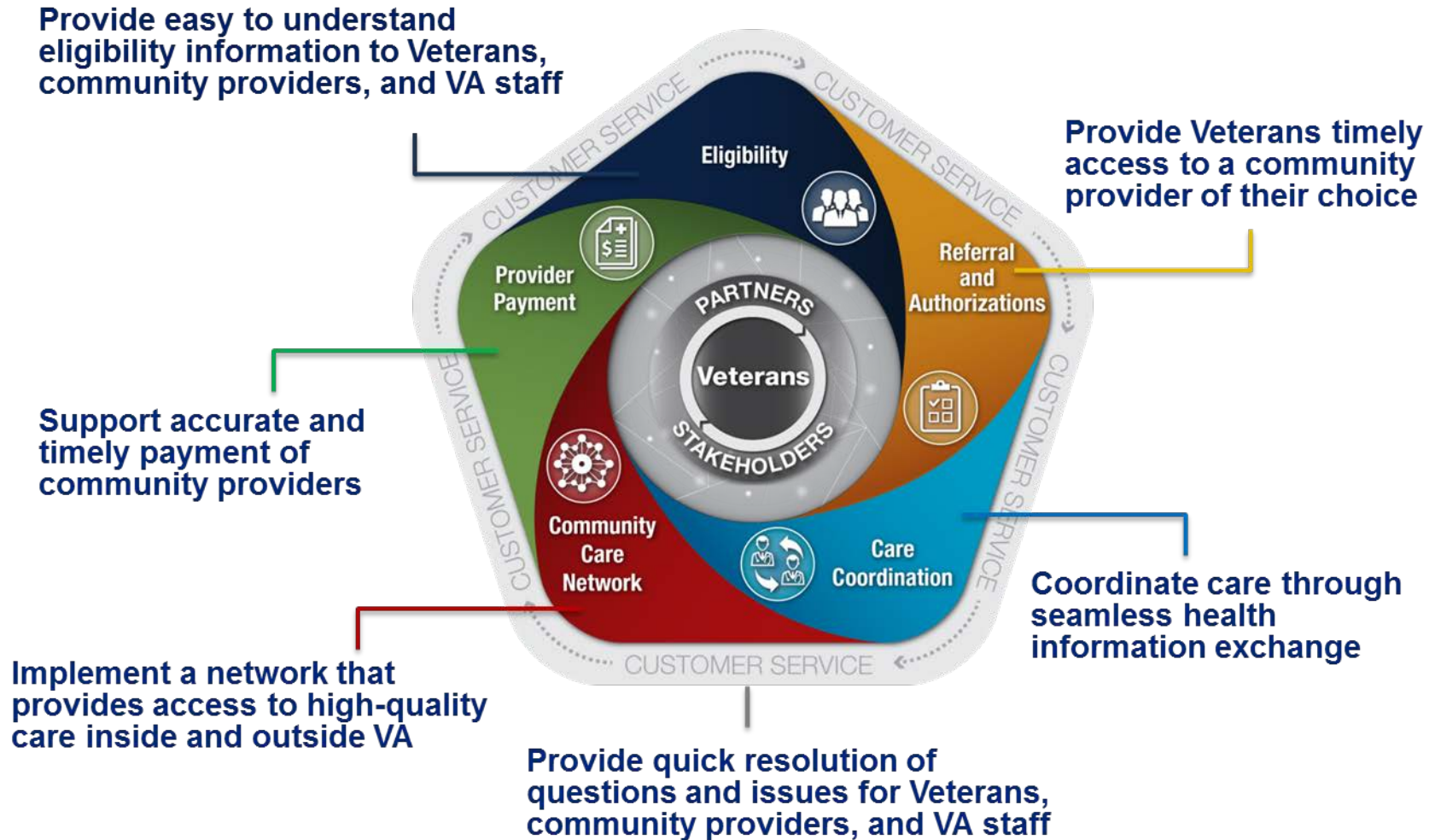


VA Community Care Network PWS

Deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA Staff

