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POLICY BRIEF

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VA Utilization Management: High Performing Provider Project

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Introduction to the VA Utilization Management High Performing Provider Project

The 2018 MISSION Act (formally known as the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act) expanded Veterans' ability to seek medical care from community-based providers outside of Veterans Health Administration (VHA).[1] If Veterans meet certain criteria — such as if VHA is inaccessible due to geography or long wait times — the Department of Veterans Affairs (VA) will pay for Veterans' medical care from community providers. Since the implementation of the Veteran Community Care Program, community care visits have been increasing.[2] In 2019, almost 2 million Veterans received care in the community and the number of visits is expected to continue to increase, as well as the budget required to cover the cost of that care.[3]

Since expanding Veterans' access to care in the community, wait times for appointments have decreased, particularly for specialty care. Increased access to care is generally considered desirable, but it does not indicate the quality of that care. By purchasing care in the community, VHA may experience less control over the quality and coordination of care that Veterans receive.[4] Taking on the role of insurer, VA has a financial interest and responsibility to make sure that Veterans receive high quality care in the community. Aligned with this interest, VA has launched the Utilization Management: High Performing Provider (UM HPP) Project. This project aims to connect Veterans seeking community care with High Performing Providers to ensure that they are receiving a high standard of care outside VHA.

How the Program Works

Veterans Affairs relies on the Community Care Network (CCN) to refer Veterans to services in the community, which is comprised of six regional networks in the U.S. and its territories.[5] CCN is a mechanism to pay for services and manage provider networks. The network is maintained and operated by contracted companies, such as Optum TriWest and TriWest Healthcare Alliance. The UM HPP Project works within the CCN structure to identify "High-Performing Providers" (HPPs) to help guide patient referrals to high-quality community-based provider networks. Scheduling staff at VHA facilities are able to view the designation when referring and scheduling Veterans with community care providers (*see Figure 1*).

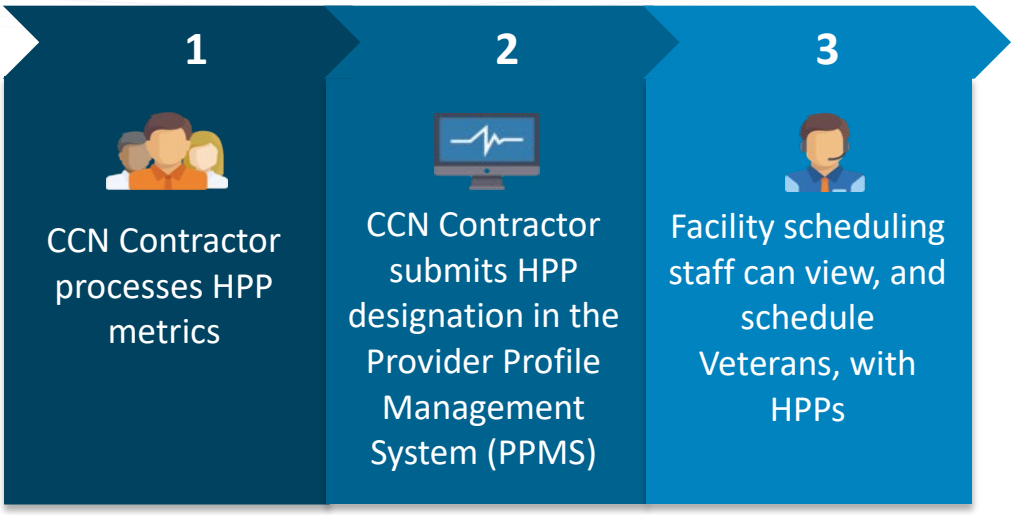

Figure 1: Workflow for HPP Project (adapted from OCC, 2020)

The vendor contracted to run the Community Care Network is tasked with designating a provider as "high-performing," but the parameters are set by VHA. In order to be an HPP, a provider must meet certain quality standards. In regions 1-3, the provider must exceed the 75th percentile of the Healthcare Effectiveness Data and Information Set (HEDIS) measures, exceed the top 70th percentile in the Physician Quality Reporting System (PQRS), and earn the United HealthCare Premium Designation (UHC PD) compared to their local VA medical center markets. For example, in Region 4, the provider must exceed the 75th percentile of HEDIS measures for primary care. Blue Health Intelligence (BHI) Primary and Specialty Care measures specific to local VA medical center markets also inform HPP designations in Region 4. These data sets are commonly used by insurance organizations to understand the quality of care provided by a physician or other medical professional. HEDIS uses a number of domains of care such as effectiveness, access, experience, risk adjusted utilization, and quality measures reported using electronic clinical data systems to evaluate provider performance. PQRS focuses on care coordination, patient safety and engagement, clinical effectiveness, and population health.[6] Additionally, in Region 4 the provider must have no practice-level-3 findings, which indicate that they operated outside of the standard of care for their specialty. Quality standards differ by geography because regions 1-3 and Region 4 are contracted through different entities which use their own designations to inform physician quality metrics. At the time of writing this brief, the HPP program is only active in regions 1-4. Each of the provider quality measures listed above use a combination of metrics to qualify a provider as one who is reputable, provides high quality care, and operates within the standards of care for their specialty.

