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Via electronic submission (www.regulations.gov)

March 25, 2019

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

Re: Proposed Rule RIN 2900-AQ46 Veterans Community Care Program

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) Proposed Rule RIN 2900-AQ46, 84 *Fed.Reg.* 5629 (February 22, 2019) regarding the Veterans Community Care Program. 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 154 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.

The AAMC 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 of 2018, as we feel this will increase access for veterans and decrease administrative burden on VA, academic, and community-based physicians. Through the changes legislated in the MISSION Act and future regulations, we encourage the VA to continue to partner with academic medical centers (AMCs) and their physicians and encourage them to participate in community care networks by taking steps to reduce burden, improve claims processing, improve administrative processes, and establish effective communications between VA and community providers.

Many AMCs have long-standing relationships with the VA with extensive experience treating veterans, having combined educational programs and innovative research to help our veterans. AMCs have evolved from the traditional model of a medical school partnered with its teaching hospital. Today, AMCs function as integrated health care delivery systems, with robust clinical care networks, community hospitals, and strong networks of community-based providers. They also have expertise in providing highly specialized care such as treatment for severe burns, innovative neurological recovery services or neuro-ophthalmology services and treat some of the most complex and vulnerable patients. AMCs are hubs of health care innovation, education, and

integration, resulting in expanded services and more coordinated care across the continuum. They have partnered with the VA not only for clinical care but also for research and education missions. Medical schools and teaching hospitals have partnered with the Department of Veterans Affairs (VA) for over 70 years, dating back to the end of World War II. The VA has become a vital part of U.S. physician training, with more than 40,000 residents and more than 20,000 medical students receiving some or all of their clinical training at a VA facility per year.

We encourage the VA to continue to monitor implementation of the changes legislated by the MISSION Act, in order to ensure that resident training and education opportunities, along with the high-quality health care that AMCs provide to veterans continue, and are not impeded by changes to veteran care options.

The AAMC supports implementation of the MISSION Act to increase veterans' ability to access necessary care, and we appreciate the opportunity to review and comment on these proposed regulations.

Eligibility Criteria and Access Standards

The AAMC appreciates that the VA has published their eligibility criteria, including access standards, for veterans to receive care in the community, outside of the traditional VA system. We urge the VA to continue evaluating these eligibility criteria and access standards as the community care program develops, to ensure that access is adequate for veterans, and encourage the VA to be nimble in any changes they determine need to be made in the future.

We are pleased that the VA has made modifications to the access standards, particularly in moving to an average drive time instead of a dual time and distance standard that was often confusing to patients and difficult to apply in different geographic settings. However, these access standards remain arbitrary. There may be urgent or time sensitive clinical scenarios where a veteran is not able to access a VA provider or a community-based provider in a clinically appropriate amount of time, even though the designated access standards are met. The AAMC urges the VA to create an exceptions process to expedite access in these situations to ensure that the access standards do not become a barrier to veteran access to necessary care.

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 size. 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.

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. The faculty physician groups of many AMCs 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 to both the AMC and the VA. 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 veterans can access as part of the VA community care network.

Eligible Entities and Providers

The proposed rule includes language that would prohibit an entity or provider that is part of the VA, or providers who are employed by VA from furnishing care or services while acting within the scope of their VA employment, from being an eligible entity or provider in the community care program. Academic medical centers have many physicians who may be employed by both the VA and the AMC and may potentially see veterans in the AMC or faculty practice through a community care contract. The AAMC recommends that the VA recognize the importance of the close relationship between AMCs and the VA at the institutional level and individual provider level. The AAMC strongly recommends that the VA ensure that under the new community care program these physicians and providers can continue to furnish care in the VA and in their AMC, potentially under a community care contract, in order to continue to provide appropriate and high-quality care to veterans.

Telehealth

The AAMC applauds the VA for integrating telehealth into the eligibility criteria and access standards. Specifically, the VA states that if it is able to provide the veteran with care via

telehealth, and the veteran accepts the use of this modality, the VA would determine that it was able to provide care in a manner that complies with designated access standards and the veteran would not be referred for community care. However, we encourage the VA to ensure that if a veteran does not agree to this modality the option to seek face-to-face care will be available.

We know that the VA has long been a leader in telehealth implementation, and we strongly support the use of this modality, especially as a method to increase access to physicians. We encourage the VA to expand telehealth options within the community care program, so that a veteran could potentially be referred to a community-based physician and seen via telehealth. 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 continue use of telehealth as an access expansion tool.

