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BEFORE THE
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Good morning, Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for the opportunity to further discuss the plan to provide Veterans access to a community care network as described in the Department of Veterans Affairs (VA) October 30, 2015, report on the consolidation of community care programs. The community care network will provide Veterans with access to high-quality providers and the ability to make an informed choice regarding their health care. I am accompanied today by Dr. Gene Migliaccio, Deputy Chief Business Officer for Purchased Care.

VA is committed to providing Veterans access to timely, high-quality health care. In today's complex and changing health care environment, where VA is experiencing a steep increase in the demand for care, it is essential for VA to partner with providers in communities across the country to meet Veterans' needs. To be effective, these partnerships must be principle-based, streamlined, and easy to navigate for Veterans, community providers, and VA employees. Historically, VA has used numerous programs, each with their own unique set of requirements, to create these critical partnerships with community providers. This resulted in a complex and confusing landscape for Veterans, community providers, and VA employees.

Acknowledging these issues, VA is taking action as part of an enterprise-wide transformation called MyVA. MyVA will modernize VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. Included in this transformation is a plan for the consolidation of community care programs and business processes, consistent with Title IV of the *Surface Transportation*

and Veterans Health Care Choice Improvement Act of 2015, the VA Budget and Choice Improvement Act, and recommendations set forth in the *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs* (Independent Assessment Report) that was required by Section 201 of the *Veterans Access, Choice, and Accountability Act of 2014* (Choice Act).

On October 30, 2015, VA provided Congress with a plan to consolidate all VA's purchased care programs. The plan included some aspects of the current Veterans Choice Program established by Section 101 of the Choice Act and incorporated additional elements designed to improve the delivery of community care.

VA currently has a variety of agreements with providers in the community, but limited national visibility into supply and demand needs. There are no standardized approaches for provider credentialing, quality monitoring, or identification of best-in-class providers. High-performing networks in health care apply standardized credentialing and quality criteria. They can identify and recruit high-quality providers for the network. As described in the plan, the VA Core Network includes high-quality health care assets in the Department of Defense (DoD), Indian Health Service (IHS), Tribal Health Programs (THP), Federally Qualified Health Centers (FQHC), and academic teaching affiliates. The community care network includes commercial providers in Preferred and Standard tiers based on quality and value performance. Standardized credentialing will decrease administrative barriers for providers, while more rigorous and consistent quality monitoring will promote high-quality care for Veterans.

Background

To identify provider eligibility requirements and design a high-performing network for VA, we have examined best practices for provider networks, credentialing, and quality standards. Provider network design and implementation are constantly shifting to accommodate changes to the U.S. health care landscape, including coverage requirements and provider incentive models. A provider network consists of licensed health care professionals (e.g., doctors, nurse practitioners, physician assistants, and

nurses) and medical facilities (e.g., hospitals, outpatient surgery centers, and diagnostic imaging centers) that agree to provide services at pre-negotiated rates. A robust provider network has an adequate number of health care professionals in terms of quality, mix/type of specialty, and geographic distribution, as well as facilities, to meet demand needs.

High-performing tiered networks promote high-quality care, improve health outcomes, and reduce system costs. They include providers who meet the minimum standards and preferred providers who meet additional quality and value standards. These networks help patients identify providers who can deliver culturally competent care and publish provider information for patients (e.g., quality designations and patient feedback).

To effectively develop and maintain high-performing tiered networks, industry-leading organizations use network development, contracting and reimbursement, provider relations, credentialing, and clinical quality monitoring functions. The network development function implements provider payment strategies and determines the optimal size, composition, and geographic distribution of the network. Contracting and reimbursement capabilities include negotiating provider agreements, obtaining exception approvals to standard provisions as needed, and maintaining reimbursement data. The provider relations function manages ongoing communication and education initiatives with the provider community, while also addressing inquiries and grievances. To improve the stakeholder experience and simplify processes, leading organizations invest in customer service personnel and web-based tools for patients and providers (e.g., navigation tools to help patients become familiar with care processes).