UM HPP Policy Context

Restricting patient access to in-network providers is a widely used tool to align the financial and quality incentives between insurers and providers. This is the guiding principle behind narrow and tiered network approaches used in commercial insurance, which promote preferred providers through financial incentives, often through lower copays. These networks typically operate by charging less for a tier of low-cost, high quality providers. However, these networks may also be a function of contracts with provider networks that charge insurers more favorable rates, and therefore may not necessarily

promote quality patient care.[7] This structure guides patients towards providers that are advantageous to the insurer and in turn may also lower costs or improve quality for patients.

The UM HPP system has a similar theoretical framework yet operates differently in a number of ways. Firstly, the goal of the UM HPP system is not to control cost, as community care providers are reimbursed based on Medicare rates. Further, VA is prohibited from attempting to guide behavior by providing financial incentives to the patient in the same way that tiered networks do. However, it is notable that providers ranked highly in the databases, such as HEDIS, generally provide high-value care.[8] Through the UM HPP program, VA has an opportunity to maintain focus on quality of care. Given the early stages of the initiative, it remains unclear whether the quality metrics and referral system result in higher quality of care for VA patients or whether the program improves Veteran health, an important direction for future program evaluation.

In commercial insurance, tiered networks are a successful way to drive patient behavior towards providers that are ranked highly,[9,10] which supports the promise of the HPP program to guide Veterans towards high quality care. However, achieving these goals depends on successful program implementation. The HPP program is reliant on VHA scheduling staff prioritizing HPPs when referring Veterans to community providers and upon Veterans accepting those referrals. Furthermore, in other cases where members are eligible for multiple insurers— such as dual-enrollees in Medicare and Medicaid—there can be a number of barriers to providing quality health care, such as difficulties with care coordination and data collection across health systems and payors.[11] Those barriers are not addressed in the current UM HPP System.

The program also hinges on the assumption that the quality measures selected in the HPP designation (HEDIS, PQRS, BHI) provide meaningful information about quality of care and will guide Veterans and schedulers toward providers that are competent at addressing the health care needs of the Veteran population.[12] Even community providers ranked highly among these data sources may not be experienced with caring for Veterans and may operate differently from the patient-centered model that has been implemented at VA to address Veterans' needs.[13]

Conclusion

The UM HPP system provides guidance on the quality of providers to VHA schedulers and Veterans who are considering community-based care. The Veteran Community Care Program, in which VA purchases care from community providers, exhibits unique differences in its application of network-based tools compared to those employed by private HPP systems, tiered networks, and narrow networks. Unlike a traditional insurer, VA created a network that addresses community care quality without emphasis on financial incentives. Commercial systems generally rely on an approach that addresses the Centers for Medicare and Medicaid Services "quad aim" (cost, access, quality, provider burden) while VA system targets quality specifically with a unique approach to implementation. This narrow focus on quality in the HPP program may give VA an opportunity to analyze and answer some key questions about how to improve the quality of community care. The HPP program can be used to determine if relying on commercial quality metrics is sufficient for the Veteran population, how the HPP designation impacts providers' experience with Veterans or vice-versa, and how HPP providers are able to coordinate with VA system to provide appropriate care to Veterans. This initiative can be used to further determine what, if any, impact the program will have on the quality of community care for Veterans.

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ABOUT PEPREC POLICY BRIEFS

This evidence-based policy brief is written by Partnered Evidence-based Policy Resource Center (PEPReC) staff to inform policymakers and Veterans Health Administration (VHA) managers about the evidence regarding important developments in the broader health system and economy. PEPReC is a Quality Enhancement Research Initiative-funded resource center that collaborates with operational partners to design and execute randomized evaluations of VHA initiatives, develops and refines performance metrics, and writes evidence-based policy briefs.