In addition to telehealth provisions, we also recommend that VA consider implementing interprofessional internet consultations. In the 2019 Physician Fee Schedule Final Rule, CMS finalized payment amounts for two new interprofessional internet consultation codes (99452 and 99451) to capture the time physicians spend implementing an internet consultation. The AAMC and its members have significant experiences with these interprofessional internet consults through Project CORE: Coordinating Optimal Referral Experiences, which was launched through a CMMI Round Two Health Care Innovation Award in September 2014. Utilizing EHR-based communication tools (called eConsults and enhanced referrals), the CORE model aims to improve quality and efficiency in the ambulatory setting by reducing low-value referrals, improving timely access to specialty input, and enhancing the patient experience through more effective communication and coordination between providers. The CORE model provides an asynchronous exchange in the EHR, initiated by the primary care physician to a specialty, for a low-acuity, condition-specific question that can be answered without an in-person visit. This clinician-to-clinician exchange provides an opportunity to potentially avoid a visit to a specialist, if the primary care physician can be provided with the appropriate information to manage the patient's condition. Were this model implemented in the VA, there is also an opportunity to reduce the need for a veteran to seek care outside of the VA, if their physician were able to simply consult and continue managing their condition. The AAMC encourages the VA to consider implementing interprofessional internet consults to enhance access for veterans.

Episodes of Care, Secondary Referrals, Prior Authorizations

The AAMC is very supportive of the proposed definition for episode of care, which would read: "a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than one calendar year." The VA proposes to remove the qualifier at the end of the definition, "…from the date of first appointment with a non-VA health care provider." The AAMC encourages the VA to retain the qualifier, to maintain clarity and ensure that this definition is easily understandable. While the AAMC recognizes that this is not an effort to increase or broaden the standard that currently exists for duration of the episode of care, we believe that the clarification that an episode of care would include follow-up appointments and ancillary and specialty services is necessary.

AMCs have reported significant challenges with the referral and prior authorization process when a veteran is referred to a community-based provider. For example, if a veteran needed to see a cardiologist, but the wait time for an appointment at a VA cardiologist was determined to be too long, he or she could be referred to a cardiologist outside of the VA system. During the cardiology appointment, the cardiologist could determine that the veteran needs an additional test. AMC's have reported that in their experience, the cardiologist would then have to contact the VA to request approval or submit the recommendation to the VA before the veteran is able to receive an additional test. It could take multiple days to obtain approval from the VA, 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 is unable to have the test at the same time as the original appointment as a new authorization is required. We encourage the VA to develop appropriate procedures that allow the veteran to receive the necessary care within the episode without requiring the physician to seek additional prior approval or authorization for services within the episode of care. The AAMC is optimistic that renewed attention to this challenge will result in meaningful changes for veterans and providers.

The AAMC was pleased to see the proposed rule reference the role of the VA as case manager for veterans who seek care outside of the traditional VA system, keeping the responsibility for care coordination within the VA. The AAMC strongly recommends that the VA maintain the responsibility for care coordination in the new community care program to support care continuity for the veteran. We urge the VA to develop processes for community providers to share patient encounter information efficiently with the VA. The community-based provider and the VA should have seamless electronic health record connectivity so that information exchange between the community provider and VA is timely, efficient, and accurate. Having the ability to accurately communicate between the community provider and the VA will ensure that the veteran's electronic health record remains up to date and will avoid any duplication of services.

Quality

In the proposed rule, VA stated that the standards and measures for quality would not be published in the rule, as these standards and metrics are "dynamic and will evolve based on new discoveries and innovations as well as wider adoption of standardized quality measures across the US health care industry." However, the VA also noted that a report on quality standards would be submitted to Congress no later than March 4, 2019. The AAMC is disappointed that this report was not released at the same time of this proposed rule as it would have helped to inform some proposals. Quality is an extremely important issue for both veterans as patients and their providers, especially in the community. We urge the VA to release this report and ensure that the quality standards and metrics are made available for public review and comment.

