

## **U.S. Department of Veterans Affairs**



### **Surface Transportation and Veterans Health Care Choice Improvement Act of 2015**

#### **Title IV—Veterans Provisions**

#### ***“VA Budget and Choice Improvement Act”***

### **Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care**

**October 30, 2015**

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## 1.0 Executive Summary

The Department of Veterans Affairs (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 demand for care, it is essential for VA to partner with providers in communities across the country to meet the needs of Veterans. 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 and community providers, as well as the VA employees that serve and support them.

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* (also known as 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* (*The Choice Act*).

This document provides a plan for how VA could consolidate all purchased care programs into one **New Veterans Choice Program (New VCP)**. The New VCP will include some aspects of the current Veterans Choice Program (Section 101 of PL 113-146, as amended) and incorporate additional elements designed to improve the delivery of community care. The 10 elements of this plan, as set forth in law, are listed to the right. With the New VCP as described in this plan, enrolled Veterans will have greater choice and ease of use in access to health care services at VA facilities and in the community.

### VA Budget and Choice Improvement Act Legislative Elements

1. Single Program for Non-Department Care Delivery
2. Patient Eligibility Requirements
3. Authorization
4. Billing and Reimbursement Process
5. Provider Reimbursement Rate
6. Plan to Develop Provider Eligibility Requirements
7. Prompt Payment Compliance
8. Plans to Use Current Non-Department Provider Networks and Infrastructure
9. Medical Records Management
10. Transition Plan

The New VCP will clarify eligibility requirements, build on existing infrastructure to develop a high-performing network, streamline clinical and administrative processes, and implement a continuum of care coordination services. Clear guidelines, infrastructure, and processes to meet VA's community care needs will improve Veterans' experience and access to health care. VA's future health care delivery

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network will address gaps in Veterans' access to health care in a simple, streamlined, effective manner and will continue to support VA's missions of research and education.

VA is continuing to examine how the Veterans Choice Program interacts with other VA health programs, including the delivery of direct care. In addition, VA is evaluating how it will adapt to a rapidly changing health care environment and how it will interact with other health providers and insurers. As VA continues to refine its health care delivery model, we look forward to providing more detail on how to convert the principles outlined in this plan into an executable, fiscally-sustainable future state. In addition, we plan to receive and potentially incorporate recommendations from the Commission on Care and other stakeholders.

VA anticipates improving the delivery of community care through incremental improvements as outlined in this plan, building on certain provisions of the Veterans Choice Program. The implementation of these improvements requires balancing care provided at VA facilities and in the community, and addressing increasing health care costs. VA will work with Congress and the Administration to refine the approach described in this 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.

## **The Path Forward**

The design of the New VCP (*Legislative Element 1*) is based on feedback from Veterans, Veteran Service Organizations (VSOs), VA employees, Federal stakeholders, and best practices. VA's plan centers on five functional areas. Within each functional area are key points to enable Veterans to receive timely and high-quality health care.

- 1. Veterans We Serve (Eligibility)** – This area addresses overlapping community care eligibility requirements, as directed in *Legislative Element 2*. Streamlining and consolidating these requirements will allow Veterans to easily understand their eligibility for community care and access community care faster. VA and community providers will have significantly lower administrative burdens, which have often impeded timely delivery of Veterans' care. This area includes the following possible enhancements:
  - Establish a single set of eligibility criteria for all community care based on geographic access/distance to a VA primary care provider (PCP), wait-time for care, and availability of services at VA.
  - Expand access to emergency treatment and urgent community care.
- 2. Access to Community Care (Referral and Authorization)** – This area addresses the complicated process of community care referrals and authorizations, as directed in *Legislative Element 3*. VA will optimize the referral and authorization systems and



supporting processes, enabling more rapid exchange of information to support timely delivery of care. This area includes the following possible enhancements:

- Streamline business rules in referral and authorization to minimize delays in delivering care and eliminate unnecessary administrative burdens.
- Improve VA visibility into health care utilization in the community.

**3. High-Performing Network** – This area leverages components of existing non-Department networks and identifies new community partners to build a high-performing network, as outlined in *Legislative Element 8*. Addressing issues of provider eligibility requirements and reimbursement rates, as outlined in *Legislative Elements 5 and 6*, will be key to this approach. This area includes the following possible enhancements:

- Develop a tiered, high-performing provider network to better serve Veterans, consisting of the following categories:
  - **VA Core Network:** Includes existing relationships with high-quality health care assets in the Department of Defense (DoD), Indian Health Service (IHS), Federally Qualified Health Centers (FQHC), Tribal Health Programs (THP), and academic teaching affiliates.
  - **External Network:** Includes commercial community providers and distinguishes Preferred providers based on quality and performance criteria.
- Move towards value-based payments in alignment with industry trends.
- Implement productivity standards to better manage supply and demand.
- Develop dedicated customer support to improve Veteran and community provider experiences.

**4. Care Coordination** – This area focuses on improving medical records management and strengthening existing care coordination capabilities, as directed by *Legislative Element 9*. Improving medical records management will support a high-performing network and enable better decision making through analytics. It will also support more effective care coordination and improved Veteran health care outcomes. This area includes the following possible enhancements:

- Offer a continuum of care coordination services to Veterans, tailored to their unique needs.
- Use analytics to improve Veterans' health by guiding them to personalized services and tools (e.g., disease management, case management).
- Enable community providers to easily exchange health information with VA.
- Design customer service systems to help resolve inquiries from Veterans and community providers regarding care coordination.

**5. Provider Payment** – This area focuses on improving billing, claims, and reimbursement processes, as well as Prompt Payment Act (PPA) compliance for purchasing care, as directed by *Legislative Elements 4, 5, and 7*. This area includes the following possible enhancements:

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- Implement a claims solution which is able to auto-adjudicate a high percentage of claims, enabling VA to pay community providers promptly and correctly.
- Move to a standardized regional fee schedule, to the extent practicable, for consistency in reimbursement.

The New VCP will use a **system of systems approach** to enhance these five functional areas as part of the larger VA health care transformation. This approach stresses the interactive, interdependent, and interoperable nature of external and internal components within VA's health care delivery system. The New VCP includes enhancements to the following systems, which will have a positive impact on VA and the greater Veterans' health ecosystem:

- **Integrated Customer Service Systems** – Provide a reliable, easy-to-use way for Veterans and community providers to get their questions answered, provide feedback, and submit inquiries.
- **Integrated Care Coordination Systems** – Establish a clear process for Veterans to seamlessly transition between VA and community care, supporting positive health outcomes wherever the Veteran chooses to receive care.
- **Integrated Administrative Systems (Eligibility, Referral, Authorizations, and Billing and Reimbursement)** – Simplify eligibility criteria so Veterans can easily determine their options for community care, streamline the referral and authorization process to enable more timely access to community care, and standardize business processes to minimize administrative burden for community providers and VA staff.
- **High-Performing Network Systems** – Enable the development and maintenance of a high-performing provider network to maximize choice, quality, and value for Veteran health care.
- **Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting)** – Define ownership and management of community care at all levels of VA, local and national, and institute standard metrics to drive high performance and accountability across facilities.

The New VCP plan envisions a three-phased approach to implement these changes to support improved health care delivery, as outlined in the Transition Plan (*Legislative Element 10*). This will deliver incremental improvements while planning for a future state consistent with evolving health care best practices. **The first phase will include development of the implementation plan and will focus on the development of minimum viable systems and processes that can meet critical Veteran needs without major changes to supporting technology or organizations. Phase II will consist of implementing interfaced systems and community care process changes. Finally, Phase III will include the deployment of integrated systems, maintenance and enhancement of the high-performing network, data-driven processes, and quality improvements.**

Executing the New VCP will not be possible without approval of requested legislative changes and requested budget. The primary objectives of the legislative proposal

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recommendations are to make immediate improvements to community care, establish a single program for community care, and implement necessary business process improvements. The budget section of this plan is divided into three parts: (1) System Redesign and Solutions; (2) Hospital Care and Medical Services, including Dentistry; and (3) Expanded Access to Emergency Treatment and Urgent Care. System Redesign and Solutions include enhancements to the referral and authorization process, care coordination, customer service, and claims processing and payment. These changes are expected to improve the Veteran experience with community care. As a result, this may increase Veterans' reliance on VA community care, leading to increased Hospital Care and Medical Services costs. Expanded Access to Emergency Treatment and Urgent Care is important in providing Veterans with appropriate access to these services, but is severable from other aspects of the Program and could be implemented separately.

The incremental costs of the enabling System Redesign and Solutions for the New VCP are estimated to range between \$400 and \$800 million annually during the first three years. VA's community care programs (hospital care, medical services, and long-term services and supports) prior to the enactment of *The Choice Act*, cost roughly \$7 billion per year. Continuing the Veterans Choice Program, as amended, beyond its current expiration will cost approximately an additional \$6.5 billion per year, assuming no changes are made to its current structure (eligibility, referral and authorization, provider reimbursement, etc.). Improvements to the delivery of community care as described in this plan would require additional annual resources between \$1.5 and \$2.5 billion in the first year and are likely to increase thereafter. The proposed expanded access to emergency treatment and urgent care requires an additional estimated \$2 billion annually. Refer to the estimated costs and budgetary requirements (*Section 5*) and legislative proposal recommendations (*Section 6*) for additional information.

The estimated costs reflected in this report represent the funding required to maintain VA's delivery of community care at current levels, as well as incorporating the considerations outlined in this plan.

VA cannot reach the future state alone. Ongoing partnership with Congress will be critical to addressing the budgetary and legislative requirements needed for this important transformation, including outstanding decisions on aspects related to sustainability and cost-sharing. The support and active participation of Congress, Federal partners, VA employees, VSOs, and other stakeholders are necessary to achieve more efficient, effective, and Veteran-centric health care delivery.

## Conclusion

Transformation of VA's community care program will address gaps in Veterans' access to health care in a simple, streamlined, and effective manner. This transformation will require a systems approach, taking into account the interdependent nature of external and internal factors involved in VA's health care system. MyVA will guide overall

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improvements to VA's culture, processes, and capabilities and the New VCP will serve as a central component of this transformation. The successful implementation of the New VCP will require new legislative authorities and additional resources and will position VA to improve access to care, expand and strengthen relationships with community providers, operate more efficiently, and improve the Veteran experience.

## 2.0 Purpose of the Report

Each section of this report (Figure 1) directly addresses the legislative elements set forth in the *VA Budget and Choice Improvement Act*, Plan to Consolidate Care in the Community Programs of the Department of Veterans Affairs to Improve Access to Care, in the *VA Budget and Choice Improvement Act* and discusses in detail the key enhancements that will eventually shape the future of VA health care delivery.

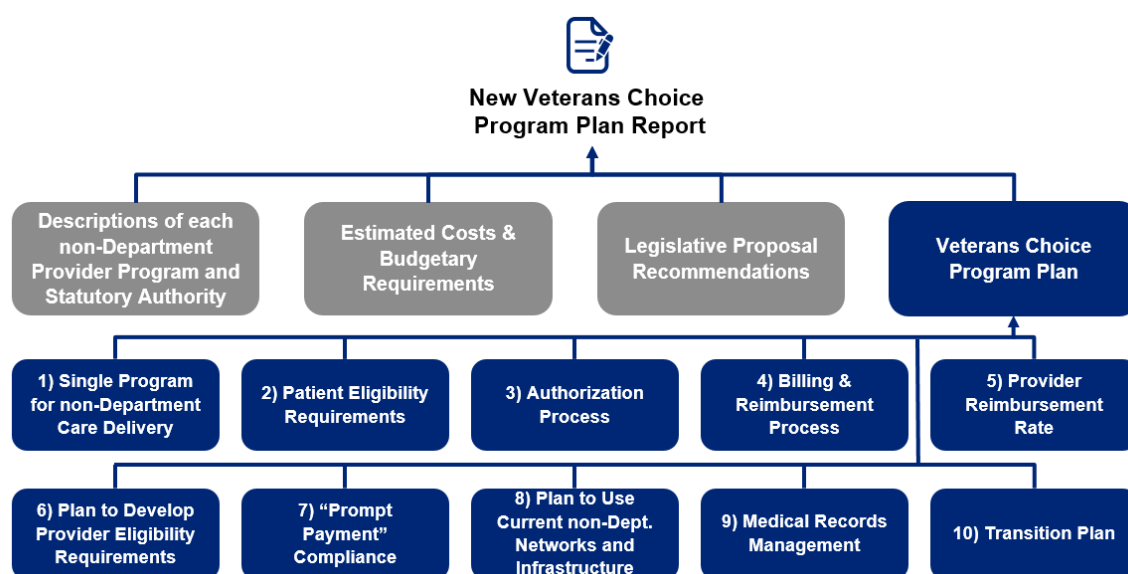


Figure 1: New VCP Report Outline

- **Introduction:** The introduction outlines the future of VA's health care delivery and includes the stated objectives of the New VCP in the larger context of the VA delivery system, including enhancements to care coordination, and how these enhancements align with MyVA.
- **Plan to Consolidate Community Care Programs – The New VCP (*Legislative Element 1*):** Plan to consolidate and streamline existing programs into one community care program implemented locally with national oversight. Outlined below are proposals to establish the following:
  - **Patient Eligibility Requirements (*Legislative Element 2*):** Define a single set of eligibility requirements for the New VCP.
  - **Authorizations (*Legislative Element 3*):** Streamline the complex referrals and authorizations process currently required for Veterans to access non-VA care.
  - **Billing and Reimbursement (*Legislative Element 4*):** Improve claims processing to efficiently reimburse community providers.
  - **Provider Reimbursement Rates (*Legislative Element 5*):** Standardize overlapping and disconnected fee schedules.

- **Provider Eligibility Requirements** (*Legislative Element 6*): Identify provider eligibility requirements and structure the high-performing network.
  - **Prompt Pay Act Compliance** (*Legislative Element 7*): Design systems to address payment backlogs and comply with the PPA.
  - **Utilizing Current Non-VA Networks and Infrastructure** (*Legislative Element 8*): Strengthen existing provider relationships and create new relationships through simplified provider agreements and contracts.
  - **Medical Records Management** (*Legislative Element 9*): Develop a health information environment that is electronic, secure, efficient, effective, Veteran-centric, and standards based.
  - **Transition Plan** (*Legislative Element 10*): Identify a three-phased approach to transition to the New VCP, including requirements of the five systems identified and associated risks, timeline, milestones, and estimated costs for implementation, outreach, and training.
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- **Estimated costs and budgetary requirements:** Provide the estimated range of costs and budgetary requirements necessary for VA to successfully implement the New VCP plan.
  - **Legislative proposal recommendations:** Provide any recommendations for new legislative proposals necessary for VA to successfully implement the plan.
  - **Description of each non-Department provider program and statutory authority:** Provide a description of each non-VA provider program and the respective statutory authority for each.

### 3.0 Introduction

VA is committed to providing Veterans accessible, timely, and high-quality care with the utmost dignity and respect. At the heart of this mission is a commitment to improving performance, promoting a positive culture of service, increasing operational effectiveness and accountability, advancing health care innovation through research, and training future clinicians.

Health care delivery models must adapt and evolve to meet the needs of patients. Overall, the U.S. health care system is changing significantly with regard to the types of care demanded and the way patients seek care. New technologies are drastically changing how patients access care and how providers and patients interact. Innovations in precision medicine, telehealth, value-based care models, genomics, and overall operational efficiency represent only some of the trends in U.S. health care over the last several years.

VA is evolving to meet the distinct needs of Veterans, driven by aging and an increased number returning from war with mental and physical conditions unique to service,<sup>1</sup> while also adapting to broader health care trends. Over the last several decades, VA has seen an increase in demand for primary and preventive care and a decrease in demand for hospital-centric inpatient care. In 2016, VA estimates that there will be more than 101million outpatient visits annually, an increase of 2.8 million visits per year from 2015.<sup>2</sup> Furthermore, the number of women Veterans requesting health care from VA has increased by 80 percent over the last decade, meaning VA is experiencing a greater demand for care and services that have not been traditionally provided at VA facilities (e.g., obstetrics and mammography). The lack of available services at VA facilities means that women Veterans must seek community care. In fact, women Veterans are more than twice as likely as men to receive community care.<sup>3</sup>

As the health care landscape changes, VA understands that its health care delivery system must also change to better meet the evolving needs of Veterans. In August 2014, Congress enacted *The Choice Act*, which required VA to establish the Veterans Choice Program to address VA's health care access challenges. The Veterans Choice Program became an additional method for VA to purchase community care, but added complexity and confusion for Veterans, VA staff, and community providers.

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<sup>1</sup> "The Critical Need for Military & Civilian Mental Health Professionals Trained to Treat Post Traumatic Stress Disorder & Traumatic brain Injury." <http://www.apa.org>. Accessed October 5, 2015.  
<http://www.apa.org/about/gr/issues/military/critical-need.aspx>.

<sup>2</sup> United States. Cong. Senate. Committee on Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies. Budget Request for Fiscal Year 2016, Apr. 21, 2015. 114th Cong. 1st sess. Washington: GPO, 2005 (statement of The Honorable Robert A. McDonald, Secretary, Department of Veterans Affairs).

<sup>3</sup> Sourcebook Vol. 3 - Part 4: Non-VA (Fee) Medical Care Utilization, FY12

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VA's future health care delivery system must address Veterans' access to health care in a simple, streamlined, and effective manner. Veterans should receive uniformly high-quality care, whether at VA or in the community. The future VA health care delivery system must operate more efficiently, better adopt technological advances, and develop and maintain relationships with strategic partners to support an equitable experience inside and outside of VA. To reach this desired state, VA plans to use a system of systems approach that will address the enterprise-wide challenges in meeting the unique needs of Veterans.

### **3.1 Stakeholder Feedback**

VA leadership engaged a variety of stakeholders to inform the future of VA health care and the development of a single community care program. VA gathered insights from Veterans, Veterans Service Organizations (VSOs), VA leaders, staff and clinicians, Federal and academic partners, Tribal health partners, Congressional Committee staff, and health care industry leaders on the new community care model. The feedback collected was largely consistent with the Independent Assessment Report (refer to the Appendix for additional information) that provided recommendations focused on streamlining the purchase of community care.<sup>4</sup> These insights informed the vision for VA's health care delivery system and the plan for the New VCP.

**VSOs:** VSOs emphasized the need for Veterans' choice in how and where Veterans receive care. Other key themes include:

- Continue to provide a unique environment and culture for Veterans' health care
- Recognize that some Veterans are willing to travel farther to see their VA provider
- Clarify processes for accessing community care, as current processes are confusing
- Address concerns that the current VA provider system would be underfunded to purchase community care
- Be the face of care coordination for Veterans
- Streamline emergency treatment regulations, processes, and procedures, which are complex, inconsistently applied across Veterans Health Administration (VHA), and cause significant confusion for VA staff, Veterans, and community care providers

**VA Staff and Clinicians:** VA staff and clinicians work hard to serve Veterans every day; however, they need additional support. Feedback from the field identified the following themes:

- Retain elements of the non-VA care program that worked well and relationships that were effective prior to the Veterans Choice Program and can be used as best practices

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<sup>4</sup> "VA and Congress should articulate a clear strategy governing the use of purchased care." Independent Assessments C. Care Authorities

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- Improve efficiency/timeliness of business processes and clinical pathways to support Veterans to successfully connect to community care
- Simplify and consolidate various programs to reduce confusion
- Increase staffing and dedicate VA employees to the coordination of community care
- Implement technologies to replace manual processes and increase information sharing
- Establish quality metrics/quality review processes for care delivered in the community

**Federal Partners:** Discussions with DoD, OMB, agencies of the Department of Health and Human Services (HHS), including the Centers for Medicare and Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), and the IHS yielded the following themes:

- Partner to deliver health care services, reducing redundancies in Federal health services and increasing access
- Advance new care models and information sharing
- Work together to continue leading in interoperability and care coordination

**Tribal Consultation:** Tribes from around the country were given the opportunity to provide feedback about the role of IHS and THP in the VA health care system, as well as VA's efforts to streamline the provision of non-VA care to Veterans. Responding tribes indicated the following:

- Strong support for the inclusion of IHS and THP as key partners in VA's community network.
- Maintain and strengthen the current agreements between VA, the IHS, and THPs.
- Interest from IHS and THPs in potentially serving non-Native Veterans.

**Health Care Industry Leaders:** Leaders from across the health care industry, focusing on health plan capabilities and integration with a provider organization, raised the following themes regarding best practices and opportunities for a future VA community care program:

- Adopt best practices in clinical and administrative decision making by using data on the needs of Veterans and metrics on the quality of providers
- Build a sound technology infrastructure and utilize new technologies and predictive analytics to optimize health outcomes and enhance Veterans' experience
- Lead in the field of care coordination
- Provide the care and services Veterans require through a high-performing network

Along with extensive input from across VA, these stakeholders helped identify key requirements for the future of VA health care, of which the New VCP is one component.

## 3.2 Future of VA Health Care

As the health care landscape and the needs of Veterans change, VA's health care delivery model must also change. Historically, VA's identity has been a hospital-based provider organization. This delivery model is evolving into team-based care delivered in a variety of settings, including virtual- and home-based care. Simultaneously, VA is increasingly becoming a larger purchaser of care, in addition to being a provider. VA will focus on the following set of guiding principles to direct the evolution of VA health care delivery:

**Invest in and grow VA's core competencies.** In a transformation such as this, organizations must make decisions about where to invest resources. No organization can excel at every capability; high-performing organizations define their core competencies and excel at those. Service delivery systems designed around core competencies distinguish organizations from others and provide the highest potential value to their customers. VA establishes a relationship with Veterans as they transition out of military service. Unlike commercial health plans, where beneficiaries change plans periodically and disrupt continuity of care, Veterans are Veterans for life. This transformation is both a unique opportunity and responsibility for VA to address Veterans' health care more holistically. As VA continues to optimize its health care delivery system, it is important to continue to focus on areas of critical need to Veterans, as well as where there are gaps in private sector care (e.g., service-related injuries, traumatic brain injuries (TBI), post-traumatic stress disorder, and integrated mental health).

**Maintain a high-performing network to deliver care.** A high-performing network refers to an ecosystem of health care providers that optimize the health of beneficiaries and operational efficiencies. High-performing networks deliver patient-centered care, are comprised of high-performing providers, monitor quality, incentivize clinicians through innovative reimbursement models, use data to adapt services, and create a better environment for customers. High-performing networks are enabled by tools and practices that drive efficiencies, cost savings, and customer experience.<sup>5</sup> As part of a high-performing network, VA will identify and focus on core clinical competencies and will partner with community providers to deliver high-quality, complementary services.<sup>6</sup>

### High-performing Network Enablers

- Delivery of high-quality care
- Payment and quality improvement incentives
- Performance and outcomes-based metrics
- Interoperable health information technology platforms
- Team-based care coordination

<sup>5</sup> American Medical Group Association, "Six Characteristics of 'High-Performing' Health Systems"

<sup>6</sup> "Systematically study opportunities to improve access to high-quality care through use of purchased care." Independent Assessment Report Section B. Health Care Capabilities.

**Deliver personalized, proactive, and patient-driven health care.** Delivering Veteran-centric care requires sensitivity to the Veteran culture and creation of care plans tailored to their specific health needs. While VA providers are familiar with the Veteran culture, community providers may need additional education and support through training and decision support tools. Within VA, information systems will allow clinicians, Veterans, their families, and caregivers to identify health goals and track effectiveness of interventions on clinical, social, and behavioral determinants of health. By delivering personalized, patient-driven care, VA will support holistic care, increase Veteran participation in health care, and provide tailored therapies unique to the needs of each Veteran, their family, and their caregivers.

**Use metrics and data analytics to drive improvement.** Providing care through a high-performing network is a data-intensive undertaking requiring a system of systems approach. From a clinical care perspective, monitoring quality and value of care requires the ability to report outcomes measured through the exchange and aggregation of data. From a clinical capacity perspective, VA will track utilization, provider productivity, and quality to understand when and where Veterans need care and to balance resources as those needs change. From a process improvement perspective, workflows and systems will be designed and evaluated to promote the best experience for Veterans, VA staff, and community providers. From a quality improvement perspective, interventions to improve care will be evaluated to determine their efficacy. Data-driven decision making requires a robust technology infrastructure that allows for appropriate data capture, exchange, transparency, and analysis.

**Focus on research and education missions.** VA has a long history of research and medical education. These missions are integral to providing high-quality care to Veterans now and in the future. Clinicians trained in VA facilities have experience treating Veterans and a deep understanding of Veterans' health. Whether their clinical career is in a VA facility or in the community, these trainees are the future providers of a high-performing network. Similarly, VA supports research that focuses on Veteran-specific health needs to understand and improve treatment.

**Use innovative technologies and value-based care models to optimize health outcomes.** The health care landscape continues to evolve. Technology continues to push the boundaries of health and wellness. As an example, Telemedicine Intensive Care Unit (TeleICU) programs allow remote monitoring of patients by providing real-time, high-quality data to an intensivist across the street or the country. This increases the capacity of a single intensivist to care for a panel of patients and allows patients to be in intensive care close to family support, even if an on-site intensivist is not available. In addition to advancements in technology, CMS is driving innovation in how health care is paid for by sponsoring pilots for a variety of value-based care models, identifying how organizations can work together to provide high-value care to patients. Innovation in care delivery models, technology, and the combination of the two will continue to change the face of health care. VA must continue to adapt to the

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evolving health care landscape and adopt new technologies, but should also recognize that current methods for measuring success in this area may be limited.

Consistent with the Independent Assessment Report, VA plans to employ a system of systems approach for the development, deployment, long-term oversight, and coordination of health care delivery.<sup>7</sup> This is defined as “The design, deployment, operation, and transformation of metasystems that must function as an integrated complex system to produce desirable results. These metasystems are themselves composed of multiple autonomous embedded complex systems that can be diverse in technology, context, operation, geography, and conceptual frame.”<sup>8</sup> This recognizes that systems are constructed from components and optimization of a single component may negatively affect others.

In this report, we identify requirements of five systems necessary to VA health care and the New VCP:

1. Integrated Customer Service Systems
2. Integrated Care Coordination Systems
3. Integrated Administrative Systems (Eligibility, Patient Referral, Authorization, and Billing and Reimbursement)
4. High-Performing Network Management Systems
5. Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting)

Some components of these systems already exist at VA. For these systems to work together seamlessly with care provided at VA and non-VA facilities, they must be designed as a system of systems. From that perspective, while the elements of this report focus on the purchase of community care, the development of a high-performing network cannot occur without addressing both care delivery by VA providers and care purchased in the community. Therefore, in addressing systems supporting the purchase of community care, VA must ensure that these systems are fully integrated with those supporting Veterans’ care within VA.

Care coordination is critical to support the delivery of VA health care as Veterans access care at VA facilities, virtually, and in the community. The relationship of the Veteran (and caregivers) to his or her primary care team is central to coordination. Care coordination, however, is not a one-size-fits-all model; it occurs on a spectrum. As a Veteran’s needs evolve, VA will need to tailor care coordination to each situation.