Five Key Components Trace the Veteran Community Care Journey

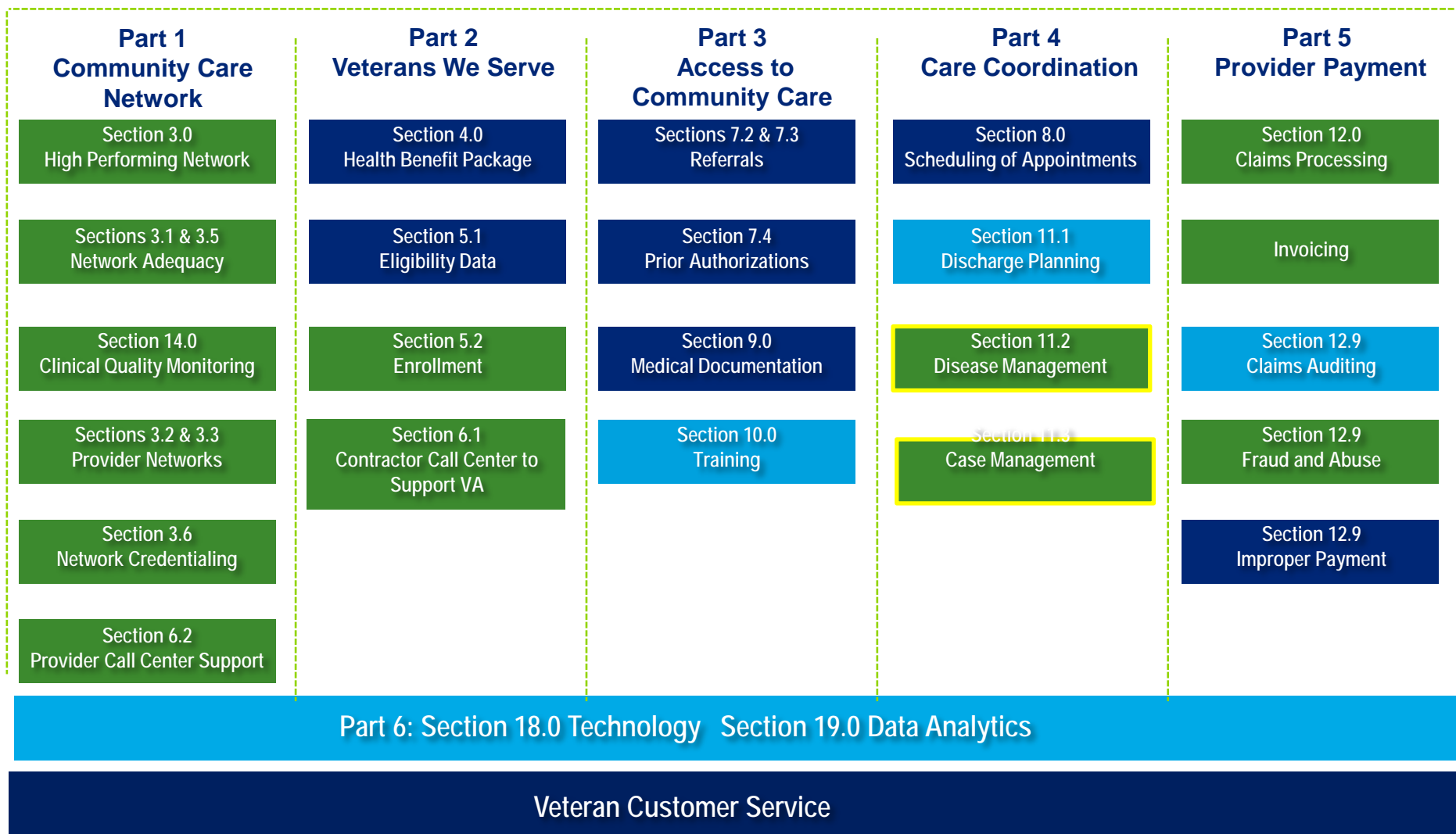


How Will We Get There?