Credentialing is the process of reviewing the general qualifications and practice history of providers using guidance from organizations such as the National Committee for Quality Assurance (NCQA) or The Joint Commission. Commercial provider networks review education, training, employment, and disciplinary history. Leading

organizations use credentialing systems that automate tasks and incorporate analytics-driven decision-making. The processing time for credentialing a new provider in a commercial network is typically 30 business days. Commercial networks re-credential providers to monitor ongoing adherence to standards based on regular intervals (usually 24 – 36 months). Providers that do not meet specific standards (e.g., because of recurring malpractice claims or sanctions against a professional license) can be removed from the network.

In the U.S., health care is not delivered consistently. There are notable differences in health care spending, resource utilization, and quality of care depending on factors such as the licensed health care professional, medical facility, geographic region, and patient population. Increased utilization and spending do not always lead to better outcomes. To promote consistent high-quality care that is safe, timely, effective, efficient, and patient centered, industry-leading organizations are working to measure provider performance and recognize high performers. Metrics employ evidence-based performance criteria based on rigorous and transparent methodologies. Sources for quality measures can include NCQA, the National Quality Forum, Agency for Healthcare Research and Quality, and The Joint Commission. Effective coordination of care and health information management also directly affects quality of care.

Current State

Current VA community provider relationships are formed through multiple overlapping programs with federally funded health care entities and commercial providers. VA contracts or has agreements with approximately 40 DoD facilities (with access to TRICARE Managed Care Contractors on a case-by-case basis), 100 IHS facilities, 80 THPs, 700 academic teaching affiliates, 700 FQHCs, 76,000 locally contracted providers, and 200,000 additional providers through current national contracts, such as PC3 and Choice. Despite the large numbers of providers, VA does not have ongoing visibility into many provider locations, nor an understanding of supply and demand imbalances. Therefore, VA does not have coverage in certain areas to

provide accessible care to Veterans, nor a single mechanism to actively manage provider relationships.

VA has multiple processes for credentialing community providers and different credentialing criteria, depending on the authority that is the basis for furnishing community care. VA does not have a standardized approach to measure delivery of quality care furnished through contracts and agreements with community providers. Some sharing agreements are administered locally, and quality reporting requirements vary depending on the agreement. As a result, VA currently has limited visibility into best-in-class providers. Once providers have agreed to provide care to Veterans, VA does not have a national mechanism to track quality of care issues. With variable quality monitoring processes, providers are held to different standards and VA faces a larger burden in monitoring quality compliance.

Future State

To align with VA's mission to better serve Veterans, VA plans to provide access to a high-performing network drawing from best practices across industry and federally funded organizations. Key elements of the high-performing network include:

- Appling industry-leading health plan practices for tiered network design;
- Enhancing unique relationships with federally funded and academic teaching affiliates;
- Promoting Veteran choice, access to care, and high-quality care delivery;
- Using streamlined and consistent credentialing and quality monitoring processes;
- Incorporating network management functions, including network development, contracting and reimbursement, credentialing, clinical quality monitoring, and provider relations;
- Consistently monitoring supply and demand changes to make appropriate network adjustments, achieving access standards, and coverage for primary and specialty care;
- Effectively coordinating care in a Veteran-centered way; and

- Using clinical and administrative metrics to continually measure and improve performance.

As proposed in the October 30, 2015, report on the consolidation of community care programs, the VA Core Network will include providers in the DoD, IHS, THPs, FQHCs, and academic teaching affiliates. VA's relationships with these providers are unique and have evolved over time. Sustaining and expanding Core Network relationships aligns with VA's mission, vision, and strategies. VA will work to develop simple and consistent agreements with Core providers that are principle-based and focus quality and outcomes.