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<sup>7</sup> Independent Assessment Report

<sup>8</sup> Keating, C., Rogers, R., Unal, R., Dryer, D., Sousa-Poza, A., Safford, R., Peterson, W. and Rabadi, G. (2003) ‘System of systems engineering,’ *Engineering Management Journal*, Vol. 15, No. 3, pp. 36–45.

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### 3.3 Care Coordination

VA can be a leader in care coordination. While this is a broad term with a variety of interpretations in health care, the Agency for Healthcare Research and Quality (AHRQ) states that, “care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care”. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.”<sup>9</sup> The goal of care coordination is to meet patient needs and deliver high-quality, high-value care from the perspectives of the patient and family, provider team, and the health system. Care coordination should improve health outcomes, prevent gaps caused by transition of setting or time, and support a positive and engaging patient experience.

Operationally, care coordination is a team-based activity that includes the patient, family, caregivers, staff, and clinicians. Each part of the team has different needs for services and information (clinical and administrative) during a transition of care, such as referral to a specialist, hospital discharge, or a period of time between clinical visits. In the example of a referral, a PCP and a patient decide to seek the input of a specialist on a specific condition. The patient and caregivers need to know how to choose a provider, what to do before the visit, when to go, and how to follow up appropriately. The primary care team needs to communicate clinical information to the specialist; understand when the visit has occurred; what the diagnosis was; and how to support any subsequent care plan. VA staff need to know how to help patients and caregivers to schedule and attend the appointment and how to direct appropriate information to the team. For this transition to be seamless, all parties need access to systems that supply accurate, timely information, workflows that address the needs of the team members, and metrics to understand the success of these interactions. As a result, care coordination is complex and information intensive, requiring a cohesive approach. While this is an area of intense focus for the health care industry, the private sector has not converged on a standardized care coordination model. This makes care coordination an opportunity for VA to be a leader in developing innovative solutions with strategic partners within the high-performing network.

For all Veterans, care coordination will fall along a continuum of intensity, from basic care coordination or patient navigation to care/disease management to case management, as illustrated in Figure 2. This continuum is influenced by a variety of factors: the complexity of clinical conditions, Veterans’ preference around engagement, PCP choice, and care setting. VA currently offers many diverse care coordination programs that can be difficult to understand and navigate. VA plans to consolidate these

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<sup>9</sup> <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html> (accessed September 22, 2015)

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programs into an integrated, enterprise-wide model implemented locally. As care coordination matures at VA, it will be provided as a service to community providers who care for Veterans in need of more intensive coordination. The impact of this coordination continuum is to enable Veterans receive the type of care management and coordination necessary to achieve positive health care outcomes.



*Figure 2: Continuum of Care Coordination*

## Basic Care Coordination/Patient Navigation

Basic care coordination involves the coordination of appointments and scheduling for Veterans and their caregivers, enabling them to know who to see, when to go, and why. Most Veterans will utilize this level of care coordination and patient navigation. This requires support from staff responsible for medical data integration, referral coordination, and appointment scheduling assistance. This also includes second-line support available for administrative questions and self-service options, such as a web-based portal or mobile apps, to engage Veterans in their wellness and allow them to quickly complete transactions.<sup>10</sup> Patient navigation is an intervention or a specific person who helps Veterans access care. These services are aimed at helping Veterans who have multiple comorbidities and providers, but do not need complex care coordination.

<sup>10</sup> Independent Assessment Report H. Health Information Technology. "VA should explicitly identify mobile applications as a strategic enabler to increase Veteran access and satisfaction and help VHA transition to a data-driven health system."



## **Care/Disease Management**

Care management is the oversight and management of a comprehensive care plan for a population of patients with specific diseases. Care management facilitates the delivery of clinically recommended care to optimize health outcomes for Veterans and avoid gaps or duplications in care. Veterans in need of care management will be identified through clinical information and PCP referrals. This program will allow VA to proactively conduct Veterans' outreach, encourage healthy behavior, advance clinical best practices, provide disease education, and engage Veterans in self-management. As a result, VA will be in a position to better address care needs earlier and support positive long-term outcomes.

## **Case Management**

Case management is a specialized and highly skilled component of care coordination. Case management emphasizes a collaborative process that assesses, advocates, plans, implements, coordinates, monitors, and evaluates health care options and services, so they meet the unique needs of the complex patient. Case management is the most intensive level of care coordination. A multidisciplinary team manages care for Veterans with the most catastrophic and complex conditions (e.g., TBI and spinal injury) and coordinates treatments across multiple providers and venues of care. Dedicated case managers use a holistic approach to coordinate and manage Veteran health care, including consideration of psychosocial factors that affect care. Innovation in this area can include novel methods for the integration of housing assistance with substance abuse and mental health care for homeless Veterans.

Veterans who require case management often have a family member or caregiver who assists them with a variety of personal care activities, ranging from assistance in arranging and coordinating care, to assistance with Activities of Daily Living (ADL) and/or Instrumental ADL, or keeping them safe in the community. Support of family members and friends who serve as caregivers is essential in order for Veterans to achieve their treatment goals. Caregiver training and support programs also will be available to family members and caregivers of Veterans who are being treated for complex conditions, allowing Veterans to obtain the comprehensive, integrated support they need.

## **Care Coordination Enablers**

Robust care coordination, for any of the three levels on the continuum, requires a strong health IT platform and a highly trained team. VA's future health IT platform will perform the following functions: maintenance of a care plan; a user-friendly interface for Veterans and caregivers to see their information; and an accurate, timely information for providers. Needs will be tracked in the care plan and will include social and behavioral determinants of health. Patient-facing and telehealth technologies will allow Veterans to update their health and needs status in addition to the ability to view their health data and care plan. Providers will use VA's medical records exchange to support health



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information transactions and care teams will use the platform to support Veterans in their health care experience. Through team management, aspects of patient navigation, care management, and case management can address short-term issues or issues over extended periods of time.

In addition to individual Veterans and their care teams, information and coordination can also support population management. Population management is a data-driven process for proactively defining a cohort of patients who might benefit from a health care plan or intervention aimed at primary or secondary prevention. This allows care teams to offer the right service to the right Veteran at the right time.

## Care Coordination Relationships

The relationship between a Veteran and their primary care team is the foundation of high-quality health care. Veterans will access care coordination differently based on where they choose to receive their primary care. Veterans with a VA PCP will have the support of the Patient-Aligned Care Team (PACT), VA's patient-centered medical home, to deliver basic care coordination/patient navigation. Veterans with a community PCP will have basic care coordination/patient navigation through their PCP's associated care team. As team-based care models mature and the New VCP evolves, VA will increasingly partner with community PCPs who have adopted patient-centered medical home models. All Veterans, whether they have a VA or community PCP, will have access to VA support, as needed, and to disease and care management programs. Figure 3 outlines two scenarios of how PCPs and Veterans will partner for care coordination relationships.

Veteran's PCP Choice	Care Coordination Experience
 <p data-bbox="397 1228 573 1283">Veteran with VA PCP</p>	<p data-bbox="597 1228 1419 1283">Veterans partner with their VA PCP to manage and coordinate care. Veterans can access care management and case management services offered by VA.</p>
 <p data-bbox="397 1354 573 1409">Veteran with Community PCP</p>	<p data-bbox="597 1333 1419 1430">Veterans who choose to have a community PCP through the network will work with their PCP team for care coordination. The Veteran and their PCP can receive support from the VA call center as needed. The Veteran also may choose to use disease and care management programs offered at VA.</p>

*Figure 3: Care Coordination Experience Based on Veteran's PCP Choice*

Using a system of systems approach, VA will ensure care coordination is a seamless and effective tool for Veterans and their families, VA, and community providers to create a positive health care experience.



### 3.4 Alignment with MyVA

The MyVA Transformation Plan will modernize VA's culture, processes, and capabilities in order to put the needs, expectations, and interests of Veterans first. It will improve the Veteran experience by empowering employees to deliver excellent customer service, improving or eliminating processes that impede customer service, and rethinking how to become more Veteran centric.<sup>11</sup> The five priorities of MyVA align directly with the components of the New VCP.

#### MyVA Priorities

- Improving the Veteran Experience
- Improving the Employee Experience to Better Serve Veterans
- Increasing Internal Support Services
- Establishing a Culture of Continuous Improvement
- Enhancing Strategic Partnerships

**Improving the Veteran Experience.** VA exists to serve Veterans. The service provided to Veterans should be world class and leave

Veterans satisfied with their experience, including the care they receive, the manner in which they receive it, and the ease of understanding that care. In designing the future of VA health care, emphasis will be put on understanding how Veterans experience their care, at VA or in the community, and how it can be improved to achieve health outcomes. The New VCP will have dedicated customer service representatives with information to help Veterans access care, high-quality care coordination to help Veterans navigate transitions between providers and services, and access to a high-performing network of providers.

**Improving the Employee Experience to Better Serve Veterans.** Providing VA employees with easy access to information and tools that will better equip them to answer Veterans' questions and consistently provide correct information. Automation of many business processes and removal of unnecessary steps will allow employees to focus on Veterans' needs rather than manual tasks. Formalized training programs will ensure employees have the right knowledge of the New VCP to support Veterans and providers.

**Improving Internal Support Services.** Foundational process improvements also will be made to internal support services. Referrals, authorizations, and claims will be processed efficiently and transparently by appropriate experts within VA, reducing administrative burden and allowing VA staff to focus on health care delivery. Call centers for Veterans and community providers will be available along with a provider health information gateway for efficient information exchange.

**Establishing a Culture of Continuous Improvement.** Maintaining a culture of continuous improvement will save time for VA staff and facilitate more rapid access to

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<sup>7</sup> VA Announces Single Regional Framework under MyVA Initiative, January 26, 2015 (<http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2672>)

care and improve the experience of Veterans. This culture is key to a system of systems approach and will require VA to simplify processes and reduce waste. Data analytics are required for this type of improvement, such as identification of the highest performing community providers or outreach to Veterans who would benefit from higher intensity care coordination. Continuous improvement aligns VA with health plan best practices and will be necessary for ongoing PPA compliance.

**Enhancing Strategic Partnerships.** Enhancing strategic partnerships will allow VA to provide higher-quality care to Veterans and better manage costs. VA will continue to strengthen relationships with: DoD, IHS, THP, FQHC, and academic teaching affiliates. VA will also identify and engage high-quality community providers in an external network to provide Veterans with the best possible health care. Finally, VA will work with CMS and Accountable Care Organizations (ACOs) to evolve toward value-based care models. This will support VA's high-performing network.

### **3.5 Impact to Veterans, Community Providers, and VA**

The design of the future VA health care delivery system, including the New VCP, is intended to advance Veterans' well-being and support their caregivers, community providers, and VA, as a whole, through improvements in clinical care, business processes, and customer service.

**Impact to Veterans.** Veterans should have access to the best care anywhere through a high-performing network that preserves a Veteran's choice in choosing community providers. Access to emergency treatment will be expanded and Urgent Care needs will be addressed. VA will actively engage Veterans, their families, and caregivers in their health care choices, providing innovative tools to help Veterans stay healthy and manage chronic conditions, as well as connect with their care team in person or virtually. Enhanced care coordination will improve Veterans' health outcomes and improve health care services received by Veterans. The consolidated community care program will have clear eligibility criteria, streamline referral and authorization processes, make customer support available when needed, and eliminate ambiguity around eligibility and personal financial obligations for care. While providing clarity, eligibility criteria will also be flexible enough to respond to unique needs of Veterans, such as excessive burden in travelling to a VA facility or the clinical need to be seen by a provider in a timeline that is shorter than the VA wait-time standard for a particular service. Veteran eligibility for community care will be evaluated over time depending on health care innovations and changes to the Veteran population, such as the increasing number of women Veterans.

**Impact to Community Providers.** With the enhancements of the New VCP, community providers will want to work with VA. A single, efficient referral process will reduce confusion in care transitions and expedite the process of getting Veterans the care they need. Increasing health IT adoption and interoperability standards will provide

easy access to clinical information, simplifying care coordination between VA and community providers. The New VCP focuses on operational efficiencies, including standardized billing and reimbursement, and geographically adjusted fee schedules tied to Medicare, as appropriate, to make it easier and more appealing for community providers to work with VA. Additionally, improvements in how VA processes claims will enable VA to reimburse community providers in a timely fashion. VA's purchasing power for supplies, such as pharmacy and durable medical equipment (DME), will allow community providers easy access to items critical to Veterans' care, reducing their administrative burden.

The New VCP will allow VA to establish clear and straightforward participation agreements with community providers, which will have a positive impact on the number of providers joining the network. Increasing the number of providers in the network should ultimately improve access, decrease wait-times. Over time, VA will work with community providers on value-based payment models to provide the highest quality care to Veterans.

**Impact to VA.** The New VCP will allow VA to resolve issues in the current Veterans Choice Program and strengthen internal capabilities for the future state of VA health care delivery. VA plans to consolidate multiple community care programs into a single, simplified program with clear guidelines, infrastructure, and processes. VA will work to improve business processes that support clear and consistent Veteran and provider eligibility, referral and authorization, billing and reimbursement, provider reimbursement rates, PPA compliance, medical records management, and care coordination. VA should see an increase in efficiency and processing speed through claims auto adjudication that will minimize errors due to manual processing.

### **3.6 Implementation Dependencies and Requirements**

Achieving the enhancements discussed above and arriving at the future state of VA health care will not happen overnight. Without the necessary resources, authorities, and legislation, the New VCP will not succeed. The transformative changes set forth in this plan will require an investment of time and resources to enable Veterans to effectively access community care. VA will need the ability to evaluate its physical footprint to support appropriate resource allocation. In addition, funding and budgetary relief is requested to supplement the capital investment required to build and enhance existing systems; details are included in the cost and budget portion of this report (*Section 5*). VA also requires the necessary authorities to consolidate its programs and design the system of systems that will be the future of VA health care delivery. Specific legislative proposal recommendations are included in this report (*Section 6*). VA will work closely with members of Congress and their staff on legislation to establish the New VCP and welcomes discussion on how these changes will affect Veterans.

## 4.0 Plan to Consolidate Community Care Programs

### 4.1 Element 1: Single Program for Non-Department Care Delivery

#### Legislation

“A standardized method to furnish such care and services that incorporates the strengths of the non-Department provider programs into a single streamlined program that the Secretary administers uniformly in each Veterans Integrated Service Network (VISN) and throughout the medical system of the VHA.”

#### Summary

In order to provide Veterans with more intuitive, convenient, and timely access to community care, VA plans to consolidate and simplify methods for purchasing care under a single program called the New VCP. This change responds directly to the recommendation to “streamline programs for providing access to purchased care and use them strategically to maximize access” contained in the Independent Assessment Report.<sup>12</sup>

#### Key Activities

- Consolidate existing community care programs
- Create a governance structure to integrate community care with VA provided care at the local and national level
- Use a system of systems approach to design the future state

VA considered the larger VA health care system and the environment of health care as a whole when consolidating community care programs. The New VCP will have a single set of eligibility criteria for Veterans seeking community care. This program will also improve the Veteran experience by providing a level of care coordination that meets the needs of the individual Veteran. It will establish a high-performing provider network, structured with tiers that will allow VA to preserve existing relationships with Federally funded partners and academic teaching affiliates, while increasing access to high-quality community providers. It will also implement a consistent approach for accessing care (referrals and authorizations), sharing medical information, and processing provider payment (claims). Over time, existing mechanisms for purchasing care will either be folded into the New VCP or phased out.

To support a consistent and positive Veteran experience, VA plans to implement a streamlined system of systems approach for the New VCP that will be integrated with the VA's internal health care system. The component systems for the New VCP are: 1) Integrated Customer Service Systems, 2) Integrated Care Coordination Systems, 3) Integrated Administrative Systems (Eligibility, Patient Referral, Authorizations, Billing, and Reimbursement), 4) High-Performing Network Systems, and 5) Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting).

<sup>12</sup> Independent Assessment Report Section B. Health Care Capabilities

This program represents a significant organizational change for VA. It will require detailed planning, system and process redesign, and implementation, as well as action by Congress. Accordingly, VA has developed a transition plan that will be implemented over three phases (see *Legislative Element 10—Transition Plan*). This phased approach will allow VA to make necessary changes to meet the care needs of Veterans in the short term, while simultaneously designing and implementing an integrated system that supports the long-term vision for VA health care.

Programs, such as the Civilian Health and Medical Program of the VA (CHAMPVA), Camp Lejeune Family Member Program, Spina Bifida Health Care Benefits Program, Children of Women Vietnam Veterans (CWVV) Health Care Program, and the Foreign Medical Program (FMP), will continue to exist as they do today because their eligible populations do not typically receive care at VA facilities and foreign care requires a specialized set of administrative processes. VA will, however, use standardized systems established for the New VCP to promote operational efficiency for all community care programs.

## Background

Historically, to meet the evolving needs of Veterans, additional methods for purchasing non-VA care were created rather than augmenting or enhancing existing programs. These methods typically served a specific population (e.g., Project Access Received Closer to Home (ARCH) to meet geographic access challenges) or responded to a specific need in the population (e.g., Dialysis Contracts). Many of these methods have overlapping or inconsistent eligibility criteria, employ multiple processes for the same activity (e.g., claims management), and implement varying reimbursement models. These fragmented methods create a community care experience for Veterans that is not consistent or well integrated with the larger VA health care system.

### Representative Community Care Programs for Veterans will be consolidated into the New VCP

- Veterans Choice Program
- Patient-Centered Community Care (PC3)
- Project ARCH
- “Fee Basis” Care
- Dialysis Contracts
- Retail Pharmacy Network Contracts
- Emergency Care (38 U.S.C. Sections 1703, 1725, and 1728)
- Federally funded partners (DoD, IHS, THP, FQHC) and academic teaching affiliates

This approach is also inconsistent with best practices in other Federal programs and private industry for purchasing community care. A best practice is to design a single, adaptable product for each population (e.g., the employees of a large company), while establishing a flexible operational foundation for consistent product delivery across patient populations and provider networks.

## Current State

VA has a number of statutory authorities, programs, and other methods for purchasing community care, as outlined in the *Descriptions of Each Non-Department Provider Program and Authority* section of this report. As mentioned above, the various methods for receiving community care have conflicting structures, responsibilities, ownership, and management, with different application at the local and national levels. This leads to inconsistencies in their use and implementation across facilities, from Veteran to Veteran, and from one episode of care to another. Ultimately, the multiple methods and overlapping roles, responsibilities, and processes lead to inefficient execution and significant confusion among Veterans, community providers, VA providers, and staff. In addition, many of these methods have differing requirements and processes for key components, including, but not limited to, eligibility criteria and eligibility determinations; referrals and authorizations; provider credentialing and network development; care coordination (including medical records management); reimbursable out-of-pocket expenses (e.g., urgent/emergent outpatient prescriptions); and claims management. This challenge is exacerbated by the inconsistent level of customer service available to Veterans and community providers, creating difficulties in resolving inquiries, appeals, and grievances. Finally, it is difficult to evaluate which programs are operating well because performance data is not consistently collected.

## Future State

The New VCP plans to consolidate existing methods for community care into a single, efficient program integrated into the broader context of VA's health care system. A Veteran-centric design will provide straightforward eligibility criteria and a single set of clinical and administrative systems and processes, allowing Veterans' choice in providers and effective care coordination. This addresses the Independent Assessment Report recommendation that "VA and Congress should eliminate inconsistencies in current authorities and provide VA with more flexibility to implement a purchased care strategy."<sup>13</sup> The New VCP will honor VA's special relationships with strategic partners, such as DoD, IHS, THP, FQHC, and academic teaching affiliates.

The Program also will involve the design and implementation of the five component systems that will integrate into the system of systems for the New VCP. The component systems of the New VCP are 1) Integrated Customer Service Systems, 2) Integrated Care Coordination Systems, 3) Integrated Administrative Systems (Eligibility, Patient Referral, Authorization, and Billing and Reimbursement), 4) High-Performing Network Systems, and 5) Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting). This section provides a high-level description of the consolidation of existing methods for purchasing community care as well as each of the component systems and processes for the New VCP. Additional details on many aspects of the program are contained later in this report.

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<sup>13</sup> Independent Assessment Report Section C. Care Authorities



### ***Consolidation of Existing Methods for Purchasing Community Care***

Some existing methods for purchasing Veteran community care will be phased out, while other methods, particularly those that provide VA with access to provider networks and special partnerships (e.g., federally funded and academic teaching affiliates) will continue in the New VCP. Consolidating these methods under a single program will enable a seamless experience for Veterans and community providers. In the short term, VA will preserve the ability to execute ‘one-time’ referrals when a network provider is not available using provider agreements as described in the *Legislative Proposal Recommendations* section of this report. However, these referrals will decrease over time as VA’s provider networks become more robust.

Agreements with Federal and federally funded partners and with academic teaching affiliates will continue to form a key component of the VA provider network, but agreements will become more standardized, with a focus on continuity and quality of care. The consolidated Program aims to expand emergency treatment (currently provided through 38 U.S. Code (U.S.C.) Section 1703, 38 U.S.C. Section 1725, and 38 U.S.C. Section 1728) and remove certain requirements in order to limit the denial of emergency treatment claims (see *Legislative Element 2—Patient Eligibility Requirements*). Programs executed through contract (e.g., Patient-Centered Community Care (PC3), Project ARCH, and Dialysis) may be renewed, modified, phased out, or replaced in accordance with the provider network strategy for the New VCP. This addresses the Independent Assessment Report recommendation to “Develop a long-term comprehensive plan for provision of and payment for non-VA health care services.”<sup>14</sup>

### ***System of Systems for the New VCP***

In addition to streamlining systems for purchasing community care, the New VCP will form an integrated component of the future system of systems that will support the delivery of high-quality care and a consistent Veteran experience inside and outside of VA facilities. The system of systems that will support the New VCP is illustrated in Figure 4. The VA care delivery process that informs the system structure was developed by considering the Veteran journey and desired Veteran experience in the context of the five focus areas of this report (Veterans We Serve (Eligibility), Access to Community Care (Referral and Authorization), High-Performing Network, Care Coordination, and Provider Payment (Claims)). The requirements necessary to support the desired Veteran experience were then grouped into a set of supporting systems and processes. The VA system of systems that will support the New VCP will enable a seamless care delivery experience, regardless of where care is provided.

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<sup>14</sup> Independent Assessment Report Section I. Business Processes

## Plan to Consolidate Community Care Programs

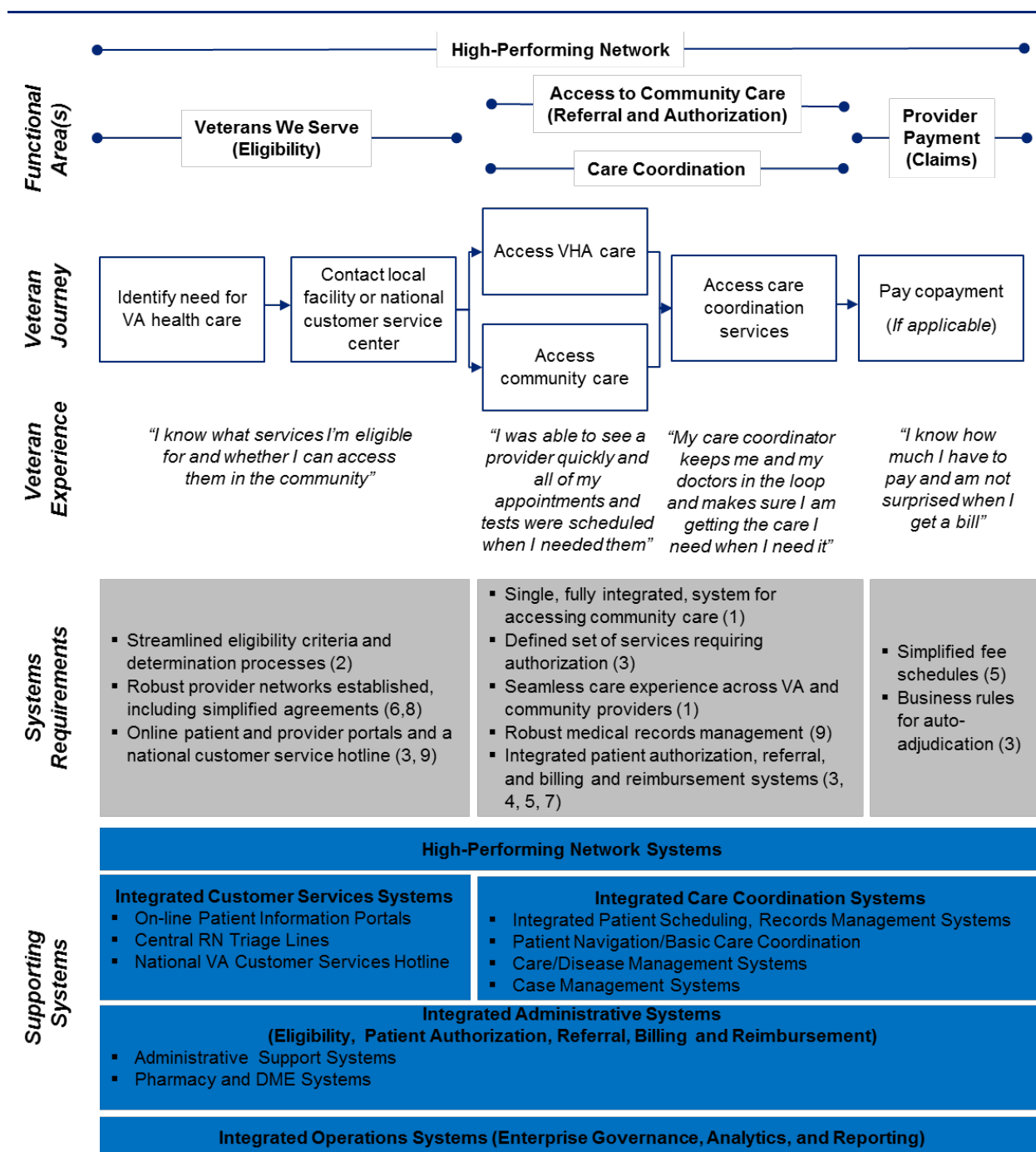


Figure 4: System of Systems Approach for the New VCP

Additional details on the component requirements and processes for these systems are contained within this report. The system of systems approach will enable Veterans and community providers to have a clear understanding of how community care is accessed; how payments are processed; what documentation is required; and where to go with inquiries, appeals, and grievances. It will also allow for the collection and



analysis of outcome-focused quality of care and performance metrics to support leadership reporting and process improvement.