- **By leveraging both VA and community provider networks**
- **VA is seeking industry input and collaboration to design a program that meets our goal for VA Community Care**
- **The draft PWS outlines the requirements for the Community Care Network**
- **The draft RFP is the next step in the acquisition process**

Community Care Network PWS Overview

■ VA
 ■ Contractor
 ■ Both
 Optional



Create a comprehensive network of qualified healthcare providers and practitioners to improve Veterans' access to timely, high-quality care

High Performing Network

Provider Networks include the following groups of providers:



Health Care Services: Includes medical care and services for inpatient, outpatient, professional, dental, pharmacy (urgent only), DME (urgent only).



Complementary and Integrative Health Services: Includes alternative treatments such as relaxation therapy, Tai Chi, Native American Healing, Hypnotherapy, etc.

High Performing Network

Healthcare Services Network will include Pharmacy, DME and Dental for eligible Veterans and specific time periods:



Pharmacy: PBM services to provide a retail pharmacy network to fill urgent or emergent prescriptions (maximum 14 day prescription)



DME: Services to provide urgent and emergent DME products (i.e. crutches, braces, walkers, etc.)

- Includes optional line item for providing eyeglasses in the community



Dental: Services to provide a dental network of community providers

**Ensure the size, scope and capacity of the
Community Care Network is adequate to
ensure timely access to care**

Community Care Network Regions

The Community Care Network is divided into 4 regions, aligned for the most part, with MyVA Districts



- Regions divided by state boundaries
- Region boundaries established by:
 - volume of veterans enrolled in VA system
 - number of Community Care referrals in FY15 by state

Network Adequacy

Contractor shall develop a Network Adequacy Plan during the implementation period.

- Network Adequacy Performance Report to include:
 - Average drive times
 - Average appointment times
 - Other analysis to include complaint (provider and Veteran) information
- If a performance deficiency is identified, the contractor shall submitted a Network Adequacy Corrective Action Plan with in 10 days

Network Adequacy

Drive Times and Appointment Availability Standards for Healthcare Services Network, Complementary and Integrative Health Services (CIHS) Network, and Dental Network

Drive Times			
Primary Care	30 minutes	45 minutes	60 minutes
General Care	45 minutes	100 minutes	180 minutes
Appointment Availability			
	Urban	Rural	Highly Rural
Emergent	24 hours	24 hours	24 hours
Urgent	48 hours	48 hours	48 hours
Routine	30 days	30 days	30 days

Network Adequacy

Dental Network Adequacy has additional metric for provider density

Dental Network Adequacy	
Urban	98% of Veterans have access to a general dentist within 10 miles of Veterans residence
Rural	90% of Veterans have access to a general dentist within 50 miles of Veterans residence
Highly Rural	90% of Veterans have access to a general dentist within 150 miles of Veterans residence

Pharmacy Network Adequacy is measured by pharmacy density

Pharmacy Network Adequacy	
Urban	90% of Veterans have access to a pharmacy within 2 miles of Veterans residence
Rural	90% of Veterans have access to a pharmacy within 5 miles of Veterans residence
Highly Rural	70% of Veterans have access to a pharmacy within 20 miles of Veterans residence

**Ensure all services, facilities and providers
are in compliance with accreditation and
credentialing requirements prior to serving
Veterans**

Network Credentialing and Accreditation

Provider Credentialing

- All providers in the contractor's network must be credentialed

Accreditation Requirements

- Contractor network provider credentialing process must be accredited by a nationally recognized accrediting organization (e.g. NCQA or URAC)
- The Provider Network must be accredited by nationally recognized accrediting organization (e.g. NCQA or URAC)

Note: The contractor is responsible for meeting credentialing and accreditation requirements

Provider Credentialing

VA will delegate provider credentialing to the Contractor. However, the contractor will meet the following interim provider credentialing criteria until accreditation is attained:

Provider Credentialing Requirements

Comply with all applicable federal and state laws	Confirm participation with Medicaid or Medicare	Maintain \$1 Million dollars of liability insurance	Confirm provider is not on the HHS debarment list	Confirm NPI and DEA number	Confirm provider has a compliance program
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Establish clinical quality monitoring of the provider network to ensure Veterans receive the highest quality care

Network Provider Quality Criteria

- All providers in the Health Care Services Network will be offered the opportunity to submit information on a set of quality and performance criteria determined by VA.
- The quality and performance metrics will be refined and ranked during implementation to determine thresholds.