External providers – those outside the Core Network – can belong to Standard or Preferred tiers, which will expand over time. VA plans to make the process for joining the external network simple. Providers in the Preferred and Standard tiers must meet uniform credentialing requirements to participate in the high-performing network. Based on industry feedback received from the Department's February 9, 2016 "VA Community Care Network" draft performance work statement, VA is working to develop requirements that match industry standard. Providers in the preferred tier must meet minimum credentialing requirements while also demonstrating high-value care.

The high-performing network will require network development, contracting and reimbursement, credentialing, clinical quality monitoring, and provider relations functions. VA will employ an audit function to oversee credentialing and adherence to quality standards. Veterans will have the ability to choose community providers and make informed decisions based on publicly available information. Veterans currently accessing community care can remain with their community providers, if the provider meets minimum requirements, or choose other providers in the network. Veterans also can recommend their providers for inclusion in the network. VA will consider publishing provider designations, credentials, and Veteran feedback. To promote awareness about military culture and unique issues Veterans face, VA will encourage providers to complete relevant trainings and make available educational resources.

VA faces significant access challenges in delivering care to Veterans due to geographic limitations and the unique needs of the Veteran population. VA plans to include the highest quality providers, but also recognizes the need to establish a broad and flexible network providing convenient care near to where Veterans live. In the high-performing network, credentialing processes will be simple, consistent, and in alignment with best practices. The re-credentialing process will evaluate ongoing provider qualifications to confirm health outcomes and adherence to standards. These can include value, complaint history, Veteran experience, and a baseline assessment of care appropriateness every 24 – 36 months. VA will audit and enforce credentialing practices in the high-performing network. High-level provider credentialing standards include:

- Educational credentials, certifications, licensure, training, and experience;
- Employment and pre-employment history;
- Supplemental attestation questions, disciplinary screening, and sanctions; and
- Agreements with providers to meet access and quality of care standards.

VA will work directly with providers currently caring for Veterans to include them in the network for continuity of care. Providers who meet credentialing criteria will complete a simple enrollment process and can join the VA network. Over time, poor performing providers will be removed from the network.

In the VA Core Network, VA will delegate credentialing or perform credentialing functions when applicable. Federally funded credentialing institutions include DoD, IHS, FQHCs, and THPs. In the external network, either VA or a “network manager” will assume ownership of credentialing and will apply industry-leading practices. VA will work toward establishing simple, consistent, and high-quality agreements with Core and external providers in the high-performing network. In order to promote quality of care, VA will monitor and enforce rigorous quality reporting and performance standards in line with industry, conduct data analytics on disease management, and share VA critical pathway information. VA plans to shift toward adopting value-based care models in the high-performing network.

Creating a community care network will maximize the use of high-quality federally funded health care assets, while sustaining unique and important VA relationships. In addition, VA promotes high-quality care by creating preferred and standard tiers. For the preferred designation, providers must meet quality and value metrics that are based on evidence-based care guidelines. VA plans to uniformly apply best practices to determine criteria for both tiers. VA will work to determine specific metric reporting and performance benchmarks using recognized institutions.

Conclusion

VA appreciates the opportunity to discuss the community care network element of our plan. The Network system described in our plan would empower Veterans to make informed decisions about which providers they want to use, by highlighting providers with higher quality, care coordination, and satisfaction scores. Additionally, it will help reduce confusion for Veterans as they interact with and transition between VA facilities and community facilities. This provision also supports our efforts to make our system more in line with industry standards, as tiered networks are common in the delivery of value-based care, as seen with TRICARE and many private sector health plans.

As we have described at other hearings, VA will implement improvements to the delivery of community care through an incremental approach as outlined in the plan. VA looks forward to continued discussions on how to refine the approach described in our plan, with the goal of improving Veteran's health outcomes and experience, as well as maximizing the quality, efficiency, and sustainability of VA's health programs. These improvements, like many of the enhancements VA has already made, are only possible with Congressional support, including legislation and necessary funding.

Mr. Chairman, I appreciate the opportunity to appear before you today. We are prepared to answer any questions you or other Members of the Committee may have.