### ***Integrated Customer Service Systems***

The New VCP will offer standardized customer service systems to address inquiries, appeals, and grievances from Veterans and community providers. These systems will be a part of the MyVA customer service infrastructure to enable a seamless Veteran experience across VA. The customer service systems necessary to support the New VCP will require properly resourced customer service centers with appropriate training to handle and resolve inquiries from Veterans and community providers (e.g., eligibility determinations, covered services). It will also require escalation processes for timely resolution of issues that cannot be addressed by front-line staff, through a formal appeal process for authorizations and/or claims payment focused on timely issue resolution. In addition to traditional telephonic customer service, the program will implement multichannel options for accessing customer service, including a web-based portal, email, and self-service. This will allow Veterans and community providers to interact with VA in the manner and time of their choice.

### ***Integrated Care Coordination Systems***

Effective care coordination is critical to enabling a Veteran-centric care experience and supporting positive health outcomes through clear continuity of care and appropriate care and disease management. The New VCP defines a clear process for transfer of medical documentation between VA and community providers when Veterans are referred into the community (see *Legislative Element 9—Medical Records Management*). The program also will establish objectives, roles, and processes for care coordination to enable a smooth Veteran experience across VA and community providers. The care coordination process for the New VCP will be centered on Veterans' relationships with their PCPs. The PCP and supporting coordinator staff, whether at a VA facility or in the community, will assist Veterans with basic care coordination and patient navigation regarding scheduling appointments and seeking appropriate follow-up care. Veterans receiving care from community PCPs that do not have the capacity or capability to provide required coordination will be able to rely on VA for those services. For Veterans requiring more robust care coordination, regardless of whether they see a VA or community PCP, VA also will provide programs for care and disease management and case management, as appropriate. This model will integrate with and utilize established and evolving care coordination models at VA, such as PACT.

### ***Integrated Administrative Systems (Eligibility, Patient Referral, Authorizations, and Billing and Reimbursement)***

The New VCP will establish a single set of eligibility criteria for Veteran community care with a focus on providing access to care while allowing Veterans a choice in the

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providers they wish to see (see *Legislative Element 2—Patient Eligibility Requirements*). The New VCP also establishes a single streamlined process for referrals and care authorizations and will define a select list of services requiring prior authorization (see *Legislative Element 3—Authorization Process*). The Program will implement a claims solution to accurately and efficiently adjudicate all claims for community care, based on a simplified reimbursement rates and value-based payments (see *Legislative Element 4—Billing and Reimbursement Process*, *Legislative Element 5—Provider Reimbursement Rate*, and *Legislative Element 7—Prompt Payment Compliance*). The New VCP also will provide more convenient access to pharmacy services and DME while preserving VA's favorable, volume-driven rates for these services. It will also include partnering with a retail pharmacy network to support convenient access for "urgent/emergent fill" prescriptions. The revised processes will preserve VA's volume-driven buying power while providing these services in a more intuitive and convenient way for Veterans and community providers.

### ***High-Performing Network Systems***

The New VCP defines a clear strategy for identifying and credentialing community providers to create a high-performing community network. This network will provide Veterans with the tools and information necessary to choose a high-quality provider that is right for their health care needs. The network will have a tiered structure with a core tier, including established Federally funded partners (DoD, IHS, THP, FQHC) and academic teaching affiliates. It will also identify Preferred providers based on quality, value and a compact to serve Veterans. Finally, network management systems will include quality and value of care metrics that will support consistent evaluation and refinement of the New VCP network (see *Legislative Element 6—Plan to Develop Provider Eligibility Requirements*).

### ***Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting)***

The New VCP will be managed by a new DUSH for Community Care who will be designated to administer VA's community care program. Establishing national management of and accountability for the program, with the right leadership structures and resources, will support a consistent experience with the New VCP across facilities. Similarly, leadership and management structures for community care will be standardized locally within facilities to support consistent implementation and management of the program. This addresses the Independent Assessment Report recommendation that "VA should develop a stronger program management structure for purchased care and allocate responsibility and authority to the most appropriate levels."<sup>15</sup>

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<sup>15</sup> Independent Assessment Report Section C. Care Authorities

In order to provide VA and Congressional leadership with visibility into the performance of the New VCP, VA will implement a consistent reporting process across facilities, using best practices for metrics, data collection, and reporting. Wherever possible, metrics will be consistent with industry and other Federal agencies to allow VA to benchmark quality of care and program performance against peer organizations. Metrics will include outcomes related to Veterans' access to care, utilization of care, the quality and value of care, and Veteran and community provider satisfaction with the program. Metrics will provide VA with the information necessary to improve care and health outcomes for individuals (e.g., using claims and medical records data to identify conditions requiring disease management), which will show the Program's impact on Veterans. This aspect of the New VCP also responds to the recommendation that "VA should collect better data to accurately estimate the demand for and use of purchased care" from the Independent Assessment Report.<sup>16</sup>

**Risks and Implementation Considerations:** Refer to the *Transition Plan (Legislative Element 10)* section of this report.

## Impact

*Table 1: Impact of the Single Program for Non-Department Care Delivery*

Stakeholder	Potential Impact
<b>Veteran</b>	The New VCP creates an efficient, intuitive, and Veteran-centric experience for community care through streamlined eligibility criteria and administrative and clinical processes. There will be less confusion for Veterans as to when and how they can access community care.
<b>Community Provider</b>	The New VCP will simplify and standardize community providers' interaction with VA. Streamlined processes for referrals and authorizations, exchange of medical records and care coordination, and claims submission and reimbursement consistent with best practices should increase providers' willingness to participate in the VA network.
<b>VA</b>	Consolidating existing community care programs into the New VCP will reduce confusion among VA providers and staff about when and how to use community care. It should also greatly improve VA's community care operations, allowing VA to focus on providing excellent care and service to Veterans.

<sup>16</sup> Independent Assessment Report Section C. Care Authorities

## 4.2 Element 2: Patient Eligibility Requirements

### Legislation

“An identification of the eligibility requirements for any such care and services, including with respect to service-connected [(SC)] disabilities and non-SC disabilities.”

### Summary

Currently, overlapping eligibility criteria for different methods of accessing community care creates confusion among Veterans, community providers, and VA staff. Eligibility to enroll in and access VA's health care system will not change with the New VCP. However, the New VCP defines a single set of eligibility requirements for the circumstances under which Veterans may choose to receive health benefits from community providers. This will enable timely and convenient access to care in alignment with best practices.

#### Key Activities

- Create a single, consistent set of eligibility requirements
- Expand and simplify access to emergency treatment and urgent care

### Background

Current eligibility creates confusion due to multiple, overlapping criteria for each different method of purchasing care. The New VCP will reduce confusion by standardizing requirements across facilities regarding when a Veteran may choose to receive community care, while still providing local flexibility to respond to unique needs of Veterans (e.g., local services, geography, and undue burden). The need for simplifying eligibility criteria directly addresses the recommendation to “Streamline programs for providing access to purchased care and use them strategically to maximize access.” outlined in the Independent Assessment Report<sup>17</sup> The eligibility criteria will be grouped into the following categories:

- **Hospital Care and Medical Services:** Patient eligibility criteria for the New VCP will provide Veterans with timely and convenient access to care based on wait-times, distance to a VA PCP, or availability of services.
- **Emergency Treatment and Urgent Care:** Eligibility criteria will increase access to these services and simplify access rules to prevent the denial of claims for the appropriate use of these services.
- **Outpatient medication and DME; extended care services:** Eligibility criteria will not be altered in this report, as any adjustment would constitute a fundamental change to the VA health benefit.

VA compared the current eligibility criteria for purchasing community care to commercial health plans and Federal program approaches to develop the New VCP criteria. A number of findings from this review informed design of the patient eligibility criteria for the New VCP.

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<sup>17</sup> Independent Assessment Report Section B: Health Care Capabilities

### ***Eligibility for VA Health Benefit and Eligibility for Community Care***

Eligibility for community care is independent of eligibility to enroll in VA health benefits. A Veteran must be eligible for and enrolled in the VA health benefit before VA will evaluate the Veteran for eligibility for community care. Eligibility for enrollment in the VA health benefit is based on level of SC disability, other special attributes (e.g., winners of the Medal of Honor and former Prisoners of War), and income. These characteristics determine a Veteran's enrollment priority group. Enrollment priority groups range from 1 to 8, with 1 being the highest priority. All enrolled Veterans enjoy access to VA's comprehensive medical benefits package; however, some benefits (e.g., dental care) have additional statutory eligibility requirements. After a Veteran is enrolled in VA health care, the criteria for VA's various methods for purchasing care in the community then can be applied to determine when a Veteran may receive his or her health benefits outside of a VA facility.

### ***Unique Considerations for VA***

There are a number of factors that make VA unique compared to commercial health plans.

- **Coverage** – VA is required to provide coverage to Veterans in areas where VA does not have physical facilities or an established provider network. Commercial health plans generally do not offer products where they cannot meet coverage requirements.
- **Other Health Insurance (OHI)** – Approximately 78 percent of Veterans have OHI and only rely on VA for certain services (e.g., hearing aids and eyeglasses). Changing the services Veterans are eligible to receive in the community or what they pay for those services could affect Veteran's reliance on VA versus OHI, including TRICARE, Medicare, and Medicaid.
- **Teaching and Research Missions** – In addition to providing high-quality care to men and women Veterans, VA has research and education missions critical to the VA system and the nation as a whole. In 2014, VA supported 2,224 medical and prosthetic research projects totaling \$586M in research investment<sup>18</sup> and provided clinical training to 41,223 medical residents, 22,931 medical students, 311 Advanced Fellows, and 1,398 dental residents and dental students<sup>19</sup>. In addition, many Veterans value participation in VA training and research and consider them to be an important part of the VA care experience. Over time, decreasing utilization of VA facilities may jeopardize VA's ability to deliver on these missions.

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<sup>18</sup> Source: Veterans Health Administration, Office of Research and Development

<sup>19</sup> Source: Veterans Health Administration, Office of Academic Affiliations

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## Current State

VA has multiple sets of eligibility criteria for the various authorities and methods of purchasing community care. Several of these criteria overlap, creating confusion among Veterans, community providers, and VA staff and providers. Broadly, these criteria have focused on providing surge capacity and have been grouped into three categories:

1. **Wait-Times for Care:** VA was not able to provide the service within an acceptable time frame, based on medical need.
2. **Geographic Access/Distance:** A VA facility was not available within an acceptable travel distance of the Veteran's home.
3. **Availability of Service:** A facility in the local VA network either did not provide the required service or there was a compelling reason why the Veteran needed to receive care from a community provider.

Additionally, eligibility varies by the category of care (hospital care and medical services; emergency treatment; extended care; outpatient medication; and DME):

## Hospital Care and Medical Services

Community care eligibility for Hospital Care and Medical Services, including Dentistry, is the primary source of Veterans' confusion. Table 2 highlights the overlaps caused by the presence of several methods for purchasing care.

*Table 2: Current-State Eligibility Criteria—Hospital Care, Medical Services, and Dentistry*

Eligibility Category	Specific Criteria	Example of Methods Using the Criteria
Wait-Times for Care	An appointment cannot be scheduled within the wait-time goals for VA to provide the service or within the clinically necessary time frame indicated by the provider if that time frame is less than the wait-time goals of VA.	<ul style="list-style-type: none"> <li>▪ Veterans Choice Program</li> </ul>
	A facility determines that service cannot be provided within an acceptable wait-time.	<ul style="list-style-type: none"> <li>▪ PC3</li> <li>▪ Individual authorizations</li> <li>▪ Federally funded partnerships</li> <li>▪ Academic teaching affiliates</li> </ul>
Geographic Access/ Distance	<p>The Veteran lives &gt;40 miles driving distance from the closest VA facility with a full-time primary care physician</p> <p><u>OR</u></p> <p>The Veteran faces an excessive burden in accessing a VA facility, including:</p> <ul style="list-style-type: none"> <li>▪ Geographical challenges</li> <li>▪ Environmental factors</li> <li>▪ Medical conditions that affect travel</li> </ul>	<ul style="list-style-type: none"> <li>▪ Veterans Choice Program</li> </ul>

Eligibility Category	Specific Criteria	Example of Methods Using the Criteria
	<ul style="list-style-type: none"> <li>Other factors (nature of care, frequency of care, and need for an attendant)</li> </ul>	
	A facility determines that service cannot be provided within an acceptable geographic distance.	<ul style="list-style-type: none"> <li>PC3</li> <li>Individual authorizations</li> </ul>
	Veteran lives more than 60 minutes' driving time from nearest VA health facility (primary care), 120 minutes (acute hospital care), or 240 minutes (tertiary care).	<ul style="list-style-type: none"> <li>Project ARCH</li> </ul>
Availability of Service	<p>A facility determines that service cannot be provided internally because the facility does not provide the service or has chosen to 'buy service' from the community.</p> <p><u>OR</u></p> <p>A facility determine there is a compelling reason why a Veteran needs to receive care from a community provider.</p>	<ul style="list-style-type: none"> <li>PC3</li> <li>Individual authorizations</li> <li>Federally funded partnerships</li> <li>Academic teaching affiliates</li> <li>Dialysis Contracts</li> </ul>

## Emergency Treatment

Currently, a Veteran is eligible to receive emergency treatment through community care by authority of 38 U.S.C. Section 1703, 38 U.S.C. Section 1725, and 38 U.S.C. Section 1728. Eligibility for emergency treatment varies by authority. Table 3 outlines the current-state eligibility criteria for emergency treatment.

*Table 3: Current-State Eligibility Criteria—Emergency Treatment*

Authority	Specific Criteria
38 U.S.C. Section 1728	<p>It is determined that the care needed met the definition of emergency treatment under 38 U.S.C. Section 1725(f)(1)</p> <p><u>AND</u></p> <p>The Veteran was receiving care for an SC condition or a non-SC condition is held to be aggravating an SC condition, or the Veteran is permanently and totally disabled, or in certain instances when the Veteran is participating in a vocational rehabilitation program under 38 U.S.C. Chapter 31</p> <p><u>AND</u></p> <p>The claim is filed within two years of the date of service</p>
38 U.S.C. Section 1725	<p>It is determined that the care needed met the definition of emergency treatment under 38 U.S.C. Section 1725(f)(1)</p> <p><u>AND</u></p> <p>The emergency services were provided in a hospital emergency department or similar facility held out as a providing emergency care to the public</p> <p><u>AND</u></p> <p>The Veteran is enrolled for VA health care</p> <p><u>AND</u></p> <p>The Veteran has received care from VA in the 24 months prior to the receipt of the emergency care</p> <p><u>AND</u></p> <p>The Veteran is personally liable for the payment for the care</p>



Authority	Specific Criteria
	<p><u>AND</u> The Veteran is not eligible for reimbursement under 38 U.S.C. Section 1728</p> <p><u>AND</u> The claim was filed within 90 days of the date of service</p>
38 U.S.C. Section 1703	<p>VA was notified within 72 hours of the episode of care</p> <p><u>OR</u> The Veteran was referred by VA to a community emergency room (ER) from a VA facility or nursing home</p>

*Note: “Prudent Layperson” Definition of Emergency. “When such care or services are rendered in a medical emergency of such nature that a prudent layperson reasonably expects that delay in seeking immediate medical attention would be hazardous to life or health.”<sup>20</sup>*

Since determination of these claims is nuanced, and unclear for Veterans, there are a large number of denied claims. When denied, the financial responsibility for these claims, which can be substantial, often falls on Veterans or their OHI, resulting in unanticipated financial challenges for Veterans. As an example, between the beginning of FY 2014 and August 2015, approximately:

- 89,000 claims were denied because they did not meet the timely filing requirement.
- 140,000 claims were denied because a VA facility was determined to have been available.
- 320,000 claims were denied because the Veteran was determined to have OHI that should have paid for the care.
- 98,000 claims were denied because the condition was determined not to be an emergency.<sup>21</sup>

In FY 2014, approximately 30 percent of the 2.9M emergency treatment claims filed with VA were denied, amounting to \$2.6B in billed charges that reverted to Veterans and their OHI. Many of these denials are the result of inconsistent application of the “prudent layperson” standard from claim to claim and confusion among Veterans about when they are eligible to receive emergency treatment through community care. Additionally, VA is not authorized to reimburse Veterans for urgent care, which is typically lower cost than emergency treatment, and encourages health care in the appropriate setting.

### ***Extended Care***

VA provides extended care through community providers via a number of different mechanisms. It is out of the scope of this effort to adjust the eligibility criteria for

<sup>20</sup> Source: 38 U.S.C. § 1725(f)(1)(B)

<sup>21</sup> Source: VHA Chief Business Office, Office of Informatics

extended care, as any change would constitute a fundamental change to the VA health benefits package.

### ***Outpatient Medication and DME***

In order to take advantage of favorable rates for outpatient medication and DME, VA currently requires Veterans to receive these services through VA facilities in most cases. The primary exception to this requirement is urgent prescription fills when a VA pharmacy is not available. However, VA currently does not have a national contract for a retail pharmacy network to provide these services. Currently, Veterans must pay for medications out of pocket and then seek reimbursement from VA.

### **Future State**

The New VCP does not make changes to the VA health benefit or eligibility requirements for enrollment in VA health care. The Program will give Veterans who are eligible for community care the choice to access some or all of their health benefits in the community, when the medically needed care is not conveniently available in a VA facility.

The objective of the New VCP is to create a set of criteria that are simple and intuitive for Veterans, community providers, and VA staff. This will be accomplished by eliminating the multiple overlapping criteria for accessing Hospital Care and Medical Services, including Dentistry, in the community. The single, nationally defined set of eligibility criteria for the New VCP can be consistently implemented while providing VA facilities the flexibility to respond to unique circumstances, such as excessive burden in traveling to a VA facility or the medically-indicated need to see a provider in a timeline shorter than the VA wait-time standard for a service. In addition, the New VCP includes simple criteria for accessing Emergency Treatment and Urgent Care. This should increase access and reduce denied claims while incentivizing appropriate use of these services.

Eligibility criteria for each category of care are described below.

### ***Hospital Care and Medical Services***

The eligibility criteria for Hospital Care and Medical Services, including Dentistry services, in the community will continue to be focused broadly on wait-times for care, geographic access/distance, and availability of services. The criteria will be streamlined into a single set of rules applied across the VA health care system. To ensure VA meets the unique needs of Veterans, VA will have flexibility at the local level through clarified guidance on exceptions. The process also will include clear appeal and grievance mechanisms for Veterans to dispute eligibility determinations.

When Veterans are determined to be eligible for community care, VA will provide them with information on providers and appointment availability at VA and in the community. This will allow Veterans to choose a convenient appointment from the provider of their choice. The proposed eligibility criteria for Hospital Care and Medical Services are outlined in Table 4.

*Table 4: Future-State Eligibility Criteria—Hospital Care and Medical Services*

Eligibility Criteria	Proposed Criteria Veterans Choice Program Future State
Wait-Times for Care	An appointment cannot be scheduled within VA wait-time goals for providing the service or within the clinically necessary time frame indicated by the provider if that time frame is less than VA wait-time goals
Geographic Access/Distance	The Veteran lives 40 miles or farther driving distance from a PCP as designated by VA <u>OR</u> The Veteran faces excessive burden in accessing care at a VA facility, including: <ul style="list-style-type: none"> <li>• Geographical challenges</li> <li>• Environmental factors</li> <li>• Medical conditions that affect travel</li> <li>• Other factors (nature of care, frequency of care, and need for an attendant)</li> </ul>
Availability of Service	A facility does not provide the service or has chosen to ‘buy’ service from the community <u>OR</u> There is a compelling reason why the Veteran needs to receive the service outside a VA facility (e.g., female victims of MST unable to be seen by a female provider)

The primary change in this proposal is to focus eligibility for geographic access/distance on access to a PCP. PCPs play a critical role in coordinating care and providing preventative care, so convenient access is necessary. Veterans eligible for the New VCP under either of the geographic access/distance criteria will have the option to choose a community PCP. The community PCP could then refer the Veteran to specialty care in the community or at VA as appropriate and authorized by VA. This approach is consistent with best practices, which emphasize providing access to a PCP.

### ***Emergency Treatment and Urgent Care***

Under the New VCP, VA plans to extend access to emergency treatment and urgent care in the community to all eligible Veterans. VA plans to provide Veterans access to urgent care centers. Industry best practice minimizes the denial of emergency treatment claims to avoid discouraging patients from seeking necessary emergency treatment. The New VCP criteria are consistent with this approach, and will focus on a more consistent application of the “prudent layperson” definition of emergency treatment across claims. More consistently applying this definition will also reduce the administrative burden on VA to conduct a nuanced review of each emergency treatment claim. Detailed overviews of Emergency Treatment and Urgent Care eligibility criteria are outlined in Table 5.

*Table 5: Future-State Eligibility Criteria—Emergency Treatment and Urgent Care*

Eligibility Criteria	Proposed Criteria Veterans Choice Program (Future State)
Emergency Treatment	<ol style="list-style-type: none"> <li>1. The Veteran is enrolled in VA health benefits.</li> <li>2. The Veteran has received care through VA within the last 24 months.</li> <li>3. Symptoms satisfy the “prudent layperson” definition of emergency.</li> <li>4. There is no authorization requirement (preservice or post-service) for emergency treatment.</li> </ol>
Urgent Care	<ol style="list-style-type: none"> <li>1. The Veteran is enrolled in the VA.</li> <li>2. The Veteran has received care through VA within the last 24 months.</li> <li>3. Accesses care at a VA designated urgent care center.</li> </ol>

While VA seeks to provide eligible Veterans with increased access to emergency treatment and urgent care in the community, it is important to encourage Veterans to use these services appropriately and not as a substitute for primary care. Consistent with industry best practices, the New VCP will require cost-sharing for emergency treatment and urgent care. This is an important tool to encourage Veterans to utilize their PCPs for most care and seek emergency treatment or urgent care only when necessary. Cost-shares will be waived if the Veteran is admitted from the emergency room or urgent care center or if it represents an undue financial burden to the Veteran.

### ***Extended Care***

No changes are being made to how VA provides extended care in the community. The majority of these services are provided in the community today and changing the eligibility criteria would constitute a fundamental change to the VA health benefit.

### ***Outpatient Medication and DME***

No changes are being made to VA’s approach to provide routine outpatient medication and DME due to the favorable rates available to VA. VA’s evidence-based formulary management system enhances medication safety and cost-effectiveness. However, in the implementation phase, VA will work to establish new processes for coordinating orders between VA facilities and community providers to support convenient access to these services. In the case of non-VA prescribed medications, VA has an approved and funded IT project (Inbound Electronic Prescribing) to streamline this process. Additionally, VA plans to develop requirements for a national retail pharmacy network contract needed to meet its current needs for urgent prescription fills in the community.

**Risks and Implementation Considerations:** Refer to the *Transition Plan (Legislative Element 10)* section of this report.

## Impact

*Table 6: Impact of the Patient Eligibility Requirements*

Stakeholder	Potential Impact
<b>Veteran</b>	The New VCP eligibility criteria will reduce confusion among Veterans about when they are eligible to receive community care and for what services they are eligible. It also will expand access to community care for emergency treatment and urgent care services and limit cases where Veterans are held responsible for a bill for emergency treatment or urgent care because they did not fully understand the criteria for VA coverage. In addition, the New VCP will provide Veterans with increased choice in providers they can see in the community.
<b>Community Provider</b>	Community providers will have a clearer understanding of what services the Veterans they see are eligible to receive under the New VCP.
<b>VA</b>	The New VCP eligibility criteria will provide VA providers and staff with clear, consistent guidance on when Veterans should be referred to the community. They also will reduce confusion about which method to select for purchasing care for a particular Veteran or service and reduce the administrative burden on VA of individually reviewing all emergency treatment claims.

## 4.3 Element 3: Authorizations

### Legislation

“A description of the authorization process for such care or medical services, including with respect to identifying the roles of clinicians, schedulers, any third-party administrators (TPAs), the VA’s Chief Business Office, and any other entity involved in the authorization process.”

### Summary

Currently, VA’s process for referrals and authorizations to coordinate care, manage clinical utilization, and improve health outcomes is largely manual. This causes delays in care and inconsistency in reviews. Best practices call for automation and process improvement for authorization reviews. VA will use a system of systems approach to establish and refine business rules, create a central authorization center, train staff, and implement technologies to support referrals and authorizations. VA will standardize the approach to referrals and authorizations. The business rules and process will be consistent for internal and community provided services. VA intends to benchmark and monitor performance, addressing the Independent Assessment recommendation to “align performance measures to those used by industry, giving VA leadership meaningful comparisons of performance to the private sector.”<sup>22</sup>

#### Key Activities

- Redesign clinical authorization process
- Create centralized authorization function
- Reduce number of services requiring authorization
- Create and collect metrics to monitor effectiveness of new authorization process

### Background

Referrals and authorizations are mechanisms to coordinate and manage community care while managing medical need and cost, as defined in Table 7

*Table 7: Referral and Authorization Definitions*

Key Word	Definition
<b>Referral</b>	A written or electronic transfer of care initiated by a clinician that enables a patient to see another provider for specific care or to receive medical services.
<b>Authorization</b>	A decision that a health care service, treatment plan, prescription drug, or DME is medically necessary.

PCPs play a pivotal role in coordinating care. Referrals enable a Veteran to receive services through another provider. However, certain services, such as purely cosmetic procedures not related to remediation of an underlying health condition, high-cost services, or experimental services, require additional clinical review to confirm necessity

<sup>22</sup> Independent Assessment Report Section I. Business Processes

and consistency with best practices. Referral and authorization processes should be standardized inside and outside VA, and facilitated through automation to enable more proactive Veteran care management. To support effective implementation, the provider network should be routinely educated. To manage disputes, a formal appeals process will be implemented.

### **Current State**

Currently, the referral and authorization process varies by program and whether a Veteran is accessing care due to wait-times or geographic access/distance criteria. All non-emergent services require a referral and administrative documentation. This process is repetitive, time consuming, and lacks clear ownership. Furthermore, a new referral or authorization may need to be generated for services covered within the same episode of care. The current process is variable across VA sites and is carried out by a variety of individuals with multiple roles and varying skill levels. There are no clear performance metrics to evaluate the efficiency of the process. Consequently, there is no clear ownership of the process, making it challenging to track and improve.

### **Future State**

The New VCP will improve the referral process through automation and removal of redundant reviews. A subset of services will require an authorization for the care to be provided based on medical necessity to improve visibility into utilization of these services. For consistency, authorizations will be managed centrally and supported with industry accepted standards and clinical guidelines. This will facilitate the development of performance metrics to continuously evaluate and improve the authorization process, and support improvement in utilization of services for best value for the Veteran.

A call center will be available for questions from Veterans, caregivers, and community providers. A formal, timely appeals process will provide Veterans a clear point of contact for concerns about the status of their authorization.



**Risks and Implementation Considerations:** For additional information, refer to the *Transition Plan (Legislative Element 10)*.