Quality and performance criteria are based on industry standards and include HEDIS, CMS, HCAPS, care coordination with VA, and Veteran satisfaction.

Institutional Providers
(Inpatient and
Outpatient Facilities)



Group Practice
Providers



Individual Providers

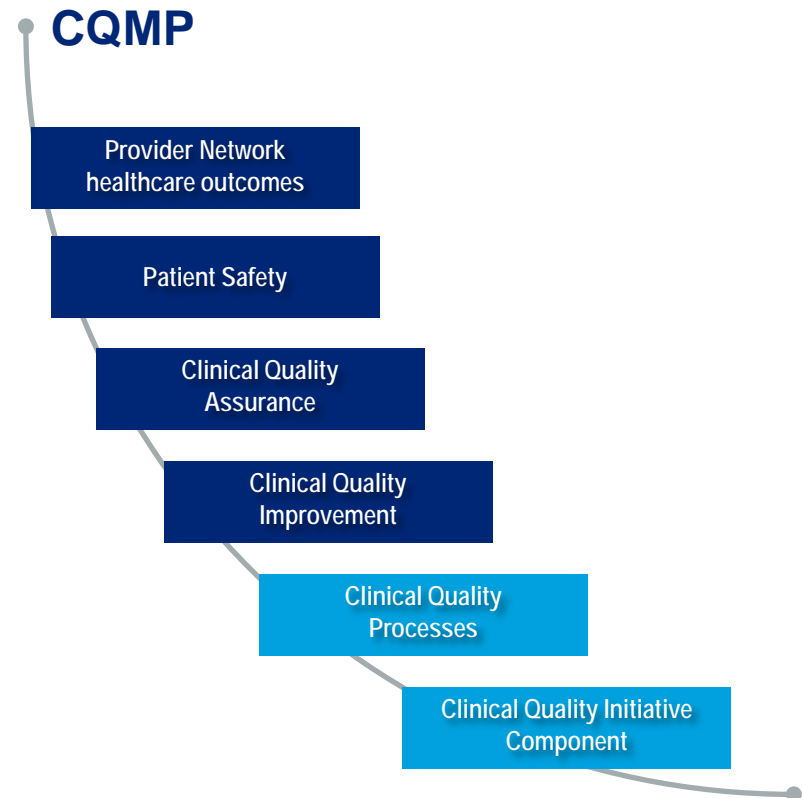
Network Quality Monitoring

Contractor must establish a Clinical Quality Monitoring Plan (CQMP) that describes the purpose, methods, goals and objectives to ensure the highest quality clinical care

The CQMP will monitor:

- Provider Network healthcare outcomes
- Patient Safety
- Clinical Quality Assurance
- Clinical Quality Improvement
 - Clinical Quality processes that improve: healthcare delivery, error reduction, safety and the care of high-risk or high volume users
 - Clinical Quality Initiative Component to include initiatives to improve clinical administrative processes and program related issues

