Provider Credentialing

Under the current VA community care program, academic medical centers report significant challenges with third-party administrators credentialing their physicians and other health care professionals. To avoid credentialing problems, many AMCs prefer to have a payer delegate provider credentialing to the AMC, establishing an agreement where the AMC would agree that their providers meet the payer's requirements, and agree to be audited if necessary. Many AMCs and academic faculty practice plans consist of a large number of physicians and health care professionals (average is around 1000 clinicians), and often prefer to complete and maintain their provider credentialing in-house, as it is administratively less burdensome. We encourage the VA to maintain this option for academic medical centers and associated faculty practice plans to ensure that veterans do not experience delays in accessing providers.

The VA should ensure that the provider directories provided to veterans are clear and that they are updated on a timely basis to reflect the providers that they can access as part of the VA community care network.

Concerns with Secondary Referrals and Prior Authorizations

The AAMC has heard concerns from academic medical centers about the VA's policies on referrals and prior authorizations in the community care programs. While we understand and support the VA's interest in providing medical management to veterans, there are some hurdles in the referral and prior authorization process once the veteran is referred to a community-based provider. For example, if a veteran needs to see a cardiologist, but the wait time for an appointment at a VA cardiologist is determined to be too long, he or she may be referred to a cardiologist outside of the VA system. Once at the cardiology appointment, the cardiologist may determine that the veteran needs an additional test. Currently, the cardiologist would have to contact the VA to request approval or submit the recommendation for the veteran to receive an additional test. This could take multiple days, if not longer, and requires administrative work on the part of the referring cardiologist as well as the approving physician at the VA. It also is inconvenient to the veteran who may have been able to have the test at the same time as the original appointment except for the fact that a new authorization is needed. The AAMC encourages the VA to develop a method that would allow the physician to efficiently seek approval for the veteran to receive care that is deemed necessary. We encourage the VA to maintain the role as case manager for veterans, and to work to develop a system to efficiently address referrals and prior authorizations.

One way to address this may be in the documentation for the initial referral or prior authorization from the VA. If the documentation were broad enough to cover services for the episode of care, not just a single appointment, the treating physician would have more freedom to send the veteran for additional services. Additionally, if the treating physician determines that the need is medically time sensitive, the VA should consider developing a system to expedite the approval process or defer to the referring physician's decision so that patient care is not negatively affected by administrative requirements.

Another method would be for the VA to work with providers to establish standards of care or care protocols for certain conditions. These protocols would outline the best practices of care, and by both the provider and the VA agreeing on it, the VA would then agree to reimburse for any care associated with that condition as long as it met the standards or care or followed the care protocol. However, it would also be necessary for exceptions to be made quickly and efficiently when it is determined that the patient would benefit from a different type of treatment.

Timeliness of Payments

In the past, providers have experienced significant delays in receiving reimbursement from the VA. For example, some AMCs received no payment for 6 months for services provided. To encourage participation in the VA community care program, it is important for the VA to ensure that providers claims are processed and paid on a timely basis, particularly "clean claims." We recommend that the VA review the Medicare standards for processing claims and consider implementing similar standards.

Telehealth

We applaud the VA on the recently finalized telehealth rule that allows for telehealth services when the physician is in a different state than the patient, and we hope that they will be equally innovative in other areas of telehealth. We encourage the VA to continue to seek out ways to incorporate telehealth as a method to improve access for veterans. Telehealth innovations assist in care coordination between providers and patients and enhance access to care for populations that experiences barriers to services. As

the VA works to improve the community care programs, the goal of which is to expand appropriate access to patients, we encourage the VA to use telehealth as an access expansion tool.

Interoperability and Use of Technology

The VA should establish a portal for community-based providers and VA providers, as well as administrative staff, to communicate all administrative and case management details. Providers should be able to submit and receive referrals or prior authorizations, transmit medical records, submit claims, fill out forms, and other related activities through the portal. We advise the VA to have their forms, such as the 10-7078, available on this portal electronically, instead of having to scan and email or fax the forms to the provider. This portal should be efficient and simple for providers to use. Additionally, we recommend that whichever portal or system is chosen, that the community-based providers (specifically the large academic medical centers and faculty practice plans) be able to designate multiple staff to access the portal. One of the limitations of current portals is that some of them only allow one staff from each provider to access the portal, which is extremely inefficient.

Further, AAMC recommends that both VA and non-VA providers' electronic health records systems incorporate a military history prompt. The AAMC believes that this unique patient data is critically important. On April 18, 2014, the AAMC submitted comments¹ to the Office of the National Coordinator (ONC) regarding the 2015 Edition EHR Standards and Certification Criteria Proposal Rule (RIN0991-AB92). 79 *Fed.Reg.* 10880 (Feb. 26, 2014). In those comments, the AAMC strongly endorsed the ability for CEHRT to include questions about whether an individual served in the military. The AAMC continues to support the inclusion of these questions, because the response they garner will help providers to better serve veterans and their families. The collection of this information would help facilitate teaching of health conditions that are prevalent among military service members and veterans. Including this information in CEHRT that VA and community-based providers use would create the possibility of more coordinated care across VA and community health care systems.

Quality

We encourage the VA to develop quality measurement programs using measures that are meaningful to the unique population that the VA serves. We advise the VA to perform an assessment to identify the types of measures that are meaningful to veterans. We also encourage the VA to review CMS' Meaningful Measures initiative, and incorporate those principles of a clear, meaningful, and transparent quality measurement program to any VA quality programs. Any measures developed, including existing measures, should be risk adjusted for complexity and sociodemographic status. We encourage the VA to consider aligning any quality programs with existing programs, in order to reduce provider burden, and to consult with both hospitals and physicians before implementing the program in order to ensure that it will not be overly burdensome. Lastly, we advise the VA to ensure that any attribution within the program is appropriate.

Maintaining VA Facilities as a Choice for Veterans

While the community care program is an important part of increasing access and providing care to veterans, the AAMC wants to emphasize that if a veteran chooses to remain within the traditional VA system, instead of being referred to a community provider, that choice should be respected, as long as the VA has treatments options available. Many patients who have complex medical needs, like spinal cord or brain injury patients, see a wide variety of health care providers for their ongoing health care, and may prefer to stay with those providers within the traditional VA system, even if they may be able to access a community-based provider in a more timely manner, or a community-based provider is located closer to

¹ AAMC Comment Letter to ONC Re: 2015 Edition EHR Standards and Certification Criteria Proposed Rule (RIN 0991-AB92), April 18, 2014, <https://www.aamc.org/download/377636/data/aamc-jf-onccommentletter041814.pdf>

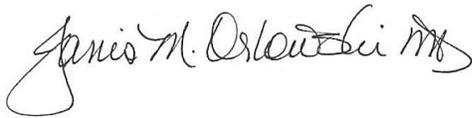
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them. Additionally, elderly patients may prefer to stay within the traditional VA system because it is familiar to them, and we believe that to the maximum extent possible, this should be respected and accounted for as well.

Conclusion

We appreciate the opportunity to comment and look forward to continuing to work with the VA on these important issues. If you have any questions, please contact Kate Ogden at 202-540-5413, or kogden@aamc.org.

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orlowski MD". The signature is written in a cursive, flowing style.

Janis Orlowski, MD, MACP
Chief Health Care Officer, AAMC

cc: Ivy Baer, JD, MPH, AAMC
Gayle Lee, JD, AAMC
Kate Ogden, MPH, AAMC