## Impact

*Table 8: Impact of Authorizations*

Stakeholder	Potential Impact
<b>Veteran</b>	Veterans will have timely access to care and a clear understanding of when and where they are eligible for care. When authorization questions arise, there is a clear path for appeals through the call center. Veterans will receive care that is effective and consistent with clinical guidelines and industry practices.
<b>Community Provider</b>	Community providers will benefit from authorization requirements consistent with industry standards and experience a decrease in administrative burden. This will provide more of an incentive to participate in the high-performing network.
<b>VA</b>	VA will benefit from a decreased administrative burden and have a standard process with defined accountability, consistent outcomes, and reduced turnaround times. Central authorization control will enhance VA's visibility into Veterans' needs. The central authorization process will improve staff competency and efficiency.

## 4.4 Element 4: Billing and Reimbursement

### Legislation

“The structuring of the billing and reimbursement process, including the use of third-party medical claims adjudicators or technology that supports automatic adjudication.”

### Summary

The current billing and reimbursement system is a decentralized and highly manual process. A successful billing and reimbursement system auto adjudicates a high percentage of claims to pay providers promptly and correctly. To achieve this, best practices dictate using centralized services and technology, combined with standardized processes and business rules. This addresses the Independent Assessment Report recommendation to “employ industry standard automated solutions to bill claims for VA medical care (revenue) and pay claims for Non-VA Care (payment) to increase collections, to improve payment timeliness and accuracy.”<sup>23</sup> To achieve these improvements, VA will implement new business processes and conduct analyses to determine potential claims solutions.

#### Key Activities

- Introduce automation, including auto adjudication, to billing and reimbursement processes
- Create and collect metrics to monitor effectiveness of billing and reimbursement processes

### Background

Efficient adjudication is the key to effective billing and reimbursement processes. High-performing networks invest in centralized, scalable auto adjudication technology platforms and use simplified product and reimbursement rules to facilitate high levels of auto adjudication. This enables automation of most claims and only requires review of claims in question, reducing delays in payment. While this type of technology investment will have significant up-front costs, efficiency gains, savings, and additional key analytic capabilities will be generated once the solution is complete.

Auto adjudication of claims is made possible by establishing standard rules and processes, and integrating with complete patient and provider data. Systems interoperability allow for flexibility, enabling organizations to quickly respond to regulatory and best practice changes. Modern claims platforms can model care outcomes, and identify fraud, waste, and abuse through data analytics. Industry standards do not require the receipt of medical records for payment. VA does have this requirement, which often causes delays in payment. As VA improves claims processing, VA will no longer require medical records for reimbursement. VA will strive to improve the automation of systems to process medical records and conduct

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<sup>23</sup> Independent Assessment Report Section I. Business Processes

retrospective audits to confirm their receipt and develop lessons learned to support continuous improvement.

## **Current State**

The current VA claims infrastructure and claims process are complex and inefficient due to highly manual procedures, and VA lacks a centralized data repository to support auto adjudication.

There are more than 70 centers processing claims across 30 different claims systems, resulting in inconsistent processes. Limited automation and manual matching of claims to authorizations prevents efficient adjudication. Low electronic data interchange (EDI) claims submission rates, decentralized and inconsistent intake processes, and limited staff productivity standards (i.e., workload metrics) result in labor-intensive, paper-based processes that generate late, and sometimes incorrect payments.

## **Future State**

VA will pursue a claims solution and simplified processes as it evolves to achieve parity with best practices. VA will focus on:

- Standardizing business rules and logic to support claims processing.
- Improving reimbursement processes by removing the requirement for medical records returns with claims submission for payment.
- Implementing productivity standards to better manage supply and demand (claims adjudicators).
- Improving interfaces and coordination with dependent systems (e.g., Eligibility).
- Implementing reimbursement models to recognize and promote Connected Health activities, such as outreach to Veterans for self-help, health promotion and secondary prevention, telehealth, team-based care, and Veteran education.

In the long term, VA will use a scalable, flexible claims platform that supports emerging value-based care models, and streamlines data maintenance, storage, and retrieval. This new claims solution will support VA's efforts to reduce waste, fraud, and abuse. In addition, the VA claims solution will integrate with Veteran Eligibility Systems, Authorization Systems, and standardized fee schedules to support auto adjudication. Integration with fee schedules will support new payment models and enable better tracking and billing integration with OHI (See *Legislative Element 5—Provider Reimbursement Rate*). VA will also integrate the claims processing system with patient information, increasing VA's ability to efficiently bill OHI. As VA becomes more efficient with processing claims, it will consider consolidating claims processing for other programs (e.g., CHAMPVA). Taken together, the new claims solution will allow VA to pay on time and correctly while meeting PPA compliance (see *Legislative Element 7—Prompt Payment Compliance*). VA will coordinate referral management with tracking financial obligations to provide the basis for resource and process adjustments based on forecasted versus actual use of funds.

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VA will determine whether to improve the system through the adoption of a new system or by purchasing the required capabilities externally. VA will oversee adherence to business rules, standardize internal controls, and have proper access to systems holding information to be reviewed. Keeping in line with best practices, VA will conduct claims audits for accuracy. VA also will provide compliance oversight for the New VCP Prompt Payment compliance process owner in accordance with VA Directives, Handbooks, and other applicable policies. To monitor and improve performance of billing and reimbursement, VA will use industry standards as metrics for continuous process improvement.

**Risk and Implementation Considerations:** For additional information, refer to the *Transition Plan (Element 10)* section of this report.

## Impact

*Table 9: Impact of Billing and Reimbursement*

Stakeholder	Potential Impact
<b>Veteran</b>	<p>Implementing new claims systems will reduce the risk of billing Veterans when provider reimbursement is either delayed or denied.</p> <p>Communications improvements in customer care will directly improve the Veteran experience. Systems integration and auto adjudication will improve the efficiency and accuracy of claims from community providers, and thereby introduce more clarity around timing of billing and reduce the risk of Veterans referred to collections notices by community providers.</p> <p>Timely re-imbursement of community providers will motivate such providers to participate in the VA provider network, thereby improving access for Veterans.</p>
<b>Community Provider</b>	<p>Improved processes, rules, and systems will improve claims processing accuracy and predictability, enable VA to comply with the PPA, and therefore provide an incentive for providers to join and remain in the network.</p>
<b>VA</b>	<p>By improving VA's billing and reimbursement policies and processes, VA will improve timeliness, accuracy, and efficiency of claims processes, reducing costs associated with late penalties, and strengthen business analytics and utilization review capabilities of the Department.</p>

## 4.5 Element 5: Provider Reimbursement Rate

### Legislation

“A description of the reimbursement rate to be paid to health care providers under such program.”

### Summary

Currently, VA establishes provider rates through local negotiations using a complex, inconsistent process. This results in a lack of transparency for community providers and VA staff regarding reimbursement rates. High-performing networks provide transparency to providers through

standardized, negotiated reimbursement rates. VA will standardize reimbursement rates to align with regional Medicare rates under a single program and will remain the primary payer. For services not covered by Medicare, VA will use other fee schedules or conduct negotiations around usual and customary (U&C) rates. U&C rates are rates paid for a medical service in a geographic area based on the amount providers in the area usually charge for the same or similar medical service. This is consistent with the Independent Assessment Report recommendation “VA and Congress should adopt a consistent strategy for setting reimbursement rates across purchased care initiatives.”<sup>24</sup> VA will continue to use established payment mechanisms with DoD, IHS, THP, FQHC, and academic teaching affiliates while at the same time moving toward paying Medicare rates for commercial partners. The change will allow VA staff to more easily match rates and reduce variance in the rates being paid to community providers. As the health care industry evolves, VA will participate in models of value-based care to provide the highest quality care for Veterans.

#### Key Activities

- Consolidate fee schedules and tie to Medicare
- Increase transparency of reimbursement rates to providers
- Allow regional variation, as needed

### Background

The purpose of a fee schedule is to communicate the rate a provider will be paid for the services they render. The design of the fee schedule may incentivize providers to participate in the network and can be used to reward delivery of high-quality care.

CMS is the largest primary payer in the U.S. and employs a Medicare rate-setting committee that influences market reimbursement rates. The CMS fee schedule includes geographic variations for care along with Graduate Medical Education, among other factors. For services not specified in the fee schedule, organizations will pay U&C or negotiated rates.

To create incentives for better health outcomes, best practices are shifting from a fee-for-service model to value-based care arrangements. In this model, organizations

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<sup>24</sup> Independent Assessment Section C. Care Authorities

reward based on achievement of quality processes and clinical outcomes (e.g., measuring blood pressure and cholesterol or achieving control of blood pressure and cholesterol). Providers may be penalized for poor outcomes, medical errors, or increased costs. CMS is currently piloting various models of value-based care, which VA can work to replicate, as appropriate.

## **Current State**

Through legislation and VA-implemented programs, a number of community care programs overlap in the services they provide and have multiple fee schedules. The schedules are set both locally and nationally, which increases variation and complexity across programs and medical centers. Finally, in some instances, VA pays billed charges for services without a corresponding rate in a schedule in lieu of negotiating a more favorable rate.

The current state is confusing for VA staff and community providers. Staff performing this function are challenged to accurately identify the appropriate reimbursement rate, causing lengthy processing times and overpayment. Community providers are unsure about what rate they will be paid when seeing Veterans

## **Future State**

VA will standardize, to the extent practicable, to Medicare rates for the external network. VA proposes a single rate schedule for the New VCP to provide a clear basis for claims payment, which will promote timely payments and prevent overpayments through negotiated rates when a Medicare rate does not exist. This will end the existing structure of providers having multiple schedules per service. Dentistry<sup>25</sup> will be reimbursed differently as the Office of Dentistry will continue to use the market to determine and apply regional market rates for their services. VA will continue using existing agreements with partners in the VA Core Network; pending legislation will allow VA to direct care to these authorities (see *Legislative Element 6 – Provider Eligibility*).

VA also plans to evolve toward a value-based care model as the concept matures. As a facet of value-based care, Preferred providers will be incentivized with higher reimbursement rates when they meet or exceed performance metrics. Providers may receive higher reimbursements based on their performance against quality metrics. In contrast, providers who consistently perform below expected levels may be dropped from the network. Further, VA will employ an audit function to verify quality in the value-based model.

Due to their geographic and/or market cost distinctions, VA will customize fee schedules for certain areas (e.g., Alaska, Hawaii, Guam, Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands) or certain services (e.g., scarce

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<sup>25</sup> Dental Payment Methodology (From NVCC Future State)

specialties and dental care) to maintain a sufficiently robust provider network in these regions.

**Risks and Implementation Considerations:** For additional information, refer to the *Transition Plan (Legislative Element 10)*.

## Impact

*Table 10: Impact of Provider Reimbursement Rate*

Stakeholder	Potential Impact
<b>Veteran</b>	Veterans will benefit from increased provider participation and choice in options since providers are reimbursed at predictable industry rates. Veterans also will have access to high-performing providers. This will lead to greater access to providers in the community.
<b>Community Provider</b>	Community providers will benefit from consistent reimbursement rates. Standardized fee schedules will decrease provider confusion and reduce payment errors. Since rates will be based on a common schedule with which they are already familiar, there will be little surprise for providers who see increases or decreases in their rates per service.  As value-based reimbursement is implemented, providers will be rewarded for providing higher-quality care.
<b>VA</b>	For VA, consistent reimbursement rates will allow for better cost prediction. Reimbursement rates under the New VCP will reduce payment errors due to elimination of manual selection of various fee schedules by examiners. Consistent payment rates will enable better data analytics to support fraud detection



## 4.6 Element 6: Plan to Develop Provider Eligibility Requirements

### Legislation

“An identification of how the Secretary will determine the eligibility requirements of health care providers at non-Department facilities to participate in such program, including how the Secretary plans to structure a non-Department care network to allow the maximum amount of flexibility in providing care and services under the program.”

### Summary

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. To move toward this best practice, VA plans to provide Veterans access to a tiered, high-performing network (Core and External). The network will reward providers for delivering high-quality care, while promoting Veteran choice and access.<sup>26,27,28</sup> The VA Core Network includes high-quality health care assets in the DoD, IHS, THPs, FQHCs, and academic teaching affiliates (see Figure 5). The External Network includes commercial providers in Standard and Preferred 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.<sup>29,30</sup>

#### Key Activities

- Create tiered high-performing provider network
- Create simplified provider agreements
- Standardize credentialing and quality monitoring

### Background

To identify provider eligibility requirements and design the high-performing network for VA, this element examines best practices for provider networks, credentialing, and quality standards.

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<sup>26</sup> Independent Assessment Report (Demographics—Section 1), “Prepare for a changing Veteran landscape”

<sup>27</sup> Independent Assessment Report (Demographics—Sections 2), “Anticipate potential shifts in the geographic distribution of Veterans, and align VA facilities and services to meet these needs”

<sup>28</sup> Independent Assessment Report (Health Care Capabilities—Sections 5), “Take significant steps to improve access to VA care”

<sup>29</sup> Independent Assessment Report (Care Authorities—Section 7), “VA purchased care contracts should include requirements for data sharing, quality monitoring, and care coordination”

<sup>30</sup> Independent Assessment Report (Health Care Capabilities—Section 8), “Systematically study opportunities to improve access to high-quality care through use of purchased care”

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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 providers in terms of quality, mix/type of specialty, and geographic distribution to meet supply and demand needs.

High-performing tiered networks promote high-quality care, improved health outcomes, and reduced system costs.<sup>31,32</sup> 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). High-performing tiered networks balance access to care in areas with few providers and choice of providers.

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, 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 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., recurring malpractice claims or sanctions against a professional license) can be removed from the network.

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<sup>31</sup> R. Steinbrook, "The Cost of Admission—Tiered Copayments for Hospital Use," *New England Journal of Medicine*; 2004

<sup>32</sup> J. Burns, "Narrow Networks Found to Yield Substantial Savings," *Managed Care*; 2012

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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.<sup>33</sup> 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, AHRQ, and The Joint Commission. Effective coordination of care and health information management also directly affect quality of care (see *Introduction: Care Coordination and Legislative Element 9—Medical Records Management*).

## **Current State**

Current VA community provider relationships are formed through multiple overlapping programs with Federally funded health care assets 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. 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 in 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 joined the network, 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.

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<sup>33</sup> “Executive Summary—Dartmouth Atlas of Health Care.”  
[http://www.dartmouthatlas.org/pages/executive\\_summary](http://www.dartmouthatlas.org/pages/executive_summary).

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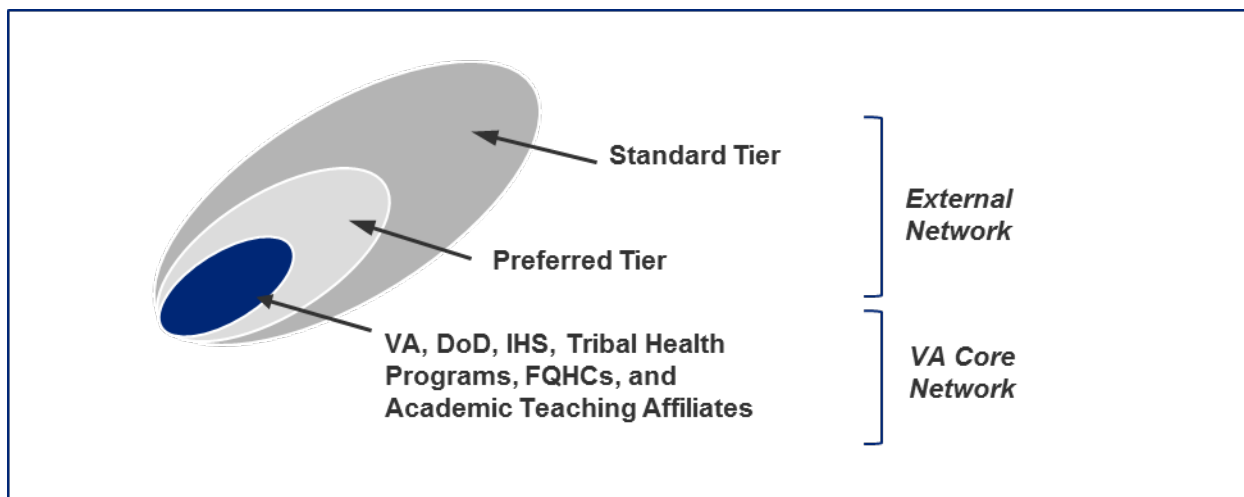
## Future State

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 (See Table 11).

*Table 11: Key Elements of the High-Performing Network*

High-Performing Network
<ul style="list-style-type: none"> <li>▪ Applies industry-leading health plan practices for tiered network design</li> <li>▪ Enhances unique relationships with Federally funded and academic teaching affiliates</li> <li>▪ Promotes Veteran choice, access to care, and high-quality care delivery</li> <li>▪ Uses streamlined and consistent credentialing and quality monitoring processes</li> <li>▪ Incorporates network management functions, including network development, contracting and reimbursement, credentialing, clinical quality monitoring, and provider relations</li> <li>▪ Consistently monitors supply and demand changes to make appropriate network adjustments, achieving access standards and coverage for primary and specialty care</li> <li>▪ Effectively coordinates care in a Veteran-centered way</li> <li>▪ Uses clinical and administrative metrics to continually measure and improve performance</li> </ul>

VA's high-performing network will be divided into the VA Core Network and the External Network (Figure 5). The External Network is subdivided into Standard and Preferred tiers. VA will work toward standardizing requirements with providers in the high-performing network.



*Figure 5: High-Performing Network Model*

The VA Core Network will include providers in the DoD,<sup>34</sup> IHS, THPs,<sup>35</sup> FQHCs, and academic teaching affiliates.<sup>36</sup> VA's relationships with these providers are unique and have evolved over time. Sustaining and expanding Core Network relationships align with VA's mission, vision, and strategies (see *Legislative Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure*). Because Core Network providers will be considered a direct extension of VA care, VA will primarily refer patients to the Core Network before the External Network.<sup>37</sup> VA will work to develop simple and consistent agreements with Core providers that are principle-based and focus quality and outcomes.

External providers 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 Standard and Preferred tier must meet uniform credentialing requirements to participate in the high-performing network. 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 public 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 addition to 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

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<sup>34</sup> The inclusion of Managed Care Contractors through TRICARE will be evaluated separately during implementation phases.

<sup>35</sup> Refers to all Tribal Health Programs that meet CMS certification and CMS conditions of participation, or have accreditation through the Accreditation Association for Ambulatory Health Care or The Joint Commission, with which VA has entered a Direct Care Services Reimbursement Agreement.

<sup>36</sup> "Academic teaching affiliates" refers to academic departments or program that have active teaching relationships with VA and can be part of the VA Core Network. Other academic institutions or departments without teaching relationships can be part of the External Network. VA plans to retain or expand relationships under VA Directive 1663.

<sup>37</sup> In general, VA plans to refer patients to Core Network providers first, with exception. For example, VA does not generally refer patients to IHS and THP providers under Direct Care Services Reimbursement Agreements, and does not plan on changing this arrangement.

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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 (see Table 12). 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.

*Table 12: High-Level Provider Credentialing Standards*

Provider Credentialing Standards
<ul style="list-style-type: none"><li>▪ Educational credentials, certifications, licensure, training, and experience</li><li>▪ Employment and pre-employment history</li><li>▪ Supplemental attestation questions, disciplinary screening, and sanctions</li><li>▪ Agreements with providers to meet access and quality of care standards</li></ul>

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 can include DoD, IHS, and the HRSA for FQHCs. VA will evaluate current credentialing practices to determine whether there are difficulties and identify ownership of the process. 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 (see *Legislative Element 5- Provider Reimbursement Rate*).

Creating a prioritized Core Network will maximize the use of high-quality Federally funded health care assets, while sustaining unique and important VA relationships. In the External Network, 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.

**Risks and Implementation Considerations:** Refer to the *Transition Plan (Legislative Element 10)* section of this report.

## Impact

*Table 13: Impact of Provider Eligibility*

Stakeholder	Potential Impact
<b>Veterans</b>	Veterans will have increased access to high-quality care through an expanded network that promotes quality. Veterans can remain with their existing community providers, if providers meet minimum requirements, or choose other providers who are best in class to support their health care needs.
<b>Community Providers</b>	Providers in all tiers will benefit from simpler, consolidated, and integrated claims processing, medical records management, and provider support services through VA. Providers in the VA Core Network and Preferred tier may see an increase in patient referral volume in addition to benefits realized in the “Standard” tier.
<b>VA</b>	VA will have increased visibility into supply and demand in the network, centrally monitor provider credentialing and quality, and promote high-value care.



## 4.7 Element 7: Prompt Payment Compliance

### Legislation

“An explanation of the processes to be used to ensure that the Secretary will fully comply with all requirements of Chapter 39 of the Title 31, United States Code (commonly referred to as the PPA), in paying for such care and services furnished at non-Department facilities.”

### Summary

Currently, VA has challenges with consistently meeting PPA requirements due to lack of an automated claims processing system. In the future, VA will consistently adhere to PPA, and follow industry best practices to measure results of the claims adjudication process. To achieve this, VA will conduct an analysis to determine the best strategies and solutions to increase its ability to provide timely payment thereby avoiding late penalties.

#### Key Activities

- Comply with Prompt Payment for all purchased care
- Reduce claims backlog

### Background

In 1982, Congress enacted PPA, which requires Federal agencies to pay vendors on a timely basis and pay interest on late payments. While PPA regulation requires payment to be made within 30 days after an invoice is received, it does not specifically reference health-related claims nor define clean claims. A clean claim is one that has all information required for processing in a timely manner; it has no defect, impropriety, or special circumstance. An unclean claim is one that is missing information. State governments have enacted different Prompt Payment legislation that requires health plans to adhere to certain time frames for claims processing. As a reference, the average state standard is 30 days for clean claims (ranging from 14-45 business days).<sup>22</sup> This requirement will be clarified in the legislative proposal recommendations.

### Current State

Currently, VA does not consistently meet PPA standards. In some programs, such as CHAMPVA, a 30-day claim processing rate of 95 percent is achieved. However, as of September 30, 2014, VA paid 76.7 percent of claims within 30 days. A root cause of low PPA compliance is that claims payment is a manual process, creating a significant backlog (See *Legislative Element 4—Billing and Reimbursement*). To address the backlog, VA developed and is executing a phased action plan in terms of people, process, and technology.

## Future State

In the short-term, VA plans to reduce the current backlog by increasing the number of claims staff. It aims to adhere to best practice guidelines used by several states (e.g., paying within 30 days for clean claims).<sup>38</sup> In the long term, VA will use industry best practices to reach a 95 percent payment rate for clean claims within 30 days. To achieve this, VA will consider alternate solutions, such as outsourcing billing and reimbursement, or deploying new technology solutions or updates.

VA will have a mechanism for the reporting and monitoring of claims processing to manage inventory to PPA standards. VA will establish internal controls that would allow regular review and updates to the process to obtain additional information about how to process claims promptly. VA will also review, update, and retrain staff on policies and procedures to comply with PPA. This will include training both internal staff and TPAs on new claims adjudication procedures. VA will establish an audit function to monitor claims processing accuracy. Efforts to develop a consolidated program and automated claims processing system will allow VA to consistently meet PPA.

**Risk and Implementation Considerations:** For additional information, refer to the *Transition Plan (Legislative Element 10)* section of this report.

## Impact

*Table 14: Impact of Prompt Payment Compliance*

Stakeholder	Potential Impact
<b>Veterans</b>	By improving timeliness of payments, providers will be more likely to participate within VA's networks. Therefore, Veterans will experience more choices in community providers.
<b>Community Providers</b>	Network providers will be paid promptly according to industry standards, providing an incentive to join the network.
<b>VA</b>	As previously discussed in Element 4, new improvements to billing and reimbursement will improve operations and enable VA to improve compliance to PPA standards for claims received under a contract or an individual provider.

<sup>38</sup> Independent Assessment Recommendations Overview: Highlighting Connections to the Future VCP Model Recommendations, Slide 15 (Sept 3, 2015).

## 4.8 Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure

### Legislative Overview

“A description of how, to the greatest extent practicable, the Secretary plans to use infrastructure and networks of non-Department provider programs that exist as of the date of the plan to implement such program.”

### Summary

VA currently uses a complex mix of authorities to provide community care. Industry-leading health plans use streamlined practices to identify and recruit high-quality providers. Their networks include an adequate number of providers in terms of quality, mix/type of specialty, and geographic distribution. As part of the New VCP, VA will develop a high-performing network (See *Legislative Element 10—Transition Plan*). This network will incorporate existing VA relationships and develop new strategic partnerships in the community, while adopting practices around tiered networks (see *Legislative Element 6—Plan to Develop Provider Eligibility Requirements*) to better serve Veterans.<sup>39,40</sup> Specifically, VA plans to retain and potentially expand agreements within its Core Network, composed of existing Federally funded partners (DoD, IHS, THPs, and FQHCs) and academic teaching affiliates. Remaining community partners can participate in the External Network.<sup>41</sup>

#### Key Activities

- Enhance relationships with Federally funded and academic teaching affiliates
- Support continuity of care for Veterans with existing community providers

### Background and Current State

VA 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 the current TPAs. Despite the large numbers of providers, VA does not have ongoing visibility into all provider locations, or an understanding of supply and demand imbalances. Therefore, VA does not have coverage in certain areas to provide accessible care to Veterans, or a single

<sup>39</sup> Independent Assessment Report (Business Processes—Section 1), “Develop a long-term comprehensive plan for provision of and payment for non-VA health care services”

<sup>40</sup> Independent Assessment Report (Health Care Capabilities—Section 7), “Streamline programs for providing access to purchased care and use them strategically to maximize access”

<sup>41</sup> For more specific information about VA’s planned use other types of existing infrastructure, please refer to the appropriate section of the report, including *Legislative Element 1 - Single Program for Non-Department Care Delivery*, *Legislative Element 3 - Authorizations*, *Legislative Element 4 - Billing and Reimbursement*, and *Legislative Element 9 - Medical Records Management*

mechanism to actively manage provider relationships (see *Legislative Element 6—Provider Eligibility*).

## Future State

VA intends to build a high-performing network using successful components of its current infrastructure to meet Veterans' needs (see *Legislative Element 6—Provider Eligibility*).<sup>42</sup> VA plans to retain and potentially expand agreements with the Core Network, composed of existing Federally funded partners (DoD, IHS, THPs,<sup>43</sup> and FQHCs) and academic teaching affiliates.<sup>44</sup> Core Network providers will be treated as a direct extension of VA care. VA will refer patients to the Core Network before referring them out to the External Network.<sup>45</sup> VA will work to develop simple and consistent agreements with Core providers driven by quality and health outcomes.