The AAMC encourages the VA to use quality measures in the community care program that are meaningful to the unique population that the VA serves. Any measures used in the program should be risk adjusted for complexity and sociodemographic status. Quality measures should be thoroughly vetted through a consensus-based entity that includes multiple stakeholders, such as the National Quality Forum (NQF), prior to use in the program. We encourage the VA to align

quality measures used in the VA community care program with quality measures used by other payers, such as Medicare, to the extent possible. Additionally, we advise the VA to ensure that there is an accurate determination of the relationship between a patient and clinician so that the correct clinician is held responsible for the patient's outcomes. We recognize that this is complicated given that most patients receive care from numerous clinicians across several facilities. The attribution method used should be clear and transparent to clinicians.

Maintaining Choice

While the community care program is an important part of increasing access and providing care to veterans, 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 the ability to treat the patient. The AAMC was pleased to see that the rule proposed maintaining options for veterans to seek care through the traditional VA system, even if one or more of the eligibility criteria for community care has been met, provided that this choice would not have a negative impact on their care. Many patients who have complex medical needs, such as 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 them. Additionally, elderly patients may prefer to stay within the traditional VA system because it is familiar to them.

Emergency Care

The AAMC was very pleased to see that the VA proposed to not require prior authorization for emergency services received outside of the traditional VA system, if going to a VA emergency department would not be feasible. Requiring prior authorization before seeking emergency care would greatly inhibit access to these important services.

While the AAMC strongly supports not having a prior authorization requirement for emergency care, we have some concerns with the restrictions placed on emergency care when sought outside of the traditional VA system or outside of a VA Medical Center. In the rule, VA states that treatment would be limited to services covered by the veteran's benefit package. In many cases, particularly in an emergent situation, a patient will not have control over what services, tests, or procedures they receive. The proposed rule also states that the veteran must receive emergency services from an eligible entity or provider. The AAMC is similarly concerned that, particularly in an emergent situation, a patient may not have the ability to make those kinds of decisions, or access information about which hospitals or providers are considered "eligible." We urge the VA to reconsider these proposals and adequately cover emergency care services that were deemed medically necessary by the provider in the facility. The VA should also consider reviewing how the private sector or Medicare program addresses similar issues, and ensure their process aligns.

Prescription Drugs

The AAMC strongly supports the VA continuing to cover prescription drugs, over the counter drugs, and medical and surgical supplies when prescribed by non-VA providers furnishing care through the community care program, as has been done in VA Choice. However, we have some

concerns with the limitation that the coverage only applies for a course of treatment lasting no longer than 14 days. The proposed rule would require veterans to have medications in excess of 14 days ordered through the VA's Consolidated Mail Order Pharmacy. While the AAMC understands that directing veterans to the VA's Consolidated Mail Order Pharmacy is an effort to control costs and quality, we have concerns that this could be overly burdensome on both the veteran and the community provider and may jeopardize the veteran's ability to obtain medically necessary medication on time. There could be situations where non-VA, community providers prescribe a course of medication for a specific episode of care for which they are treating the patient. The AAMC is concerned that the non-VA, community provider may have difficulty accessing the VA system or portal to communicate this information to the VA for any refills of medication beyond the allowed 14 days. These physicians should be able to easily access the VA Consolidated Mail Order Pharmacy as an option in their community electronic medical system. We also recommend that there be an exceptions process for this proposed policy, so that if a community-based provider prescribes a longer course of medication for the veteran's condition, the veteran can access the full course of the medically necessary prescription, and this prescription will be covered.

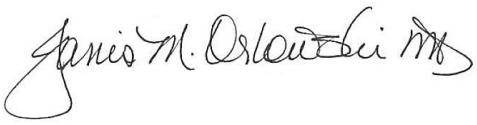
Establishing Portals to Access Information

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 sending them to the provider by email or fax. This portal should be efficient and simple for providers to use. This portal should allow the uploading of medical records, tests results etc and the community physician should not have to fill out additional material. Additionally, we recommend that whichever portal or system is chosen, it should allow the community-based providers (specifically the large academic medical centers and faculty practice plans) to designate multiple staff to access the portal. One of the limitations of current portals is that some only allow one staff from each provider to access the portal, which is extremely inefficient.

As the VA continues the process of releasing regulations related to the MISSION Act of 2018, the AAMC looks forward to thoroughly reviewing proposed rules and being given the opportunity to comment on these important changes and enhancements to the community care program. Continuing dialogue with stakeholders is exceedingly important in the redesign of this important program, and we look forward to ongoing conversations.

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

Sincerely,



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