VA's relationships with Core Network providers are unique and have evolved over time. Sustaining and expanding Core Network relationships aligns with VA's mission, vision, and strategies. VA's Core Network maximizes collaboration with Federal health organizations and supports their missions.<sup>46</sup> DoD resource sharing agreements support the nation's defense readiness mission. Relationships with academic teaching affiliates align with VA's education and research missions. High-quality providers in IHS, THPs, and FQHCs promote access to exceptional care for Veterans where they live, including rural and medically underserved communities.<sup>47</sup> FQHCs require rigorous quality and risk management policies and approximately 70 percent of FQHCs have earned Patient Centered Medical Home recognition or accreditation by the NCQA.<sup>48</sup>

Remaining community partners meeting minimum credentialing criteria will be able to join VA's high-performing network. They can participate in the Preferred or Standard tiers of the External Network. The Standard tier requires only the minimum credentialing criteria. To join the Preferred tier, these providers must also meet quality criteria and demonstrate high-value care. VA will work to include community providers currently serving Veterans to maintain continuity of care. Veterans can recommend

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<sup>42</sup> Other programs, such as the Camp Lejeune Family Member Program, CHAMPVA, and the Foreign Medical Program will continue to exist separately from the New VCP

<sup>43</sup> Refers to all Tribal Health Programs that meet CMS certification and CMS conditions of participation, or have accreditation through the Accreditation Association for Ambulatory Health Care or The Joint Commission, with which VA has entered a Direct Care Services Reimbursement Agreement.

<sup>44</sup> "Academic teaching affiliates" have active teaching relationships with VA and are part of the VA Core Network. Other academic institutions without teaching relationships are part of the External Network. VA plans to retain or expand relationships under VA Directive 1663.

<sup>45</sup> VA plans to refer patients to Core Network providers first, with exception to IHS and THPs. VA does not currently refer patients to these institutions and does not plan on changing this arrangement.

<sup>46</sup> VA 2014-2020 Strategic Plan

<sup>47</sup> VA.gov—VA Mission and Vision Statements

<sup>48</sup> "Uniform Data System, 2014—Bureau of Primary Health Care/Health Resources and Services Administration"

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existing providers for inclusion in the network and VA will work to create a simplified provider enrollment process.

**Risks and Implementation Considerations:** Refer to the *Transition Plan (Legislative Element 10)* section of this report.

## Impact

*Table 15: Impact of Network and Infrastructure*

Stakeholder	Potential Impact
<b>Veterans</b>	VA will make it simple for eligible Veterans to choose community providers through an inclusive network arrangement that maintains relationships with existing high-quality health care assets. In addition, network changes will increase Veteran choice and access to high-quality providers.
<b>Community Providers</b>	Core Network partners will have enhanced relationships with VA to serve Veterans. Community providers will have a simple process for joining the External Network.
<b>VA</b>	VA will retain and potentially expand unique and high-priority relationships with Core Network providers. VA will have increased visibility into supply and demand in the network, centrally monitor provider credentialing and quality, and promote high-value care.

## 4.9 Element 9: Medical Records Management

### Legislation

“A description of how—(A) health care providers at non-Department facilities that furnish such care or services to Veterans under such program will have access to, and transmit back to the Department, the medical records of such Veterans and (B) the Department will receive from such non-Department providers such medical records and any other relevant information.”

### Summary

Current VA health information exchange practices are primarily paper-based, with manual handoffs and inconsistent processes that create delays. Access to current health information is critical to supporting care coordination and delivery of high-quality care. In the future, VA will develop a health information environment that is electronic, secure, efficient, effective, Veteran centered, and standards based.<sup>49,50,51</sup>

#### Key Activities

- Improve consistency, simplicity, and timeliness of information exchange
- Deploy provider viewers and health information gateway
- Increase use of Health Information Exchanges

### Background

Medical records management, referred to as health information management in this element, is “the practice of acquiring, analyzing, transferring, and protecting digital and traditional medical information vital to providing quality patient care.”<sup>52</sup> Health information can be divided into two categories: clinical and administrative. Clinical information includes patient medical histories, physical findings, test results, treatments, and clinical practice guidelines that document appropriate treatments for conditions. Administrative information supports the business functions of health organizations and can include medical claims, formularies, and patient referral documents. Health systems that effectively manage health information are able to seamlessly send, receive, locate, and access reliable and relevant information.

<sup>49</sup> Independent Assessment Report (Leadership—Section 2), “Implement a single, integrated set of system-wide tools centered on a common EHR that is interoperable across VA and with DoD and community provider systems”

<sup>50</sup> Independent Assessment Report (Health Information Technology—Section 3), “VA should implement a broad process, inclusive of clinicians, to pursue requirements that support clinical documentation best practices and improved functionality and usability while considering the positive aspects of existing systems”

<sup>51</sup> Independent Assessment Report (Data and Tools—Section 1), “Use standardized clinical and administrative data for accuracy and interoperability”

<sup>52</sup> American Health Information Management Association definition—  
<http://www.ahima.org/careers/healthinfo?tabid=what>

Effectively managing clinical and administrative information affects an organization's ability to deliver coordinated, high-quality, and high-value care. Clinical information allows providers to make well-informed diagnosis and treatment decisions. Administrative information supports the execution of business functions, including claims processing and reimbursement (see *Legislative Element 3—Authorization* and *Legislative Element 4—Billing and Reimbursement Systems*). Additionally, operational analytics provide data for network managers and providers to recognize public health patterns, effective disease management programs, supply and demand trends, provider productivity, and other information useful to improve health outcomes and operational efficiency.

The Office of the National Coordinator for Health Information Technology (ONC) states that “despite the widespread availability of secure electronic data transfer, most Americans’ medical information is stored on paper.”<sup>53</sup> Technologies to support the exchange of health information are quickly evolving. Two examples are Health Information Exchanges (HIEs) and integrated web-based health information gateways. HIE is the electronic movement of health-related information among organizations using commonly recognized standards. HIEs facilitate access to and retrieval of clinical data to provide “safer, timelier, efficient, effective, equitable, patient-centered care.”<sup>54</sup> Participating organizations agree to send health information to other systems, find and request copies of health information, match patient to data, and receive updates. Key components of an HIE are standardized legal agreements, common policies and procedures, and technical infrastructure to securely send and receive clinical information. HIE connectivity is increasing, but adoption is not universal. HIEs currently reach 40 percent of U.S. hospitals and serve approximately one third of the U.S. population.<sup>55</sup>

Integrated web-based gateways leverage HIE’s to enable health care organizations to view and interact with both clinical and administrative information, depending on organizational needs. Gateways can exchange documentation around claims, referrals, authorizations of care, and critical pathways. Providers can view, append, and share information. Common characteristics include care coordination support, electronic information transfer, process automation, user-friendly design, use of mobile devices to view and transfer information, and data-driven audit and evaluation.

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<sup>53</sup> Office of the National Coordinator for Health Information Technology (ONC HIT) - <http://www.healthit.gov/providers-professionals/health-information-exchange/what-hie>

<sup>54</sup> United States Department of Health and Human Services, Health Resources and Services Administration (HRSA) definition—<http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Collaboration/whatishie.html>

<sup>55</sup> The Sequoia Project—<http://sequoiaproject.org/wp-content/uploads/2014/11/eHealth-Exchange-Overview-7-23-15.pdf>

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## Current State

VA's current process for management of health information internally and in the community needs to simplify and improve consistency and timeliness (Table 16). In the current state, after an appointment is scheduled, information enters the Veterans Health Information Systems and Technology Architecture (VistA), which provides an electronic health record (EHR) for enrolled Veterans and administrative tools. The process is different if the Veteran is seen by a provider in the contractor networks, authorized on an individual basis, or treated by a Federal provider in DoD or IHS.

*Table 16: Current-State Limitations for Health Information Management*

Current-State Limitations
<ul style="list-style-type: none"> <li>▪ Mostly manual, paper-based procedures with low EDI</li> <li>▪ Time lag for information transfer</li> <li>▪ Lack of clear definitions for information ownership at each step</li> <li>▪ Limited support for PCP care coordination</li> <li>▪ Inconsistent practices between providers</li> <li>▪ Multiple handoffs</li> </ul>

For care through contractor networks, VA manually sends clinical and administrative information through hard copies or fax to be uploaded to a contractor portal or document repository. The applicable contractor provider then downloads appropriate clinical and administrative information from the portal in preparation for the appointment. For care through individual authorizations, VA sends information directly to providers via print, fax, or sometimes electronic methods.

After the visit, contractors upload health information to the contractor portal and send paper-based versions of clinical and administrative information back to VA. VA administrative staff then manually scan and import the paper documents into VistA. Individually authorized providers can either use the same manual practices or use VA exchange services to transfer information back to VistA. VA exchange services electronically exchange clinical information with community providers, including identity, authorization and consent, and data translation functions.

After information reaches VistA from community providers (including DoD and IHS), VA providers can then log into the Computerized Patient Record System (CPRS) or VistAWeb applications, which allow providers to enter, review, and update Veteran's clinical information. VA staff with appropriate security credentials can view administrative information through VistA Imaging.

VA is working on several initiatives to promote interoperability with DoD and IHS providers, including sharing viewable data in existing (legacy) systems, developing a virtual lifetime EHR, implementing IT capabilities for the first joint Federal health care

center,<sup>56</sup> and direct secure messaging pilots. Plans also are in place to develop and pilot tools to optimize VA's infrastructure, and VA has released mobile applications to give Veterans and providers on-demand access to health information.

## Future State

VA will adopt a phased plan consistent with a systems approach to achieve a solution that is secure, efficient, effective, and standards based, using HIEs. Future state systems will facilitate data transparency to promote enterprise-wide data collection, analytics,<sup>57</sup> and prioritize data security. In the near-term, VA will focus on building upon current infrastructure to improve consistency, simplicity, and timeliness of information exchange. In the medium-term and long-term, VA plans to deploy a robust health information gateway and services, the Enterprise Health Management Platform (eHMP), and share most clinical information through HIEs.

## Near-Term Improvements

In the near term, VA is implementing a web-based Joint Legacy Viewer (JLV) to offer a simple, complete, and easy to understand view of VA and DoD patient data. Secondly, VA plans to integrate existing exchange services to receive and store standards-based electronic documents, such as Continuity of Care Documents. This reduces use of paper and builds on current VA investments. Thirdly, VA plans to expand partnerships with HIEs and use direct secure email protocols. Lastly, for health IT, built or bought, VA plans to expand the usage of national standards for clinical terminology and data elements. Community providers not using JLV or the HIEs will continue to receive requisite health information through current state infrastructure (Table 17).

*Table 17: Near-Term Improvements for Health Information Management*

Near-Term Improvements
<ul style="list-style-type: none"> <li>▪ Implementation of JLV and VA exchange services (with expanded capabilities)</li> <li>▪ Use of existing infrastructure to more simply and electronically exchange information with community providers</li> <li>▪ Integrated clinical and administrative data for metrics reporting and improved care coordination</li> </ul>

## Medium-Term and Long-Term

For all providers in the high-performing network, VA plans to create an electronic, secure, efficient, effective, and standards-based environment in compliance with relevant privacy laws affecting Veterans and their beneficiaries (Table 18). VA plans to

<sup>56</sup> "Electronic Health Records: VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration." GAO. Accessed September 30, 2015. <http://www.gao.gov/products/GAO-14-302>.

<sup>57</sup> Independent Assessment Report (Care Authorities—Section 5), "Improve collection of data on Veteran health care utilization and reliance"

implement a health information gateway and associated services, the eHMP, and share most clinical information through HIEs, when available.

*Table 18: Medium & Long Term Improvements for Health Information Management*

Medium- and Long-Term Improvements for Health Information Management
<ul style="list-style-type: none"> <li>▪ Implementation of the Health Information Gateway and Services and the eHMP</li> <li>▪ Most clinical information shared through HIEs, increasing health information interoperability and availability</li> <li>▪ Increased support for care coordination and clearer definitions of information ownership</li> <li>▪ Support for data-driven audit and evaluation<sup>58</sup></li> <li>▪ User-friendly tools involving minimized use of paper-based information</li> <li>▪ Additional mechanisms to promote data privacy and security</li> </ul>

Providers will be able to view, append, and share clinical and administrative information electronically through a VA health information gateway and associated services (Figure 6). Veteran clinical and administrative information will then be transferred back to VistA. VistA will incorporate an industry-leading information model, terminology normalization, knowledge enrichment, and search indexing for VA, Federal, and HIE partner sources. Available health information will drive enterprise-wide analytics efforts for process improvement.

Specifically, the health information gateway and services will include integrated point-of-care applications for Veterans, community providers, and staff. “Services” refer to technologies that facilitate privacy and security, data translation, and data storage. VA will create a data-driven evaluation process for provider adherence to VA critical pathways to promote high-quality and high-value care.

VA will deploy the eHMP in the medium-term, which will replace CPRS and include JLV capabilities. eHMP will integrate end-user clinical encounter and care coordination transaction capabilities, data visualization, and decision support services. eHMP will feature a common electronic care plan with standardized protocols tailored to individual Veteran needs. Information gathered through patient-facing and telehealth technologies will update the care plan (see “Care Coordination” for additional detail).

VA will share most clinical information through HIEs and work with ONC, national standards organizations, and industry associations to move toward full standardization of health IT components. VA will use national standards for data elements such as labs, medications, allergies, and vitals. Data interoperability standards will promote seamless handoffs of more complete patient records between VA and community providers.

<sup>58</sup> Expanded data and reporting documentation to include Affordable Care Act data collection standards: <http://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status> will be included to meet VHA Strategic Goal 1E

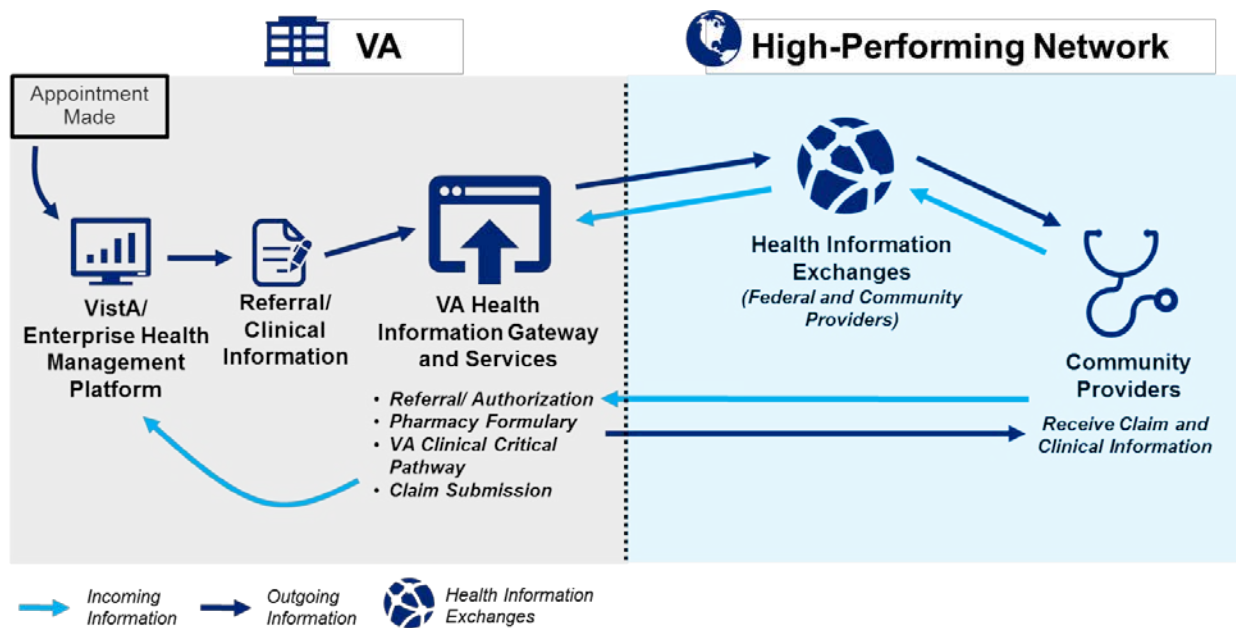


Figure 6: Diagram of Medium- and Long-Term Improvements for Health Information Management

**Risks and Implementation Considerations:** Refer to the *Transition Plan (Legislative Element 10)* section of this report.

## Impact

Table 19: Impact of Medical Records Management Requirements

Stakeholder	Potential Impact
<b>Veterans</b>	Veterans will benefit from better care coordination due to the ease of clinical and administrative information flow between VA and community providers.
<b>Community Providers</b>	Community providers will benefit from quick, user-friendly processes for accessing and submitting clinical and administrative information. Improving the community provider experience could incentivize additional providers to join VA's network. Timely access to clinical information can lead to more informed decisions to improve quality of care.
<b>VA</b>	VA providers will also benefit from ease of access to clinical information on their patients. Improved access to clinical data can lead to improved care coordination and clinical decision-making. VA will benefit from automating practices and using common standards, legal agreements, and governance, which can reduce administrative costs and promote higher-quality care delivery for Veterans. Applying analytics to health information can show public health patterns, effective disease management, and ways to use resources more effectively.

## 4.10 Element 10: Transition Plan

### Legislation

“A description of how the Secretary plans to ensure an efficient transition to such program for Veterans who participate in the non-Department provider programs, including a timeline, milestones, and estimated costs for implementation, outreach, and training.”

### Background

The New VCP is a key component of how VA will deliver care in the future. Currently, VA has multiple disconnected systems and processes to perform clinical and administrative functions for purchasing care. This is inefficient and causes confusion among Veterans, community providers, and VA staff. Under the New VCP, these disparate systems and processes will be consolidated and streamlined into an integrated system for a seamless experience for all stakeholders. In addition, as this plan is reviewed and updated to incorporate input from Congress and other stakeholders, the activities and resources required to consolidate community care programs will likely be impacted.

The New VCP will be implemented through a system of systems approach. As outlined in the Introduction to this report, a system of systems approach involves the design, deployment, and integration of meta-systems that are themselves composed of complex systems, which are integrated to deliver the desired functionality and end-to-end user experience.<sup>59</sup> Consistent with this approach, VA will begin by understanding the desired experience and required outcomes for Veterans, caregivers, VA staff, and community providers. VA will then examine all the components necessary to achieve the desired outcomes and understand how various component systems will integrate into the broader VA health care system and funding environment. To successfully implement this system of systems approach requires legislative changes, resources and budget. Requested changes are outlined in the *Estimated Costs and Budgetary Requirements (Section 5)* and *Legislative Proposal Recommendations (Section 6)* of this plan. If legislative changes are not provided within the requested timelines, it will adversely affect VA’s ability to deliver the New VCP as described in this plan.

Implementation of the system of systems approach will be executed through rapid cycle deployment using agile methodologies. This will allow VA to fix the most pressing issues with community care today, while making continuous updates to promote a learning health system that evolves with the needs of the Veteran population. This approach enables VA to implement an integrated system design that allows people,

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<sup>59</sup> Adapted from: Lia, P., Fisk, R. P., Falcão e Cunha, J., & Constantine, L. (2011). Multilevel service design: From customer value constellation to service experience blueprinting. *Journal of Service Research*, 14(2), 180–200.

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processes, facilities, equipment, and organizations to deliver high-quality, high-value care.

Based on preliminary analysis of Veteran needs and the desired Veteran experience, VA has determined that the component systems of the New VCP are 1. Integrated Customer Service Systems; 2. Integrated Care Coordination Systems; 3. Integrated Administrative Systems (Eligibility, Patient Referral, Authorization, and Billing and Reimbursement); 4. High-Performing Network Systems; and 5. Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting). These systems align to the five functional areas of the New VCP, as well as include customer service, change management, program management/enterprise governance, and data collection, analytics, and reporting activities that are critical to successful implementation (Table 20).

*Table 20: Alignment of New VCP Functional Areas to Component Systems*

Component Systems	Functional Area(s)
1. Integrated Customer Service Systems	<ul style="list-style-type: none"> <li>Customer Service</li> </ul>
2. Integrated Care Coordination Systems	<ul style="list-style-type: none"> <li>Care Coordination</li> </ul>
3. Integrated Administrative Systems (Eligibility, Patient Referral, Authorization, and Billing and Reimbursement)	<ul style="list-style-type: none"> <li>Veterans We Serve (Eligibility)</li> <li>Access to Community Care (Referral and Authorization)</li> <li>Provider Payment (Claims)</li> </ul>
4. High-Performing Network Systems	<ul style="list-style-type: none"> <li>High-Performing Network</li> </ul>
5. Integrated Operations Systems (Enterprise Governance, Analytics and Reporting)	<ul style="list-style-type: none"> <li>Change Management</li> <li>Program Management/Enterprise Governance</li> <li>Data Collection, Analytics, and Reporting</li> </ul>

In order to execute a program of this scope and scale, VA has outlined a transition plan consistent with the system of systems approach to sequence the design, development, and delivery of the New VCP. In developing the transition plan, VA considered recommendations from stakeholder feedback and the Independent Assessment Report. While the transition plan lays out a path forward for the program, the complexity of the change will require development of detailed implementation plans. In addition, any changes to the New VCP described in this plan as a result of input from Congress or other stakeholders will impact the activities described.

## Structure of the Transition Plan

Transitions of this magnitude take years to design and implement; therefore, this plan is organized into three phases. Phase I can start immediately and will last one year, assuming available resources and required legislative and regulatory changes. This phase will focus on the development of minimum viable systems and processes that can meet critical Veteran needs without major changes to supporting technology or organizations. In Phase II, also lasting approximately one year, VA will enhance the



changes implemented in Phase I through interfaced systems that will appear seamless to Veterans and community providers, but will largely continue to employ existing infrastructure and technology. Phase III will be a multi-year effort. For the purpose of this report, only the first year of Phase III has been outlined. In Phase III, VA will begin deploying an integrated system of systems that will support changes in Phases I and II and enable a seamless experience across VA and community care for all stakeholders. VA also will collect and analyze data on the progress and performance of the implementation to identify opportunities for continuous improvement. Overall, through all phases of the transition, VA will build a foundation for a health care system that can respond to the evolving needs of Veterans and the changing health care landscape at VA and in the community. Figure 7 outlines representative requirements for each component system in each phase, illustrating how each phase will build on the previous.

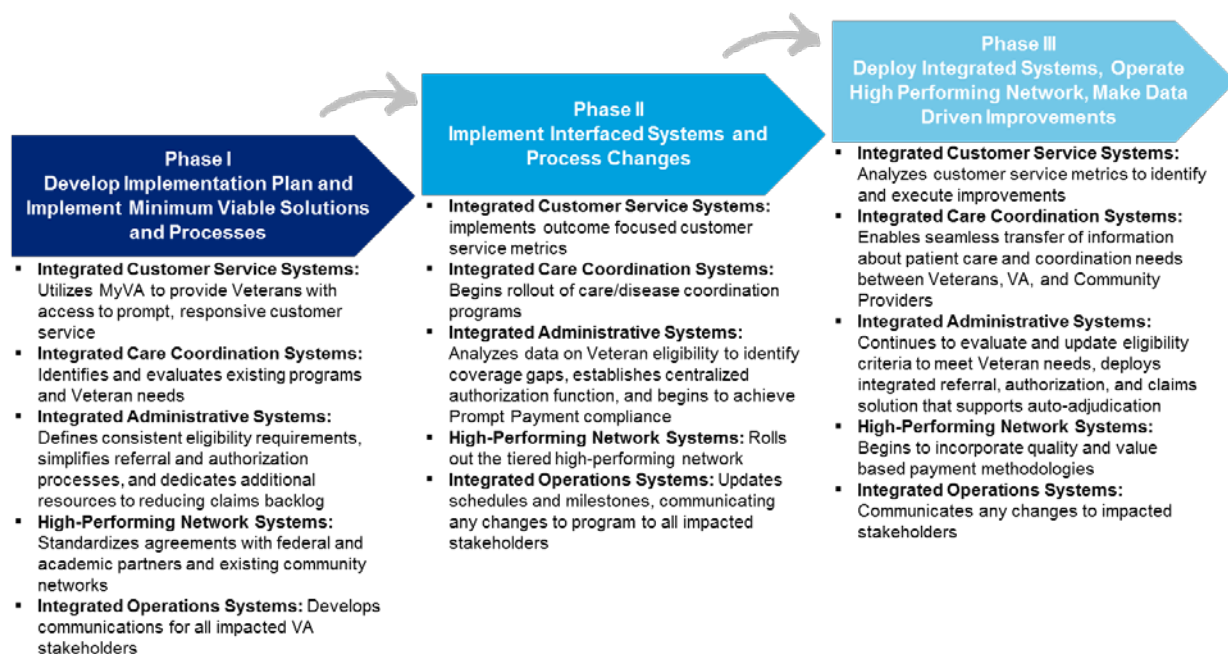


Figure 7: Phased Approach to the New VCP

## Phase I: Develop Implementation Plan and Implement Minimum Viable Solutions and Processes

During Phase I, VA will develop an implementation plan that articulates a clear path forward for each system component across the three phases. This will include decisions about long-term system changes and outcomes of make/buy analyses for clinical and administrative technology solutions and network development. Phase I will also include the implementation of minimum viable systems and processes for the Veteran, community provider, and VA staff experience. These systems will focus on improvements that can be executed without major changes to organizations or technology. Key Phase I requirements include:



**1. Integrated Customer Service Systems:**

- Align with MyVA customer service infrastructure to improve the Veteran and community provider experience.
- Develop and implement communication plans for Veterans, community providers, and VA staff on initial changes.

**2. Integrated Care Coordination Systems:**

- Evaluate Veteran needs for care coordination.
- Evaluate existing programs to identify alignment with Veteran needs and evaluate opportunities to optimize the portfolio.

**3. Integrated Administrative Systems (Eligibility, Patient Referral, Authorization, and Billing and Reimbursement):**

- Define, implement, and communicate consistent eligibility requirements for the New VCP to improve access to care and reduce stakeholder confusion.
- Determine list of services requiring clinical authorization.
- Simplify referral and authorization processes to enable consistent and efficient access to care.
- Dedicate additional resources to reducing claims backlog and develop plans to bring VA performance and metrics into greater compliance with PPA.

**4. High-Performing Network Systems:**

- Standardize agreements with Federally funded partners, academic teaching affiliates, and existing community providers.
- Develop initial requirements for participation in Core and Preferred networks to support development of the high-performing network.
- Use analytics to identify network gaps.

**5. Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting):**

- Develop detailed implementation plan, schedules, governance structure, and milestones to support transition.
- Develop appropriate communications and training for VA staff on changes to community care systems and processes.

**Phase II: Implement Interfaced Systems and Process Changes**

During Phase II, VA will implement interfaced systems and associated processes that will enable a seamless experience for Veterans and community providers. Interfaces will employ existing resources and technology infrastructure, but will appear integrated to end users. Simultaneously, VA will continue to develop fully integrated solutions that will be deployed in Phase III. Key requirements in this phase include:

**1. Integrated Customer Service Systems:**

- Continue to communicate with Veterans and community providers about the New VCP.
- Implement customer service metrics to evaluate and improve performance.

**2. Integrated Care Coordination Systems:**

- Implement continuum of care coordination with levels appropriate to Veteran needs.
- Expand care/disease coordination programs and align support roles.
- Enable medical record sharing between VA and community providers.
- Begin to analyze Veteran data to identify triggers and registries for intervention and communications about specific programs.

**3. Integrated Administrative Systems (Eligibility, Patient Referral, Authorization, and Billing and Reimbursement):**

- Centralize authorization review.
- Refine requirements and execute claims solution.
- Implement standardized claims processes and metrics to achieve greater Prompt Payment compliance.

**4. High-Performing Network Systems:**

- Analyze Veteran eligibility and usage data to identify coverage gaps.
- Implement provider credentialing and audit processes to evaluate network consistency and quality.

**5. Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting):**

- Continue to manage program budget and update schedules and milestones.
- Evaluate change management and communicate impacts of process changes to VA staff.

**Phase III: Deploy Integrated Systems, Operate High-Performing Network, and Make Data-Driven Improvements**

During Phase III, VA will begin to deploy integrated systems, including process and organization changes that will enable a seamless Veteran, community provider, and VA staff experience. These systems will build on changes in Phases I and II and will support collection of quality, value, and performance data for continuous improvements. Key requirements in this phase include:

**1. Integrated Customer Service Systems:**

- Deploy a single customer service solution and analyze customer service data to support continuous improvements.

**2. Integrated Care Coordination Systems:**

- Implement systems to monitor quality of care in accordance with Federal and industry standards.
- Continue to evaluate care/disease coordination programs to assess outcomes and identify additional needs.
- Use Veteran data to trigger outreach for care/disease coordination programs and evaluate success.
- Improve appropriate information sharing for Veterans' care between Veterans, community providers, and VA staff.
- Deploy health information gateway and services to facilitate community provider interaction with VA.

**3. Integrated Administrative Systems (Eligibility, Patient Referral, Authorization, and Billing and Reimbursement):**

- Deploy single eligibility solution supporting Veteran self-service. Continue to evaluate and update eligibility criteria to meet Veteran needs.
- Deploy integrated referral and authorization system that integrates with claims system, and enable Veteran and provider self-service.
- Deploy new claims solution that supports auto adjudication and Prompt Payment compliance.
- Utilize emerging value-based reimbursement methodologies.

**4. High-Performing Network Systems:**

- Continue to expand network, minimize coverage gaps and increase number of Preferred providers for greater Veteran choice.
- Begin to apply quality-and value-based payment methodologies in the network.

**5. Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting):**

- Continue to manage any changes to funding, schedules, or milestones.
- Integrate change management and communicate changes to the program to affected stakeholders as they occur.

**Detailed Transition Requirements by System**

The section below details key requirements for the New VCP. The section is structured around the systems described in Table 20. It provides outcomes and key requirements for each system throughout the three phases of implementation.

**1. Integrated Customer Service Systems:**

- **Purpose:** Improve the Veteran and community provider experience with community care.

- **Key Requirements:**

- **Customer Service Solutions:** VA will use customer service solutions aligned with MyVA to provide prompt, responsive customer service for the New VCP. Over time, this will include the definition of robust, outcome-focused customer service metrics that will inform regular evaluation and improvements to the process.

## 2. Integrated Care Coordination System:

- **Purpose:** Improve Veteran health outcomes through better care coordination.

- **Key Requirements:**

- **Consolidate care management system:** Design a consolidated care management system to standardize care coordination activities, analyze additional care and disease management needs, and evaluate the quality of care provided.
- **Communicate a consistent care coordination model:** Conduct a care coordination assessment to develop care coordination policies and procedures. Enhance existing pilot programs to improve Veteran health outcomes and models and begin piloting case management/disease-specific programs. Integrate programs with the health information gateway for community providers.
- **Improve information sharing:** Design a system to facilitate the sharing of medical records between providers using standards and terminology to support interoperability. Continue to expand medical records access and clinical information sharing via HIEs.
- **Apply analytics to identify target populations for care programs:** Use data to identify Veterans for disease/case management programs. Conduct outreach to VA staff, community providers, and eligible Veterans to increase awareness.

## 3. Integrated Administrative Systems (Eligibility, Patient Referral, Authorizations, and Billing and Reimbursement):

- **Purpose:** Reduce access barriers and streamline administrative processes for community care.

▪ **Key Requirements:**

– **Eligibility:**

- **Define eligibility for the New VCP:** Define and communicate eligibility to promote convenient access for Veterans, and reduce confusion among Veterans, community providers, and VA staff. This will include communication to key stakeholders regarding the impact of the New VCP and revised eligibility requirements.
- **Enable data-driven changes to eligibility:** Regularly evaluate new eligibility criteria, policies, and stakeholder experience to understand whether criteria are meeting Veteran needs. Make necessary changes, update stakeholder materials to reflect changes, and communicate with stakeholders to eliminate confusion.
- **Consolidate eligibility systems:** Provide clear visibility into Veteran eligibility for the New VCP by using an integrated system. The system will automate determinations, update Veteran eligibility (e.g., if a Veteran is added to a wait list for care or relocates), and integrate with other VA eligibility and claims systems.

– **Referral and Authorization:**

- **Streamline referral and authorization:** Simplify and streamline referral and authorization systems, including the development of a single list for services that require authorization. Communicate changes to affected stakeholders.
- **Centralize authorization functions:** Determine requirements for consistent implementation of a standard authorization system across facilities. Design appeals policies and procedures and a process to evaluate and update authorization lists. Establish a Referral Coordinator role to assist Veterans with identifying and accessing community providers.
- **Integrate referral and authorization solution:** Define requirements and implement new integrated systems, enabling the collection and analysis of necessary data for care delivered in and outside of VA facilities. Utilize data to identify areas for improvement and refine the process.

- **Billing and Reimbursement:**
  - **Eliminate claim-processing backlog:** Dedicate sufficient resources for oversight of inventory to eliminate the current claims backlog. Align to industry payment standards.
  - **Implement new claims processing solution:** Identify requirements to receive all claims electronically to enable auto adjudication of claims and increase efficiency through integration with other VA systems. Evaluate ability to add other programs (e.g., CHAMPVA) to the solution as efficiencies are gained.
  - **Align metrics with the PPA:** Continuously monitor the progress of reducing the claims backlog and use data analytics to understand claims volume and determine productivity standards. Continue to disseminate standardized claims-processing policies and procedures and establish metrics that support Prompt Payment compliance.

#### 4. High-Performing Network Systems:

- **Purpose:** Increase Veterans' access and choice in community providers.
- **Key Requirements:**
  - **Develop a high-performing network:** Identify core competencies and gaps in current networks and develop a high-performing network with the features described in this report. Continue to conduct analyses to identify network gaps and define utilization standards that are consistent for network and VA for providers. Establish necessary systems to support a high-performing network and develop communications for stakeholders.
  - **Standardize provider eligibility criteria:** Develop policies and procedures to improve operational efficiency, including standardizing fee schedules, delegating credentialing, contracting, and continuously evaluating processes and policies for further improvements. Support identification of high-performing network providers using data analytics and uniform standards.
  - **Adopt quality and value-based payment methodologies:** Support value-based payments for community providers using emerging models from industry.

- **Improve solutions to support the provider network:** Design systems to maintain up-to-date registration and management of the community provider network, including tracking of performance metrics and compliance with provider eligibility criteria. Enable Veterans to choose a network provider based on clinical need and convenience, and create a provider experience that makes VA a desirable partner in care.

#### 5. Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting):

- **Purpose:** Enable the successful implementation of the New VCP through program governance and leadership visibility into care quality and program performance.
- **Key Requirements:**
  - **Establish Governance and Management for the New VCP:** Establish local and national management for community care. Standardize management structures for community care within facilities and establish a new DUSH for Community Care to support a consistent Veteran experience with the New VCP. Develop a schedule, milestones, and budgets to support implementation of the New VCP and promote integration with the VA health care delivery system. Develop comprehensive communication and training materials for all stakeholders on changes to VA systems, policies, and procedures.
  - **Analytics and Reporting:** Support decision making by improving information and transparency to optimize health outcomes, analytics, and program management. Evaluate options for a consolidated reporting solution for the New VCP to aggregate and standardize data and conduct necessary analysis.

### Transition Considerations and Risks

The successful implementation of the New VCP transition plan will require new legislative authorities and identification of appropriate resources. This section outlines key considerations and risks that could affect VA's ability to implement the transition plan outlined above. High-level considerations include:

- **Legislative Authorities:** As VA begins to consolidate community care into the New VCP, the Department will need several new authorities to improve access to care (e.g., the ability to consolidate existing programs). Some of these authorities are critical to program stand-up and are needed immediately, while others are not necessary until later in the transition. If these authorities are not provided within the



requested timeline, VA will not be able to fully execute the New VCP. For additional information regarding requested legislative authorities, please refer to the *Legislative Proposal Recommendations* section of this report.

- **Funding:** To support the New VCP, VA will need to deploy the integrated system of systems described above. This deployment also will require a significant change management effort, including communications and training. To implement this transformation, VA will need additional funding. If funding for the changes proposed in this report is not provided, it will affect VA's ability to deliver the New VCP as described in this report. For additional information regarding requested funding, please refer to the *Estimated Cost and Budgetary Requirements* section of this report.
- **Timelines:** The estimated times for completion of phases described in this transition plan are aggressive and intended to position VA to implement streamlined processes and meet the care needs of Veterans quickly. If legislative and budgetary requests are not approved, or the New VCP does not receive appropriate support from internal and external stakeholders, these timelines may be adversely affected.
- **Culture Change:** The New VCP is a major change for VA and will require Veterans, VA staff, and community providers to embrace community care as an integral element of the VA health care system. If the program implementation or change management efforts are not well planned or managed, stakeholders may not buy in to the change, adversely affecting the program's chances of success.
- **Innovation:** Health care management practices continue to evolve, especially the use of information technology for measurement, analytics, computer-assisted clinical decision making and Veteran self-help. Over time, plans for the New VCP may need to be adjusted to accommodate the latest innovations in health care.
- **Stakeholder Input and Buy-In:** The New VCP described in this plan is notional and represents VA's perspective on the path forward for VA Community Care. Congress and other stakeholders will have input into the final design of the program. If input from stakeholders requires modifications to the New VCP as described in this plan, the transition plan and associated timelines may need to be updated to account for these changes.

In addition to these higher-level considerations, there are a number of more specific risks that VA has identified which have the potential to affect the successful transition to the New VCP (Table 21). To facilitate mapping to the previous sections of this report, risks are aligned to the Legislative Elements. In some cases, Legislative Elements have been combined if risks are consistent across elements.

*Table 21: New VCP Transition Risks*

Legislative Element	Risks	Mitigation Strategies
Element 1: Single Program for Non-Department Care Delivery	Challenges in integrating existing community care contracts and VA care, and methods to give Veterans the experience of a 'single program'	Prioritize areas with direct Veteran impact in initial efforts to introduce consistency
	Potential for further compartmentalization of activities as community care functions are consolidated under a new DUSH for Community Care	Develop regular touchpoints and communications between new DUSH and other affected areas of VHA. Understand and communicate areas of community care that require integration with other VHA functions. Foster an open and collaborative culture for the New VCP. Implement consistent performance metrics for VA providers and network providers
	Inability to cope with initial customer inquiry volume as New VCP is implemented	Provide "surge staffing" at customer service centers to support prompt responses to initial Veteran inquiries; implement robust communications campaign; unify message content at all customer service centers
Element 2: Patient Eligibility Requirements	There will be initial Veteran confusion on individual eligibility for community care under the New VCP	Develop targeted outreach and prepare customer service centers with clear scripts explaining the program. Develop and implement consistent guidance on eligibility determinations, education, training, and communication across facilities
	New Emergency Treatment and Urgent Care eligibility criteria and guidance will be susceptible to fraud, waste, and abuse	Develop business rules to trigger audit of emergency treatment and urgent care claims to identify potential overuse or fraud, waste, and abuse of these services
Element 3: Authorization	There may be significant logistical challenges associated with developing a central authorization center	VA could leverage existing resources from streamlined processes to staff the centralized authorization center
	The authorization process is not well tied to the referred consult, creating confusion or wait-time for Veterans	VA will develop and deploy standard business rules, performance benchmarks to monitor and continuously improve the Veteran experience while using automation of referrals to scheduling
	Network providers are not all educated on the revised referral and authorization process	VA will educate providers on a recurring basis to support existing and new providers in VA and the community using technology
Element 4: Billing and Reimbursement Process	Auto adjudication of "clean claims" may increase the potential for health care fraud	Increase investment in business compliance and oversight capabilities, including computerized methods to detect potentially inappropriate activity. Consider a mechanism similar to Medicare's Recovery Audit Contracts
Element 5: Provider	Performance standards are not case-mix adjusted, driving providers to optimize through lower-risk cases	VA can use more developed metrics and incentive models initially (e.g., CMS developed) to be consistent with industry direction and clinical

## Plan to Consolidate Community Care Programs

Legislative Element	Risks	Mitigation Strategies
Reimbursement Rate		relevance to account for case mix complexity, and incentivize providers to take on high risk patients
	Claims processes and rate schedules are not integrated effectively creating issues with meeting Prompt Payment rules	VA can tightly integrate claims configuration and payment schedules as it implements a revised claims-processing approach and value-based payment models. VA can analyze payments routinely to confirm consistency
	Variation in provider quality metrics/outcomes as new models and processes are implemented	VA can establish CMS and industry-consistent guidelines across VA and network providers and reinforce behavior through metrics reporting and payment models
	The transition from traditional fee for service to value-based payments is not well understood and providers may not perform as expected initially	Value-based re-imbursement will closely mimic CMS implementation; craft a communications plan, including explanations on VA's industry-consistent direction and expectations well in advance of implementation
Element 6: Plan to Develop Provider Eligibility Requirements  Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure	High-performing provider network may not have adequate coverage to serve Veterans (e.g., geographic distribution and specialties)	Research network supply and demand needs using real-time and predictive analytics and develop relationships with providers/institutions serving rural and underserved communities (e.g., FQHCs). Be upfront about regional variation with Congress and VSOs.
	Veterans may be unable to consistently assess provider performance and credentialing status due to inconsistent standards between VA and industry	Work to develop consistent quality and credentialing standards within the high-performing network, aligned to industry processes
	Community providers may not be educated about military culture and issues affecting Veterans	Encourage providers in the high-performing network to take trainings, use available educational resources, and collaborate directly with experienced VA providers
	Current community network providers may not want to join the high-performing network due to challenges in the past	Create a process that makes it simple for providers to enter the network, in addition to a simple transition process for existing providers; create timely claims processing capability; implement financial incentives to attract providers
	Unclear ownership of network management functions and personnel are not appropriately trained	Designate clear roles for industry-leading network management functions (as they relate to core, standard, and Preferred providers) and ensure personnel are well-trained
	Inconsistent management of provider data and lack of visibility into operations	Create centralized data management function, consistent data management processes, and a common source for New VCP data
	Maturity of local health networks and ACOs varies across the nation	Be transparent about regional variation with Congress and VSOs. Allow limited experimentation

## Plan to Consolidate Community Care Programs

Legislative Element	Risks	Mitigation Strategies
		with different models at the state level that does not impact the Veteran experience from site to site
	Anticipated provider shortages, especially for primary care and Mental Health, particularly in areas of greatest need	Be transparent about the regional variations that will exist, particularly for primary care.
Element 7: Prompt Payment Compliance	Lack of sufficient resources to reduce claims backlog and meet Prompt Payment guidelines	Develop and implement training for claims-processing staff. Develop clear strategy to reduce the claims backlog. Create incentives to increase electronic submission of claims
Element 9: Medical Records Management	Risk of data breach or other security issues involving Veteran personally identifiable information or protected health information	Research, select, and implement best practices for data privacy and security across people, process, and technological areas (e.g., permissions and cyber threat detection)
	Health information management tools and technologies are created without a cohesive strategy nor awareness of ongoing initiatives	Consistent communication about ongoing initiatives and development of cohesive strategy with appropriate stakeholders focused on both process and an outcome measurement
	Process and technology changes are not well-integrated into provider/staff workflows, in addition to Veteran workflows	Prioritize consistent transition planning efforts for affected stakeholders; use process mapping techniques to facilitate integration of tools and clinical workflow
	Lack of coordination and communication with DoD and IHS health information leadership to promote interoperability	Consistently communicate with appropriate contacts, agree upon data models and standards, and coordinate deadlines
	Lack of defined process owners for health information management processes	Clearly define process owners, educate owners, and perform appropriate policy development and transition planning efforts
Element 10: Transition Plan	Organizational capacity to implement major transformational change is severely limited. The New VCP could demand so many resources that VA loses attention to current operations	Fold activities into the overall reform of the VA health care system, integrated with MyVA. Use the Commission on Care to help prioritize activities. Consciously link the New VCP action plans to what is proposed in response to the Independent Assessment Report; use industry best practices for change management
	Timelines for the acquisition process may affect the delivery of some aspects of the Program	Develop anticipated list of RFPs as part of detailed implementation planning. Initiate the contracting process early to limit delays. Use early collaboration with acquisition community to structure RFPs in optimal way to avoid re-work
	Constrained IT resources may affect VA's ability to deliver technology system components along proposed timelines	Collaborate with VA Office of Information and Technology (OI&T) to develop an understanding of the IT needs and timelines

## Plan to Consolidate Community Care Programs

Legislative Element	Risks	Mitigation Strategies
	Hiring and retaining qualified staff is critical to the successful delivery of the program	Encourage staff ownership of the Program. Foster an open and innovative culture that promotes personal and professional growth
	Changing political winds could derail a multiyear initiative that will span many administrations and Congressional elections	Use the Commission on Care and other vehicles to push legislation that helps to insulate VA from short-term political considerations. Seek multiyear authorities, including ability to give key leadership positions (e.g., DUSH for Community Care), a tenure that will span administrations
	Inability to attract the caliber of leadership and expertise needed to achieve successful implementation under Federal pay schedules	Consider extent to which Title 38 hiring and compensation authorities should be expanded to include health system and health plan administrators.
	Developing the analytic and “big data” capabilities that a plan of this scope needs will take years of investment and is unlikely in the current IT environment and budget	This is predicated on a successful response to Independent Assessment H.

## **5.0 Estimated Costs and Budgetary Requirements**

### **Legislative language**

“Estimated costs and budgetary requirements to implement the plan and to furnish Hospital Care and Medical Services pursuant to such plan.”

### **Introduction**

Consolidating purchased care programs is critical for the long-term success of VA as an integrated care delivery system. Currently, VA has multiple disconnected processes to perform clinical and administrative functions associated with purchasing care. In addition, there are multiple legal authorities with different criteria and business rules for the various purchased care programs. This variation causes confusion among Veterans, community providers, and VA staff. Under the New VCP, these disparate authorities, business rules, processes, and systems will be consolidated into a single program that supports the future vision of VA outlined in this plan.

A transformation of this scale requires VA to take a system of systems approach, examining all the components of the system and optimizing desired outcomes, rather than trying to optimize component parts. This approach must take a holistic view of Veteran care and consider changes that affect care both inside the VA and in the community. Using this approach, VA has identified required changes to five clinical and administrative systems: Integrated Customer Service Systems, Integrated Care Coordination Systems, Integrated Administrative Systems (Eligibility, Patient Referral, Authorization, Billing, and Reimbursement), High-Performing Network Systems, and Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting).

Delivering the New VCP will not be successful without approval of requested legislative changes and required budget. Discussion of the estimated budget increase associated with implementing this plan is divided below into three sections: (1) System Redesign and Solutions; (2) Hospital Care and Medical Services, including Dentistry; and (3) Expanded Access to Emergency Treatment and Urgent Care. System Redesign and Solutions include enhancements to the referral and authorization process, care coordination and customer service, and claims processing and payment. These changes are expected to improve the Veteran experience with community care. This may result in an increase Veteran reliance on VA community care, leading to the increased health care costs described in the Hospital Care and Medical Services section. Expanded Access to Emergency Treatment and Urgent Care is important in providing Veterans with appropriate access to these services, but is severable from other aspects of the program and could be implemented separately. This section details the estimated budget increase associated with the each area described above, as well as the methodologies and assumptions used in generating the estimates. Note that the cost estimates in this section represent incremental increases above VA's

existing Community Care program, which includes historical costs of hospital care, medical services, and long-term services and supports (approximately \$7 billion a year in the base budget), and assumes the continuation of the existing Veterans Choice Program with no modification (approximately \$6.5 billion additional cost annually).

### **Budget Estimation Methodology**

System Redesign and Solutions budget estimates primarily refer to one-time costs of the System Redesign and Solutions delivery. Focus areas for system improvements included in the budget estimate relate to enhancements in the referral and authorization process, care coordination and customer service, and claims processing and payment. Estimates were created by joint business and IT workgroups to identify incremental costs associated with New VCP requirements. Given the short time frame required to produce this report, these estimates should be considered as rough order of magnitude estimates. Detailed requirements and/or validation with key stakeholders and SMEs are ongoing and necessary to refine these estimates.

VA estimated the Health Care Services Costs (Hospital Care and Medical Services, including Dentistry and Expanded Emergency Treatment and Urgent Care) using the VA Enrollee Health Care Projection Model, base year 2014. The New VCP is not expected to affect Health Care Services Costs in Phase I, so it will have minimal impact on the Health Care Services budget for that time period. Anticipated Health Care Services Costs for Phase II and year one of Phase III are incremental above VA's existing Community Care program, which includes historical costs of hospital care, medical services, and long-term services and supports (approximately \$7 billion a year in the base budget), and assumes the continuation of the existing Veterans Choice Program with no modification (approximately \$6.5 billion additional cost annually).

All costs described in this section are estimates. These estimates may increase based on additional analyses, as a result of increased demand for VA health care, or as a result of changes to the design of the New VCP based on input from Congress or other stakeholders.

### **Incremental Cost of New VCP System Redesign and Solutions**

The estimated incremental cost increases associated with the redesign, development, and delivery of systems and technology solutions for the New VCP are outlined in Table 22. The majority of these estimates primarily refer to one-time costs of System Redesign and Solutions. Over time, these system improvements are likely to result in cost savings as process efficiencies are realized (e.g., reduced timelines for eligibility determinations and increased auto-adjudication of claims).



Table 22: Estimated Incremental Costs for New VCP System Redesign &amp; Solutions

	Phase I Incremental (\$ M)	Phase II Incremental (\$ M)	Phase III: Year 1 Incremental (\$ M)
New VCP – System Redesign and Solutions costs (not Health Care Service related)	\$ 421	\$ 606	\$ 851

Key considerations for the System Redesign and Solutions cost drivers are outlined below:

- **Incremental Cost Estimates**—Many of the System Redesign and Solutions outlined above build upon existing improvement projects already underway at VA (e.g., medical records transfer and care coordination systems). The joint workgroups considered the scope, expected timeframes, and funding streams of these projects when developing the incremental costs for the New VCP.
- **Make/Buy Decisions**—Several systems and solutions will require VA to complete a Make/Buy analysis for a final recommendation. This report begins to identify enablers and requirements, but does not make any recommendation for Make/Buy decisions. The outcome of these recommendations will have an impact on the final cost.
- **Key Project Dependencies**—The New VCP is dependent on several improvements currently being developed by other areas of the Department. For example, updating customer service telephone infrastructure and implementing a financial management solution will be foundational to the New VCP. The costs of these key projects are accounted for elsewhere and not included in this analysis.
- **Limiting Scope of Delivery for Existing Programs**— Some programs already in development—specifically Virtual Lifetime Electronic Record and the eHMP – will need to be modified based on the requirements for the New VCP. Incorporating requirements for the New VCP into these programs early in their development may reduce the long term costs of system modifications. However, this incorporation will likely increase short term costs.

### Incremental Cost of New VCP Hospital Care and Medical Services Eligibility

The Hospital Care and Medical Services, including Dentistry, eligibility criteria for the New VCP do not represent a significant change from the eligibility criteria outlined in *The Choice Act* and the *VA Choice and Budget Improvement Act*. For example, the New VCP preserves access to community care based on wait-time and geographic access/distance criteria, the more detailed ‘excessive burden’ guidance, and recent removal of the requirement of enrollment prior to August 2014. Despite minimal changes in eligibility criteria, an increase in Veteran reliance on VA community care is expected as System Redesign and Solutions described above meaningfully improve the Veteran experience with community care. The estimates in Table 23 below document

the expected incremental costs, which are primarily associated with (1) an increased reliance on VA for those eligible under the Geographic Distance/Convenience criteria, (2) a shift to Medicare Fees Schedules, and (3) Revenue Offsets.

*Table 23: Estimated Incremental Costs for New VCP Hospital Care and Medical Services Eligibility Changes*

	Phase I Incremental (\$ M)	Phase II Incremental (\$ M)	Phase III: Year 1 Incremental (\$ M)
New VCP - Hospital Care and Medical Services Medical and Administrative Cost	\$ 0	\$ 2,064	\$ 2,318
New VCP - Hospital Care and Medical Services Revenue Offset	\$ 0	\$ (205)	\$ (171)
<b>New VCP - Hospital Care and Medical Services Changes Total Net Cost</b>	<b>\$ 0</b>	<b>\$ 1,859</b>	<b>\$ 2,147</b>

Key considerations for Hospital Care and Medical Services Eligibility are outlined below:

- **Initial Cost Drivers:** Health care costs for the New VCP are primarily driven by an increased reliance on VA for those eligible under the Geographic Distance/Convenience criteria, a shift to regional Medicare Fees Schedules, and increased Revenue Offsets from Veteran OHI.
  - **Geographic Distance/Convenience**—The New VCP Geographic Distance/Convenience eligibility criteria offer enrolled Veterans who live more than 40 miles from a VA PCP access to community care. Because of enhancements in customer service and care coordination proposed under the New VCP, a greater demand for community care is anticipated from this population. VA assumed that the reliance of the enrollee population originally eligible under *The Choice Act* (approximately 600,000) will increase to 50 percent from roughly 37 percent anticipated in 2017. In addition, for all enrollees eligible under *The Choice Act* and *The Veterans Choice and Budget Improvement Act* (approximately 900,000), approximately half of the care they would have been expected to receive in VA facilities under their historical level of reliance is expected to move to the community through the New VCP.
  - **Medicare Allowable Costs**—Cost estimates for the New VCP assume that VA will pay regional Medicare rates, plus typical administrative costs for health care services provided through the program. Because some community care has traditionally been purchased above these rates, this change will lead to a *decrease* in the cost of community care.
  - **Revenue Offset** – Increased Veteran utilization of community care as a result of New VCP System Redesign and Solution Improvements will, in some cases, lead

to increased collections from Veteran OHI. These collections will offset some of the health care services costs.

### **Incremental Cost of New VCP Expanded Access to Emergency Treatment and Urgent Care**

The current eligibility criteria for seeking emergency treatment through community care are extremely complex and require nuanced determinations for individual claims. These criteria lead to a large number of denied claims and confusion among Veterans about when they are eligible to receive emergency treatment through community care. The New VCP identifies improvements in access to emergency treatment and urgent care in the community. To encourage appropriate use of emergency treatment and urgent care services, reflect industry-leading practices, and for the purposes of modeling, this benefit includes a co-payment (\$100 for emergency treatment, \$50 for urgent care), unless the visit results in an admission or the co-payment represents an undue financial burden for the Veteran. Under the New VCP, reliance on VA health care for emergency treatment and urgent care is expected to increase, with VA becoming the payer for 75 percent of the care currently paid for primarily by Medicare, Medicaid, and commercial insurance (moving reliance from 43 percent to 86 percent for priority groups 1–6 and from 15 percent to 79 percent for priority groups 7–8). The estimated incremental costs of these changes are outlined in Table 24. The proposed expansion of emergency treatment and urgent care is independent from the System Redesign and Solutions and corresponding increase in reliance on VA Hospital Care, Medical Services, and Dentistry services described above. As such, this change could be executed separately with limited impact on the delivery of the larger program.

*Table 24: Estimated Incremental Costs for New VCP Emergency Treatment Changes*

	<b>Phase I Incremental (\$ M)</b>	<b>Phase II Incremental (\$ M)</b>	<b>Phase III: Year 1 Incremental (\$ M)</b>
New VCP - ER/Urgent Care Medical and Administrative Cost	\$ 0	\$ 2,045	\$ 2,137
New VCP - ER/Urgent Care Revenue Offset	\$ 0	\$ (644)	\$ (648)
<b>New VCP – ER/Urgent Care Total Net Cost</b>	<b>\$ 0</b>	<b>\$ 1,401</b>	<b>\$ 1,489</b>

### **Potential Offsets for Resource Requirements of the New VCP**

VA understands that the costs of health care are rising, both for care delivered at the VA and in the community. Given the rapid increase in costs, stakeholders may have to consider changes to the VA care delivery model and system. The considerations below

may represent options for offsetting health care costs of community care going forward. VA has not yet developed estimates for the magnitude of these potential savings.

- **Potential VA Facility Offset**—Delivering more community care may lead to underutilized resources within VA facilities. To better align resources, VA needs the flexibility to improve management of its current infrastructure. Currently, VA has 336 buildings that are vacant or less than 50 percent occupied. This means VA maintains more than 10.5M square feet of unneeded space—taking funding from needed Veteran services. VA is seeking the legislative authority to conduct a review of existing facilities and make changes based on excess capacity. Cost savings are likely to be significant.
- **Incentivizing Appropriate Health Behaviors**—VA has limited tools for incentivizing Veterans to seek care in a manner that supports positive health outcomes. Cost-sharing arrangements (co-payments, coinsurance, and deductibles) are one way of encouraging these behaviors. Currently, enrolled Veterans have limited cost-sharing arrangements for most services. In order to encourage Veterans to use higher-quality, higher-value providers, revisions to these arrangements should be explored. The impact on Veteran behavior and amount of any cost offset would vary greatly depending on the nature and the amount of the revised cost-sharing arrangement.
- **Identifying Services Best Performed in the Community**—As VA's high-performing network develops, certain services (high quality, high value) may be identified to be the best or more efficiently provided by the community and not by VA. Should these services shift to the community, VA may be able to repurpose associated internal facilities for other uses. The amount of potential savings from these changes depends on the specific services that are referred into the community and the timelines to repurpose resources.

## 6.0 Legislative Proposal Recommendations

### Legislation

“The Secretary shall submit to the Committees on Veterans’ Affairs of the House of Representatives and the Senate a report containing...any recommendations for legislative proposals the Secretary determines necessary to implement such plan”

### Introduction

To successfully implement critical reforms, VA needs additional legislative authorities to improve access to community care, consolidate VA’s community care programs, improve emergency treatment and urgent care services, and realign current processes to support reforms. This section provides detailed information regarding the legislative changes needed to address current deficiencies and improve the health care services Veterans receive. Without these additional authorities, VA will not be able to implement the New VCP and make critical reforms.

The primary objectives of the legislative proposal recommendations are to make immediate improvements to community care, establish the New VCP, and implement necessary business process improvements. The legislative proposal recommendations are divided into three sections: Immediate Improvements to the Veterans Choice Program, Establishing a Single Program for Community Care, and Process and Organizational Improvements.

1. **Immediate Improvements to the Veterans Choice Program.** The three legislative proposal recommendations below are necessary to provide VA with the authorities to improve access to care while beginning to consolidate community care programs. These proposals would allow VA to work more easily with community providers and provide VA the flexibility for community care funding. These legislative authorities are critical to meet the needs of Veterans today and in the future. The legislative proposal recommendations include:
  - Improving VA’s Partnerships with Community Providers to Increase Access to Care (Provider Agreements).
  - Improving Access to Community Care through Choice Fund Flexibility.
  - Increasing Accuracy of Funding by Recording Community Care Obligations at Payment.
2. **Establishing a Single Program for Community Care.** These legislative proposal recommendations allow VA to consolidate community care, establish a Community Care Account, phase out unnecessary authorities and programs for community care, and improve access to emergency treatment and urgent care. These proposals include:
  - Improving Veterans Access to Community Care by Establishing the New VCP.

- Increasing Access and Transparency by Requesting Budget Authority for a Community Care Account.
- Streamlining Community Care Funding.
- Improving Veterans Experience by Consolidating Existing Programs.
- Improving Veterans Access to Emergency Treatment and Urgent Care.

**3. Process and Organizational Structure Improvements.** The legislative proposal recommendations below provide VA with the necessary authorities to improve care coordination, collection of payments from OHI, and improve timely payments to community providers.

- Improving Care Coordination for Veterans through Exchange of Certain Medical Records.
- Aligning with Best Practices on Collection of Health Insurance Information.
- Formalizing VA's Prompt Payment Standard to Promote Timely Payments to Providers.

At the end of the section, Table 25 provides a description and the impact of the legislative proposal recommendations. Additional information or legislative text will be provided upon request.

## **6.1 Immediate Improvements to the Veterans Choice Program**

### **Title: Improving VA's Partnerships with Community Providers to Increase Access to Care (Provider Agreements)**

The purpose of this proposal is to improve VA's flexibility to meet Veterans' demand for hospital care, medical services, and extended care services. This proposal would authorize VA to purchase care in certain circumstances through agreements that are not subject to certain provisions of law governing Federal contracts. It also would amend 38 U.S.C. Section 1745 to permit VA to enter into agreements exempt from certain provisions of law governing Federal contracting. Specifically, an agreement under this section could be awarded without regard to competitive procedures and would not subject a State Veterans Home to certain laws that are applicable to providers and suppliers of health care services through the Medicare program.

This bill was recently introduced as Senate Bill S.2179 and VA supports its rapid passage.

### **Title: Improving Access to Community Care through Choice Fund Flexibility**

It is critical for VA to have flexibility to use existing Choice Funds to pay for community care. This proposal would authorize VA to use the existing Choice Funds to pay for any compensation and pension exams or any health care services under Chapter 17 of Title 38, including care for certain dependents, extended care services, and emergency treatment through non-Department provider. This is the same flexibility that was

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afforded VA by the *VA Budget and Choice Improvement Act* and it would facilitate VA's efforts to consolidate and streamline the Department's non-VA care authorities. It is critical for VA to have flexibility to use existing Choice Funds to pay for care within the community.

**Title: Increasing Accuracy of Funding by Recording Community Care Obligations at Payment**

The purpose of this proposal for appropriations act authority is to address two inefficiencies in the obligating of funds that were found during a recent Inspector General (IG) audit. In reality, current processes requirements in this area are incompatible with the efficient use of resources provided to VA. During a recent IG audit, it was determined that for FY 2013, more than \$500M in Non-VA Care deobligations had occurred in the first 18 months after the fiscal year end, foregoing funds that could have provided more health care for Veterans. Additionally, if the eventual expenditures exceed the obligation amount, a potential violation of the Anti-Deficiency Act (ADA) is created, unless sufficient prior-year deobligations from other sources are available at that time. In FY 2014, five VISNs collectively requested an additional \$110M in two-year funds that would have otherwise been available for FY 2015 requirements because they had underestimated the obligation amount required for FY 2014 authorizations.

Under current practice, VHA administratively and clinically approves community care consults. Administrative approval indicates the patient is eligible for a VHA medical benefits package and care outside the VA, if required. Clinical approval indicates the care is medically necessary for the patient's health and well-being per non-VA Care Coordination processes. After establishing administrative and clinical approval, the medical facility's non-VA Care Team generates an authorization for care. An authorization gives a community provider authority to provide health care to the Veteran patient and provides assurance of payment for those services. The authorization document binds VA to the language that is included on the authorization.

VA's legal liability to pay for community care occurs when the authorization for care is generated. In accordance with the Recording Statute, 31 U.S.C. Section 1501 and the ADA, 31 U.S.C. Section 1341(a)(1), VA records an obligation covering the estimated amount of the non-VA care. These amounts are highly unpredictable and this unpredictability has led to significant deobligations after the end of the fiscal year, resulting in large balances of expired prior-year appropriations in the Medical Services account. The unpredictable nature of the health care needed also adds significant risk of ADA violations because of under-estimated obligations.

In compliance with the Recording Statute and to protect against potential violations of the ADA, VA must record obligations when authorizations are issued. Each authorization may ultimately be used once, several times, or not at all by the Veteran

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who receives it, but VA must record an obligation amount at the time the authorization is issued that is sufficient to cover the ultimate expenditures from that authorization. Expenditures can lag several months to several years after the care has been authorized, and amounts frequently vary from the original estimated obligations. If the Veteran does not use an authorization, there are no resulting expenditures.

The penalty for over-obligation is a prior-year de obligation, foregoing funds provided by Congress with no other penalty. Conversely, the penalty for under-obligation is a potential ADA violation, with a published report to the President, Congress and the Government Accountability Office identifying the responsible officials, potential detrimental administrative action against those officials, and potential criminal penalties if the violation is determined to have been knowing and willful. Because of the difference in possible penalties, there is a strong incentive to over-obligate to preclude a potential ADA violation.

This proposed appropriations act legislation would allow VA to record the obligation when the amount is certain (i.e., when VA approves the payment of the claim for the incident of care) without regard to the requirements of the Recording Statute and ADA. It would likely reduce the potential for large deobligation amounts after the funds have expired. VA already records obligations for CHAMPVA and Millennium Bill emergency treatment claims, for which authorizations are not generated, upon payment of the claim.

This proposed legislation will greatly reduce, and probably eliminate, any potential for ADA violations, as well as the potential for large deobligation amounts after the funds have expired. VA already uses this process for CHAMPVA and Millennium Bill emergency treatment claims, which require no authorizations, without incident. Per discussion with the DoD Health Affairs TRICARE staff, who have similar authority to that proposed for VA, there have been no ADA violations resulting from this authority.

## **6.2 Establishing a Single Program for Community Care**

### **Title: Improving Veterans Access to Community Care by Establishing the New VCP**

The purpose of this legislative proposal is to establish the New VCP that would consolidate all community care programs and improve Veterans access to community care. This proposal would amend Chapter 17 of Title 38, U.S.C. to add a new section establishing the New VCP. This provision would authorize the Secretary to furnish Hospital Care and Medical Services to eligible Veterans through agreements with certain eligible entities. Veterans would be eligible for Hospital Care and Medical Services through the New VCP based on the wait-time for the needed care at VA, the availability of the service from VA, the geographic distance a Veteran must travel, or the convenience of the Veteran.

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VA relies heavily on long-term relationships with specific Federal and academic partners. Many of these relationships were disrupted due to new and cumbersome processes established in *The Choice Act* to become Choice providers. VA believes altering the new program's authorization from *The Choice Act* could remedy these problems. To preserve and build on existing relationships, certain non-Department providers, such as DoD, IHS, THP, FQHC, and select academic departments that have an affiliation agreement with VA would be considered part of VA's core provider network.

Under the proposal, a Veteran eligible for care under the New VCP program could elect to receive necessary Hospital Care and Medical Services from an eligible entity that has an agreement to provide such care and services for VA. Veterans will be responsible for paying the applicable co-payments required by statute and established in regulation to VA. The term agreement would be defined to include contracts and provider agreements.

VA would be responsible for payment for the care and services furnished under this program. VA would use existing authority to make third-party collections from a Veteran's OHI for care provided for a non-service connected condition. Under the New VCP, VA would like to evolve to value-based payment models instead of using fee for service schedules. This will require additional flexibility as pilot payment models mature. To better align resources, VA will need to be able to better manage its current infrastructure by closing locations that are not economically sustainable and old, outdated buildings.

**Title: Increasing Access and Transparency by Requesting Budget Authority for a Community Care Account**

To increase visibility and accountability within the community care program, VA will request budget authority for a new Community Care Account. By requesting separate appropriations for an account solely funding community care, VA will have a more central and coherent fiscal structure for administering this program. This will improve VA's ability to meet Veterans' needs. Section 4003 of the *VA Budget and Choice Improvement Act* requires that VA "include an appropriations account for non-Department provider programs" as part of its annual budget request.

In future budget requests, we will request that Congress appropriate budget authority to this account in the annual appropriations act. The account, which will be known as the "Community Care" account, will be the sole source of funding for care that VA provides to Veterans through community providers. Separating the funding of Veteran community care from the current VA hospital care and medical service funding will require local leaders to set a clear funding level and actively manage community care. VA will also request the appropriations act authority to transfer funds among the

Veterans Community Care, Medical Services, and Medical Support and Compliance accounts and the authority to deposit Medical Care Collection Funds receipts into the Community Care Account.

**Title: Streamlining Community Care Funding**

This legislative proposal would increase both accountability and visibility on community care resources and expenditures at local facilities and at higher levels by amending Section 106(b) of PL 113-146. This provision actually has had the effect of impeding VA from putting in place an efficient process for funding community care. Under these requirements, there is no direct link between the resources and the purchased care demand at the local VA Medical Center level.

We propose Section 106(b) be amended to adapt the current model used for funding VA's Consolidated Mail-Out Pharmacies (CMOPs), where VA Medical Centers estimate their total requirement for the year, provide the funds to their supporting CMOP, and adjust funding levels up or down for variances in demand during the year. Variances may occur for reasons unknown at the time the budget is submitted, such as the retirement of a specialty physician that causes demand for purchased care to increase until a replacement is hired. Conversely, funds that were intended for purchased care at the beginning of a fiscal year could be realigned to pay for staff at the local VA Medical Center if successful hiring of scarce medical providers offers an opportunity to deliver the required care in-house rather than through purchased care.

**Title: Improving Veterans Experience by Consolidating Existing Programs**

Consolidating and streamlining community care is a central goal of the plan required by PL 114-41. To meet this requirement, certain existing authorities and programs will need to sunset. Some of these authorities are described below:

If the New VCP outlined above were enacted, 38 U.S.C. Section 1703, which authorizes VA to contract for Hospital Care and Medical Services for certain Veterans, would be superfluous. Section 1703 should be amended to add a sunset or expiration date of December 31, 2017.

The authority to contract for scarce medical resources, 38 U.S.C. Section 7409, is no longer utilized. VA currently relies on 38 U.S.C. Section 8153 to contract for these medical resources. Section 7409 should be repealed.

Project ARCH, Section 403 of PL 110-387 (as amended), was designed to improve access for eligible Veterans by connecting them to health care services closer to home. The New VCP will address these same access issues. Project ARCH will sunset in August 2016 and VA will develop a plan to address continuity of care for affected Veterans.

The Assisted Living for Veterans with TBI (AL-TBI) pilot program authorized by Section 1705 of PL 110-181(as amended) provides assisted living services to certain eligible Veterans with TBI. The pilot program is currently scheduled to sunset in October 2017. VA does not provide assisted living services to any other group of Veterans. This pilot program should not be extended if a true consolidation of community care is to take place. This pilot of assisted living services is inconsistent with the scope of the medical benefits that VA provides in all other health programs. As required by statute, VA is providing quarterly reports to Congress on, among other things, VA's interim findings and conclusions with respect to the success of the pilot program. VA's future reports to Congress on the pilot program will make recommendations for the future direction of care for the Veteran cohort eligible for this pilot program.

**Title: Improving Veterans Access to Emergency Treatment and Urgent Care**

The purpose of this legislative proposal is to address VA's existing authorities to reimburse the cost of emergency treatment. In addition, this proposal would clarify reimbursement for emergency transportation services. Veterans often seek emergency treatment with a misunderstanding of VA's authority to pay for their treatment and are surprised when VA is unable to cover their bills. The complexities of the current law also creates confusion for those who administer the program. VA's plan envisions an expanded authority to reimburse costs associated with emergency treatment for enrolled Veterans, who are active VA health care participants, in a more consistent and understandable way.

We propose to amend 38 U.S.C. Section 1725 to authorize VA to reimburse the reasonable costs of emergency treatment and emergency transportation provided to eligible Veterans. VA would utilize a definition of emergency treatment similar to the definition specified in current 38 U.S.C. Section 1725(f). Eligible Veterans would be those who are enrolled and are active health care participants in VA. An active health care participant is a Veteran who has sought care from VA within the last 24 months. VA would be the primary payer for the treatment provided under this section. The provision would authorize VA to set the maximum amount payable under this provision and specify that VA payment is payment in full. Consolidating VA's emergency treatment authorities into a single provision and providing a consistent benefit to all eligible Veterans also would require 38 U.S.C. Section 1728 to be repealed.

In addition, the proposal would authorize VA to pay the reasonable costs of urgent care provided to an eligible Veteran through an entity under contract or other agreement with VA. The term 'urgent care' would be defined by the Secretary in regulation. Eligible Veterans would be those who are enrolled and are active health care participants in VA. VA would be the primary payer for urgent care provided under this section.

As VA improves access to emergency treatment, VA proposes to implement policies to encourage more appropriate use of emergency treatment versus other points of care provided by VA. Therefore, this proposal would require the Secretary to establish a cost share for emergency treatment. The cost share would apply to all Veterans, unless they meet a hardship exemption or are admitted to a hospital for treatment or observation following the emergency treatment.

Similarly, the proposal would require the Secretary to establish a cost share for urgent care. The cost share would apply to all Veterans, unless they are admitted to hospital for treatment or observation or if it represents a financial obstacle to the Veteran receiving required care.

### **6.3 Process and Organizational Structure Improvements**

#### **Title: Improving Care Coordination for Veterans through Exchange of Certain Medical Records**

The purpose of this legislative proposal is to improve VA's ability to share health information for care coordination with community providers. This proposal would amend 38 U.S.C. Section 7332(b)(2) to include a provision for the disclosure of VA records of the identity, diagnosis, prognosis, or treatment of a patient relating to drug abuse, alcoholism or alcohol abuse, or infection with the Human Immunodeficiency Virus (HIV) or sickle cell anemia to a health care provider in order to treat or provide care to a shared patient. This change would not amend or create a new exception to the Health Insurance Portability and Accountability Act (HIPAA). The proposal instead is to address an obsolete provision of law, only applicable to VA that hinders coordination of care.

Currently, 38 U.S.C. Section 7332(b)(2) prevents VHA from providing or sharing patient information relating to drug abuse, alcoholism or alcohol abuse, or infection with HIV or sickle cell anemia with public or private health care providers, including with IHS health care providers, providing care to the shared patient under normal treatment situations without the prior signed, written consent of the patient. This restriction poses potential barriers to the coordination and quality of care provided to our patients by public or private health care providers and actual barriers to providing health information to IHS for the treatment of shared patient populations. Furthermore, this restriction is inconsistent with other health care practices and other Federal standards related to patient privacy.

#### **Title: Aligning With Best Practices on Collection of Health Insurance Information**

The purpose of this proposal is to improve VA's ability to collect information on OHI from Veterans. Currently, other Federal partners, as well as private providers, require beneficiaries to provide information on OHI. This proposal would amend Title 38, U.S.C. by adding a new section to require an applicant for or recipient of VA medical

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care and services to provide their health plan contract information to VA. Specifically, an applicant or recipient of VA medical care or services would be required to provide information regarding their health plan coverage to include the name of the health plan contract(s), the name of the policy holder if coverage is under a health plan contract other than the name of the applicant or recipient, the plan number, and the plan's group code.

The proposal would further authorize the Secretary to define and take appropriate action when an individual who fails to provide this information. The Secretary also would be authorized to reconsider the application for or reinstate the provision of care or services once the information requested has been provided. To be clear, the proposal would not be construed as authority to deny medical care and treatment to an individual in a medical emergency. If a medical emergency exists, VA will not deny emergency treatment or services should the applicant or recipient fail to provide health plan contract information.

**Title: Formalizing VA's Prompt Payment Standard to Promote Timely Payments to Providers**

The purpose of this legislative proposal is to formalize VA's Prompt Pay standard to be in alignment with the current industry guidelines established by States. This proposal would establish a section under Title 38 for the Prompt Payment of all care provided in the community. The legislative proposal should establish what constitutes a "clean claim" that will start the payment clock. Generally, a "clean claim" is defined by States as a "claim" that has all the information a payer needs to either pay or deny the claim. A "non-clean claim" is a claim that requires additional information or documentation from the provider. Moreover, there are States that use different time frames for paper clean claims (usually 45 days) versus electronic clean claims (usually 30 days). In counting the days, states vary from "working/business days" to "calendar days" for processing of claims. VA's proposal will use the above as a guide.



## 6.4 Summary of Legislative Proposals

*Table 25: Summary of Legislative Proposals*

Title/Topic	Description	Impact/Justification
Improving VA's Partnerships with Community Providers to Increase Access to Care	Amends 38 U.S.C. Section 1745	This would allow VA to enter into agreements exempt from certain provisions of contracting law.
Improving Access to Community Care through Choice Fund Flexibility	Authorize VA to use Veterans Choice Fund to pay for non-Department Care	This would provide VA with increased flexibility to use Veterans Choice Fund to pay for health services that Veterans receive within the community.
Increasing Accuracy of Funding by Recording Community Care Obligations at Payment	Appropriations act provision to allow VA to record obligations for Community Care on the date on which payment of a claim to a provider is approved without regard to the recording statute or ADA requirements	This would allow VA to record obligations of community care at the time of claim adjudication.
Improving Veterans Access to Community Care by Establishing the New VCP	Amends Chapter 17, Title 38 to establish the New VCP	This would establish a permanent, consolidated non-Department Care program, the New VCP. The New VCP would provide VA with flexibility to meet the evolving needs of Veterans.
Increasing Access and Transparency by Requesting Budget Authority for a Community Care Account	Appropriations act to provide budget authority in the new the Community Care Account	The separate Community Care Account will increase accountability and visibility of funding for community care.
Streamlining Community Care Funding	Amends Section 106(b) of PL 113-146	This would improve the process for funding community care by allowing VA the flexibility to increase funds based on demand.
Improving Veterans Experience by Consolidating Existing Programs	Amends Title 38 to repeal and sunsets certain programs	This would repeal certain authorities to contract for care that are no longer necessary. This would also sunset certain pilot programs, including Project ARCH, which would be replaced by the New VCP.
Improving Veterans Access to Emergency Treatment and Urgent Care	Amends 38 U.S.C. Section 1725	This would improve emergency treatment services and provide reimbursement for urgent care. This provision also would authorize VA to establish a co-pay for emergency treatment and urgent care services.



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Title/Topic	Description	Impact/Justification
Improving Care Coordination for Veterans through Exchange of Certain Medical Records	Amends 38 U.S.C. Section 7332 (b)(2)	This would allow VA to share certain medical records it cannot share easily today by virtue of a special legal restriction unique to VA. This change would be fully consistent with HIPAA.
Aligning With Best Practices on Collection of Health Insurance Information	Amends Title 38 to require individuals to provide health care insurance information	This would add a new section to Title 38 that would require Veterans to provide VA with OHI information.
Formalizing VA's Prompt Payment Standard to Promote Timely Payments to Providers	Amends Title 38	This would clarify VA's Prompt Pay for medical claims by applying current industry standards.

## 7.0 Descriptions of Each Non-Department Provider Program and Statutory Authority

### Legislation

“The Secretary shall submit to the Committees on Veterans’ Affairs of the House of Representatives and the Senate a report containing a description of each non-Department provider program and the statutory authority for each such program”

### Description of each non-Department provider program and statutory authority

As more Veterans seek services through VA facilities, VA has had to increasingly depend on non-Department providers to meet the evolving needs of Veterans. Throughout the decades, Congress provided VA with several statutory authorities and established numerous programs that allow Veterans to seek community care. Additionally, VA has authority to provide some care and services to certain survivors and/or dependents. These numerous authorities and non-VA care programs are cumbersome and oftentimes confusing for Veterans, community providers, and VA staff to understand and administer.

The five tables below detail VA’s authorities to provide community care. These include VA’s contracting authorities (Table 26), reimbursement authorities (Table 27), community care programs (Table 28), benefits programs (Table 29), and authorities to contract for specific health care services (Table 30). Each table provides information regarding the statutory authority, nature of the provision, description, eligibility criteria, and beneficiary.

Table 26 provides details on three statutes that authorize VA to enter into contracts with community providers for health care services. Note: Authorities to contract for specific types of care are detailed in Table 30 below.

*Table 26: VA’s General Contracting Authorities for Health Care*

Title and Statutory Authorities	Nature of Provision	Description	Eligibility Criteria	Beneficiary
Contracts for Hospital Care and Medical Services in Non-Department facilities  38 U.S.C. Section 1703	Contracting	Authority to contract for Hospital Care and Medical Services when VA facilities are not capable of furnishing economical care due to geographic inaccessibility or are not capable of furnishing care; can	Criteria specified in statute and regulations. Authority to contract for care based on type of care needed and whether or not the Veteran is SC.	Certain Veterans as specified in statute

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Title and Statutory Authorities	Nature of Provision	Description	Eligibility Criteria	Beneficiary
		also furnish counseling and related Mental Health services under 38 U.S.C. Section 1712A(e)(1).		
Sharing of Health Care Resources  38 U.S.C. Section 8153	Sharing authority; Contracting	Broad authority to make arrangements, by contract or other forms of agreement, for the mutual use, or exchange of use, of health care resources between VA facilities and any health care provider, or other entity or individual. Sharing agreements with affiliates are executed under this authority.	VA can use the authority to provide care to any individual VA is authorized to treat (or reimburse for treating).	Veterans or individuals authorized to receive care under Title 38
Sharing of VA and DoD health care resources  38 U.S.C. Section 8111	Sharing authority	Authority to enter into sharing agreements and contracts <u>with DoD</u> for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed.	N/A	Veterans Service members

Table 27 provides details on the statutes that are cited when VA reimburses community providers for health care services. These reimbursement authorities are related to emergency treatment and care provided in IHS/THP facilities.

*Table 27: VA's Authority to Reimburse for Community Care*

<b>Title and Statutory Authorities</b>	<b>Nature of Provision</b>	<b>Description</b>	<b>Eligibility Criteria</b>	<b>Beneficiary</b>
Reimbursement for Emergency Treatment  38 U.S.C. Section 1725	Reimbursement	Authority to reimburse the reasonable value of emergency treatment furnished in a non-VA facility.	Veteran must be an active health care participant <u>and</u> personally liable for the emergency treatment (terms are defined in the law).	Certain Veterans
Reimbursement of certain medical expenses (emergency treatment)  38 U.S.C. Section 1728	Reimbursement	Authority to reimburse the U&C charges of emergency treatment furnished in a non-VA facility where such treatment was needed for/related to a SC condition or in certain instances vocational rehab (38 U.S.C. Chapter 31), or provided to a Veteran permanently and totally disabled.	Veteran must be eligible for VA health care and treatment must be rendered for conditions specified in statute.	SC Veterans
Sharing agreements with Federal agencies (IHS/THP Reimbursement Agreements)  25 U.S.C. Section 1645	Reimbursement	Authorizes the Secretary of HHS to enter into or expand sharing arrangements between IHS, tribes, and Tribal Organizations, and VA and DoD. This authority is cited in VA's Direct Care Services reimbursement agreements with IHS and THP.	In general, agreements apply to American Indians and Alaska Native (AI/AN) Veterans, eligible for services from VA and IHS or the THP. Non-AI/AN Veterans may also be eligible under agreements with Alaska THP.	Certain Veterans

Table 28 provides details on the three community care programs that allow Veterans to access community providers for health care services.<sup>60</sup>

*Table 28: VA's Community Care Programs*

<b>Title and Statutory Authorities</b>	<b>Nature of Provision</b>	<b>Description</b>	<b>Eligibility Criteria</b>	<b>Beneficiary</b>
Veterans Choice Program  PL 113-146 Section 101 (as amended)	Contracting and Provider Agreement	Temporary program to furnish Hospital Care and Medical Services to eligible Veterans through eligible non-VA providers.	Certain Veterans, generally based on residence or wait-time criteria. Criteria are specified in statute and regulations.	Certain Veterans
Project ARCH  PL 110-387 Section 403 (as amended)	Pilot implemented via contract	Pilot program in five VISNs to provide by contract covered health care services to covered Veterans. Pilot set to expire in August 2016.	Specific criteria set forth in statute, including enrollment, for a VA facility providing primary and tertiary care.	Certain Veterans based on driving times to certain services
AL-TBI Pilot Program  PL 110-181, Section 1705 (as amended)	Pilot implemented via contract	Pilot program to assess the effectiveness of providing community-based brain injury residential rehabilitative care services to eligible Veterans with TBI to enhance their rehabilitation, quality of life, and community integration.  Pilot expires on October 6, 2017.	Specific criteria set forth in statute, including enrollment in VA health care and receipt of VA care for moderate-to-severe TBI.	Certain Veterans

<sup>60</sup> This table does not include VA Dental Insurance Pilot (PL 111-163 § 510).

Table 29 provides details on six benefit programs through which VA provides health care to eligible Veterans, survivors, dependents, family members, and caregivers through community providers.

*Table 29: VA's Benefit Programs to Provide Services to Veterans, Survivors, and Dependents*

<b>Title and Statutory Authorities</b>	<b>Nature of Provision</b>	<b>Description</b>	<b>Eligibility Criteria</b>	<b>Beneficiary</b>
FMP  38 U.S.C. Section 1724	Benefit	Authority to provide Hospital Care and Medical Services outside a state if such services are needed for treatment of a SC disability or as part of a rehabilitation plan under 38 U.S.C. Chapter 31.	SC Veterans treated for SC conditions.	Veterans
CHAMPVA  38 U.S.C. Section 1781	Benefit	Provides medical care for eligible survivors, dependents, and caregivers of certain Veterans.	Specific criteria set forth in statute. Cannot be eligible for TRICARE.	Certain Survivors, Dependents, and Caregivers
Camp Lejeune Family Member  38 U.S.C. Section 1787	Benefit (Reimbursement)	Provides reimbursement to family members of certain Veterans for care associated with specific medical conditions.	Specific criteria, such as length of time a person resided at Camp Lejeune, set forth in statute and regulations.	Certain family members
Spina Bifida  38 U.S.C. Section 1803; 38 U.S.C. Section 1821	Benefit	Authority to provide children of Vietnam Veterans and Veterans of covered service in Korea suffering from spina bifida with health care. What constitutes health care is defined in statute.	Specific criteria, such as definitions of child and covered defect, set forth in statute and regulations.	Certain children of certain Veterans

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<b>Title and Statutory Authorities</b>	<b>Nature of Provision</b>	<b>Description</b>	<b>Eligibility Criteria</b>	<b>Beneficiary</b>
CWVV  38 U.S.C. Section 1813	Benefit	Authority to provide eligible CWVV with needed care for that child's covered birth defects or any disability associated with those birth defects.	N/A	Certain children of certain Veterans
Care for Newborn Children of Women Veterans Receiving Maternity Care  38 U.S.C. Section 1786	Benefit	Authority to provide care to a newborn child of a woman Veteran receiving maternity care from VA for not more than seven days after the birth of the child if the child is delivered in a VA facility or another facility pursuant to a contract.	N/A	Newborn children of certain Veterans

Table 30 provides details on 15 statutes that authorize VA to furnish specific care and services through community providers.

*Table 30: VA's Authority to Furnish Specific Services by Community Providers*

<b>Title and Statutory Authorities</b>	<b>Nature of Provision</b>	<b>Description</b>	<b>Eligibility Criteria</b>	<b>Beneficiary</b>
Contract Nursing Home Care  38 U.S.C. Section 1720	Contract	Authority to contract with certain providers for nursing home care, adult day health care, or other extended care services. Care is limited to six months, unless certain exceptions are met.	Specific criteria set forth in statute and regulations.	Veterans who have been furnished care by the Secretary in a facility under the direct jurisdiction of the Secretary and require a protracted period of nursing home care.
State Veterans Homes (Nursing Home Care)	Contract	Authority to contract or enter into an agreement with each State home for payment of nursing home care.	Certain SC Veterans	Veterans in need of care for a SC condition or Veterans who are 70 percent or more SC and in need of nursing home care.



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Title and Statutory Authorities	Nature of Provision	Description	Eligibility Criteria	Beneficiary
38 U.S.C. Section 1745				
Non-institutional alternatives to nursing home care  38 U.S.C. Section 1720C	Contract	VA may furnish care in non-institutional settings for eligible Veterans and VA shall furnish appropriate health-related services solely through contracts.	N/A	Certain Veterans
Respite Care  38 U.S.C. Section 1720B	Contract	VA may furnish respite care services to enrolled Veterans and may enter into contracts for this purpose.	N/A	Veterans
Specialized Residential Care and Rehabilitation Services to Eligible Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) Veterans  38 U.S.C. Section 1720(g)  Not implemented by VA	Contract	Discretionary authority, not implemented by VA, to contract with appropriate entities to provide "specialized residential care and rehabilitation services" to eligible OEF/OIF/OND Veterans who suffer from a TBI and meet other statutory criteria.	N/A	Certain Veterans
TBI: Use of non-Department facilities for rehabilitation	Contract	Discretionary authority, not implemented by VA that authorizes VA, in implementing and carrying out rehabilitation and reintegration plans	N/A	N/A

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Title and Statutory Authorities	Nature of Provision	Description	Eligibility Criteria	Beneficiary
<p>38 U.S.C. Section 1710E</p> <p>Not implemented by VA</p>		<p>developed under 38 U.S.C. Section 1710C, to provide Hospital Care and Medical Services, including "rehabilitative services," for eligible Veterans and Service members with TBI through cooperative agreements with appropriate entities that have established long-term neurobehavioral rehabilitation and recovery programs.</p>		
<p>Appropriate Care for Gender-Specific Disabilities of Women Veterans</p> <p>PL 98-160, as amended by PL 102-40 and PL 102-83</p>	Contract	<p>Each VA health care facility must be able to provide, directly or by contract under 38 U.S.C. Sections 7409, 8111, or 8153, as appropriate, timely care for any gender-specific disability of an eligible woman Veteran.</p>	N/A	Women Veterans
<p>Counseling and treatment for Military Sexual Trauma (MST)</p> <p>38 U.S.C. Section 1720D</p>	Contract	<p>VA shall provide counseling and services to Veterans with MST and may furnish counseling pursuant to a contract.</p>	N/A	Veterans
<p>Readjustment and Mental Health Services for OEF/OIF Veterans</p> <p>PL 111-163 § 304, as amended by PL 112-239</p>	Contract	<p>VA may contract (when VA resources are not available) with community Mental Health centers and other qualified entities to furnish peer outreach, peer support, readjustment counseling, and Mental Health services to Veterans and family members for three years post deployment.</p>	N/A	Certain Veterans and family members

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<b>Title and Statutory Authorities</b>	<b>Nature of Provision</b>	<b>Description</b>	<b>Eligibility Criteria</b>	<b>Beneficiary</b>
Substance Use Disorder Treatment  PL 110-387 § 103	Contract	Permits VA through contract or fee-for-service payments to provide a range of services for substance use disorder treatment.	N/A	N/A
Native Hawaiian Health Care Systems  PL 113-146 § 103	Contract	In consultation with Papa Ola Lokahi and other organizations to enter into contracts or agreements with Native Hawaiian health care systems for reimbursement of direct care services for Native Hawaiians.	N/A	Certain Veterans
Contract for Scarce medical specialist services  38 U.S.C. Section 7409	Contract	Authority to enter into contracts with institutions and persons to provide scarce medical specialist services at VA facilities.	N/A	N/A
Health Care for Homeless Veterans  38 U.S.C. Section 2031	Contract	Authority to contract for care, treatment, and rehabilitative services for certain Veterans.	Veterans suffering from serious mental illness and homeless Veterans	Veteran must be enrolled (or eligible to enroll) in VA health care
Procurement of Prosthetic Appliances  38 U.S.C. Section 8123	Contract and other	Authority to procure prosthetic appliances and services by purchase, manufacture, contract, or any other manner.	N/A	N/A

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Title and Statutory Authorities	Nature of Provision	Description	Eligibility Criteria	Beneficiary
Care and treatment of U.S. Veterans by the Veterans Memorial Medical Center (Philippines)  38 U.S.C. Section 1732	Contract and grant	VA is no longer contracting with the Veterans Memorial Medical Center; however, VA does provide grants for medical equipment.	N/A	N/A

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## 8.0 Appendix

### 8.1 Glossary<sup>61</sup>

**Administrative Information:** Information supporting the business functions of VA and external providers, including authorizations, medical claims, VA formularies, and referral documentation.

**Application-Programming Interface (API):** A language used by one computer system to communicate and link to another computer system.

**Authorization:** A decision that a health care service, treatment plan, prescription drug, or DME is medically necessary and will be paid.

**Claim:** Itemized statement of services and costs from health providers submitted to insurer.

**Clinical Information:** Patient medical information found in medical records, including medical histories, physical findings, test results, and treatments.

**Credentialing:** A formal review of the qualifications of a health care provider who has applied to participate in a health care system or plan.

**Critical Pathway:** An outline or diagram that documents the process of diagnosis or treatment deemed appropriate for a condition based on practice guidelines.

**EDI:** Computer-to-computer exchange of information.

**External Network:** A network of commercial community providers not in the core network divided into Standard and Preferred tiers.

**Formulary:** A list of preferred pharmaceuticals to be used by a managed care plan's network physicians, chosen based on the drugs' efficacy, safety, and cost effectiveness.

**Health Information Management:** Collection and analysis of health care data to provide information for health care decisions involving patient care, institutional management, health care policies and planning, and research; formerly known as medical records management.

**Network Manager:** VA will conduct a make/buy analysis to determine who will manage the external network. As a result, either VA or a commercial "network manager" may manage the network.

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<sup>61</sup>Definitions in glossary are drawn from VA internal sources, medical dictionaries, and institutions containing industry standard definitions. These include CMS, The Farlex Medical Dictionary for Health Professions and Nursing, and the McGraw-Hill Concise Dictionary of Modern Medicine.

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**Preferred Tier:** VA community providers that meet minimum credentialing requirements, in addition to performing highly against quality metrics, demonstrating high-value care, and signing a pledge to serve U.S. Veterans. VA will explore bonuses and incentives for providers in the Preferred tier.

**Referral:** A written or electronic transfer of care initiated by a clinician that enables a patient to see another provider for specific care or to receive medical services.

**Referral Coordinator:** A care support role that helps Veterans understand related processes and facilitates administrative care functions.

**Retail Pharmacy Network:** A network of community pharmacies capable of providing prescription fulfillment services, medication counseling, and other authorized services, following specific business rules established by VA.

**“Standard” Tier:** VA community providers that meet minimum credentialing requirements and do not fall into the VA Core Network.

**VA Core Network:** A network of high-quality providers in DoD, IHS, THP, FQHC, and academic teaching affiliates.

**VA Health Information Gateway and Services (Future State):** Online application(s) for health care providers and potentially patients to interact with patient clinical and administrative information, which is integrated with VA information systems.

**VistA:** Health information system that provides an integrated inpatient and outpatient EHR for VA patients and administrative tools to help VA deliver the best quality medical care to Veterans.

## 8.2 Acronym List

Accountable Care Organizations (ACOs)  
Activities of Daily Living (ADL)  
Anti-Deficiency Act (ADA)  
Agency for Healthcare Research and Quality (AHRQ)  
American Indians and Alaska Native (AI/AN)  
Assisted Living for Veterans with TBI (AL-TBI)  
Centers for Medicare and Medicaid Services (CMS)  
Children of Women Vietnam Veterans (CWVV)  
Civilian Health and Medical Program of the VA (CHAMPVA)  
Computerized Patient Record System (CPRS)  
Consolidated Mail-Out Pharmacies (CMOPs)  
Department of Defense (DoD)  
Deputy Under Secretary for Health (DUSH)  
Durable medical equipment (DME)  
Electronic data interchange (EDI)  
Electronic health records (EHR)  
Enterprise Health Management Platform (eHMP)  
Federally Qualified Health Centers (FQHC)  
Fiscal Year (FY)  
Foreign Medical Program (FMP)  
Health and Human Services (HHS)  
Health Information Exchanges (HIEs)  
Health Insurance Portability and Accountability Act (HIPAA)  
Health Resources and Services Administration (HRSA)  
Human Immunodeficiency Virus (HIV)  
Indian Health Service (IHS)  
Information technology (IT)  
Inspector General (IG)  
Joint Legacy Viewer (JLV)  
Military Sexual Trauma (MST)  
National Committee for Quality Assurance (NCQA)  
New Veterans Choice Program ("New VCP")  
Office of Management and Budget (OMB)  
Office of the National Coordinator for Health Information Technology (ONC)  
Operation Enduring Freedom (OEF)  
Operation Iraqi Freedom (OIF)  
Operation New Dawn (OND)  
Other health insurance (OHI)  
Patient-Aligned Care Team (PACT)  
Patient-Centered Community Care (PC3)  
Primary care providers (PCPs)

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Project Access Received Closer to Home (ARCH)  
Prompt Payment Act (PPA)  
Public Law (PL)  
Request for Proposals (RFPs)  
Service-connected (SC)  
Telemedicine Intensive Care Unit (TeleICU)  
The Department of Veterans Affairs (VA)  
Third-party administrators (TPAs)  
Tribal Health Programs (THP)  
Usual and customary (U&C)  
U.S. Code (U.S.C.)  
Veterans Access, Choice, and Accountability Act of 2014 (*The Choice Act*)  
Veterans Health Administration (VHA)  
Veterans Health Information Systems and Technology Architecture (VistA)  
Veterans Integrated Service Network (VISN)  
Veterans Service Organizations (VSOs)

## 8.3 Alignment with Independent Assessment Recommendations

Table 31: Alignment with Independent Assessment Report Recommendations

Independent Assessment Recommendation	Description of Alignment to New VCP
<b>Recommendation 1 GOVERNANCE:</b> Align demand, resources, and authorities.	
Clarify and simplify the rules for purchased care to provide the best value for patients	<ul style="list-style-type: none"> <li>The plan will consolidate existing authorities and mechanisms for delivering community care into a single program, the New VCP, simplifying the process for Veterans, providers, and VA staff (<i>Element 1: Single Program for non-Department Care Delivery and Element 2: Patient Eligibility Requirements</i>).</li> </ul>
<b>Recommendation 2 OPERATIONS:</b> Develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care	
Fix substandard processes that impede the quality of care provided to the Veteran	<ul style="list-style-type: none"> <li>The New VCP proposes revised processes for Authorizations (<i>Element 3</i>), Claims Management (<i>Element 5</i>), and Medical Records Management (<i>Chapter 9</i>).</li> <li>Care coordination should improve health outcomes, prevent gaps caused by transition of setting or time, and support a positive and engaging patient experience (<i>Introduction: Care Coordination</i>).</li> </ul>
<b>Recommendation 3 DATA and TOOLS:</b> Develop and deploy a standardized and common set of data and tools for transparency, learning, and evidence-based decision.	
Implement a single, integrated set of system-wide tools centered on a common EHR that is interoperable across VHA and with DoD and community provider systems.	<ul style="list-style-type: none"> <li>The New VCP proposes medical records management to increase electronic transfer of relevant medical records between VA, Core Network, including DoD, and community providers, improving the consistency, simplicity, and timeliness of the information exchange (<i>Element 9: Medical Records Management</i>).</li> </ul>
<b>Assessment A. Demographics</b>	
Prepare for a changing Veteran landscape	<ul style="list-style-type: none"> <li>The New VCP proposes approaches for High-Performing Network Development, including analytics, that are adaptable over time and can adjust to meet the needs of a changing Veteran population, providing them with access to a tiered network (<i>Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> </ul>
Anticipate potential shifts in the geographic distribution of Veterans, and align VA facilities and services to meet these needs	<ul style="list-style-type: none"> <li>The New VCP will develop a high-performing network nimble enough to adjust to shifts in the geographic distribution of Veterans (<i>Chapter 6: Plan to Develop Provider Eligibility Requirements and Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> </ul>
Improve collection of data on Veteran health care utilization and reliance	<ul style="list-style-type: none"> <li>The authorization, medical records management, and claims processes outlined in the New VCP support increased transparency of data on health care utilization in the community (<i>Element 3: Authorizations, Element 5: Provider Reimbursement Rate, and Element 9: Medical Records Management</i>).</li> <li>Data analytics will be used to improve health care outcomes and personalize care delivery.</li> </ul>
<b>Assessment B. Health Care Capabilities</b>	
Consider alternative standards of timely access to care.	<ul style="list-style-type: none"> <li>Shifting to a single community care program will give VA greater flexibility in identifying and responding to access issues (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>

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Independent Assessment Recommendation	Description of Alignment to New VCP
	<ul style="list-style-type: none"> <li>VA proposes to identify core competencies and develop a high-performing network in the future, which allows flexibility to determine excessive burden and account for clinical conditions (<i>Introduction: The Future of VA Health Care</i>).</li> </ul>
Develop and implement more sensitive standards of geographic access to care.	<ul style="list-style-type: none"> <li>The development of a high-performing network for the New VCP will allow VA to determine excessive burden for the ill and elderly and establish more sensitive standards for geographic access to care while having confidence that those standards can be met by the VA community network (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>
Take significant steps to improve access to VA care	<ul style="list-style-type: none"> <li>By establishing a single set of eligibility requirements, a high-performing network, and a streamlined authorization process, the New VCP aims to improve Veterans' access to care (<i>Element 6: Provider Eligibility</i> and <i>Element 8: Infrastructure</i>).</li> </ul>
Streamline programs for providing access to purchased care and use them strategically to maximize access.	<ul style="list-style-type: none"> <li>The New VCP will consolidate existing purchased care mechanisms into a single program and set of processes that will reduce confusion and improve access to care (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>
Systematically study opportunities to improve access to high-quality care through use of purchased care.	<ul style="list-style-type: none"> <li>The New VCP will be designed using industry best practices and will evolve over time to support access to high-quality care provided at VA or in the community (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> <li>A tiered network will be developed to better serve Veterans, support adequate coverage, and provide access to high-quality care (<i>Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> </ul>
Establish VA as a leader and innovator in health care redesign	<ul style="list-style-type: none"> <li>The New VCP will be designed using leading practices from industry and will evolve to incorporate innovative delivery and payment models (<i>Chapter 1: Single Program for non-Department Care Delivery</i>).</li> <li>The New VCP will be implemented using a system of systems approach that considers the interactive and interdependent nature of internal and external factors to optimize outcomes and experience for Veterans (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>
<b>Assessment C. Care Authorities</b>	
VA and Congress should articulate a clear strategy governing the use of purchased care.	<ul style="list-style-type: none"> <li>This report provides Congress with VA's proposal for a clear strategy and direction for community care, including required legislative authorities (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>
VA should collect better data to accurately estimate the demand for and use of purchased care.	<ul style="list-style-type: none"> <li>The New VCP proposes approaches for High-Performing Network Development, including analytics, that are adaptable over time and can adjust to meet the needs of a changing Veteran population, providing them with access to a tiered network (<i>Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> </ul>
VA should develop a stronger program management structure for purchased care and allocate responsibility and authority to the most appropriate levels.	<ul style="list-style-type: none"> <li>VA will designate a new DUSH to establish national management of and accountability for community care and integration with VA provided care (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> <li>Similarly, at the local level, the New VCP will also standardize community care within facilities to support consistent management (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>
VA should develop clear, consistent guidance and training on its authority to purchase care.	<ul style="list-style-type: none"> <li>This report includes a transition plan with change management and training necessary to streamline existing programs and implement improved processes (<i>Element 10: Transition Plan</i>).</li> </ul>
VA purchased care contracts should include requirements for data sharing, quality monitoring, and care coordination.	<ul style="list-style-type: none"> <li>By developing a High-Performance Network, VA plans to implement standards that improve data sharing, monitoring, and care coordination (<i>Chapter 6: Plan to Develop Provider Eligibility Requirements</i> and <i>Element 9 Medical Records Management</i>).</li> <li>VA will identify top performers, measure provider productivity, and develop incentives such as value-based payments (<i>Element 6: Plan to Develop Provider Eligibility Requirements</i> and <i>Element 9 Medical Records Management</i>).</li> </ul>
VA and Congress should adopt a consistent strategy for setting	<ul style="list-style-type: none"> <li>The New VCP proposes consistent reimbursement rates tied to regional Medicare. Rates recommendations include exceptions for specific underserved geographic areas (e.g., Alaska, Hawaii, Guam, Puerto Rico, American Samoa, and the Commonwealth of</li> </ul>

## Plan to Consolidate Community Care Programs

Independent Assessment Recommendation	Description of Alignment to New VCP
reimbursement rates across purchased care initiatives.	<p>the Northern Mariana Islands); negotiated rates for services not covered by Medicare rather than VA paying billed charges (<i>Element 5: Provider Reimbursement Rates</i>).</p> <ul style="list-style-type: none"> <li>▪ The New VCP will strengthen existing relationships with DoD, IHS, Tribal, and FQHC partners (<i>Element 5: Provider Reimbursement Rates</i>).</li> </ul>
VA should consider adopting innovative, but tested, ways to purchase care.	<ul style="list-style-type: none"> <li>▪ Over time, the New VCP will evolve to include innovative practices from industry for purchasing care, such as shifts to bundled or value-based payments (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>
VA and Congress should eliminate inconsistencies in current authorities and provide VHA with more flexibility to implement a purchased care strategy.	<ul style="list-style-type: none"> <li>▪ The New VCP proposes to eliminate inconsistencies between various purchased care mechanisms by establishment of a single program (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li> </ul>
<b>Assessment D. Access Standards</b>	
Care delivery sites should continuously assess and adjust the match between the demand for services and the organizational tools, personnel, and overall capacity available to meet the demand, including the use of alternate supply options, such as alternate clinicians, telemedicine consults, patient portals, and web-based information services and protocols.	<ul style="list-style-type: none"> <li>▪ The New VCP will be flexible to provide access to care through a high-performing network as demand changes (<i>Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> <li>▪ Services provided in the network will be complementary to internal VA health care delivery (<i>Element 8: Plans to Use Current Non-Department Provider Networks and Infrastructure</i>).</li> </ul>
<b>Assessment H. Health Information Technology</b>	
VA should explicitly identify mobile applications as a strategic enabler to increase Veteran access and satisfaction and help VHA transition to a data-driven health system.	<ul style="list-style-type: none"> <li>▪ Enhancing the mobile apps portfolio to support the future state continuum of care coordination, including aspects of patient navigation, secure messaging and mobile Blue Button (<i>Introduction: Care Coordination</i>).</li> </ul>
<b>Assessment I. Business Processes</b>	
VHA: Develop a long-term comprehensive plan for provision of and payment for non-VA health care services.	<ul style="list-style-type: none"> <li>▪ VA will pursue a claims solution and simplified processes as it evolves to achieve parity with best practices, working toward consistent, timely payment (<i>Element 4: Billing and Reimbursement</i>).</li> <li>▪ The New VCP develops a single, streamlined billing and reimbursement process to support the program (<i>Chapter 1: Single Program for non-Department Care Delivery</i>).</li> </ul>
VHA: Standardize policies and procedures for execution of non-VA Care, particularly <i>The Choice Act</i> , and communicate those policies and procedures to Veterans, VHA staff, VHA providers, and non-VA providers.	<ul style="list-style-type: none"> <li>▪ VA will standardize business rules and processes under a uniform system (<i>Element 10: Transition Plan</i>).</li> <li>▪ The transition plan lays out the key elements of the change management plan necessary to communicate changes in community care programs and processes to all stakeholders (<i>Element 10: Transition Plan</i>).</li> </ul>
VHA: Employ industry standard automated solutions to bill claims for VHA medical care (revenue) and pay claims for non-VA Care (payment) to increase collections to improve payment timeliness and accuracy.	<ul style="list-style-type: none"> <li>▪ Under the New VCP, VA will pursue a claims system that employs best practices, standardized business rules, and auto adjudication, that will help it ensure compliance with the Prompt Payment Act (<i>Element 4: Billing and Reimbursement</i> and <i>Chapter 7: Prompt Pay Compliance</i>).</li> </ul>

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VHA: Align performance measures to those used by industry, giving VHA leadership meaningful comparisons of performance to the private sector.	<ul style="list-style-type: none"><li>▪ VA will adopt clinical and administrative best practices under the New VCP using data on Veterans' needs and the quality of providers that will allow for parity inside and outside of VA (<i>Element 1: Single Program for non-Department Care Delivery</i>).</li></ul>
VHA: Simplify the rules, policies, and regulations governing revenue, non-VA Care, eligibility, priority groups, and service connections, educate all stakeholders, and institute effective change management.	<ul style="list-style-type: none"><li>▪ The New VCP defines a single set of eligibility requirements for the circumstances under which Veterans may choose to receive health benefits from community providers, enabling timely and convenient access to care in alignment with best practices (<i>Element 2: Patient Eligibility Requirements</i>).</li><li>▪ The New VCP will also include plans to communicate these changes to stakeholders (<i>Element 2: Patient Eligibility Requirements</i>).</li></ul>