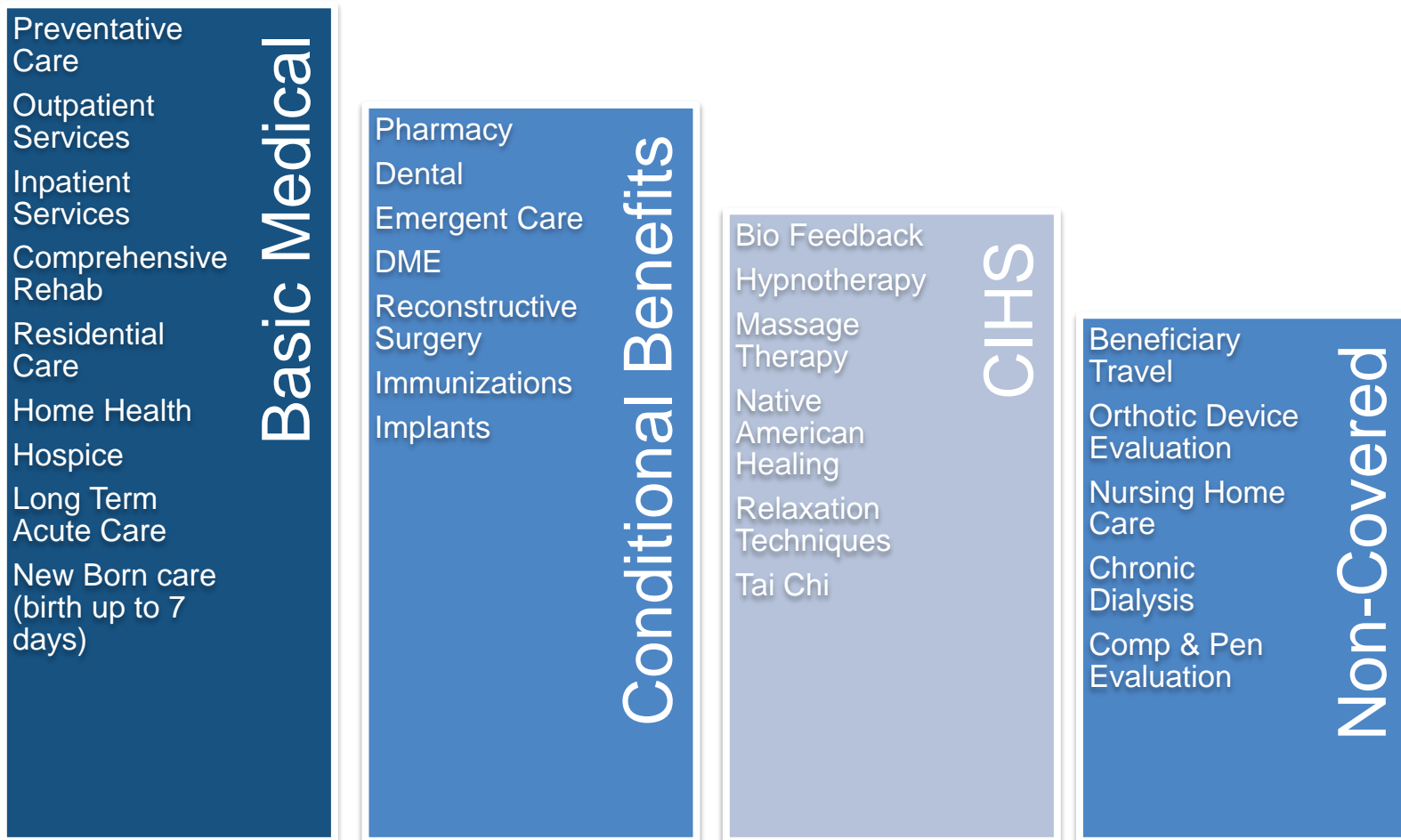
VA will review and approve the CQMP during the implementation period.



To effectively delivery the Veterans health benefit package in partnership with community providers and VA

The contractor shall provide healthcare services and complimentary and integrative health services to benefit Veterans

Health Benefit Package



Following are excluded services from the Health Benefit Package: abortion, invitro, clinical trials, gender alteration, spa and health club memberships, out of network services without a referral, care provided by any other government agency (including penal Institutions)

Confirm eligibility with VA for all Veterans who choose to receive healthcare services from the Community Care Network

Eligibility Verification and Enrollment will be managed by the VA with the Contractor

- Veteran will be offered a **choice** to obtain healthcare services from the community
- The contractor will issue cards to Enrolled Veterans with unique identifiers (VA EDIPI Number)
- Eligibility criteria will be identified as (1) Time eligible or service is not available and (2) Distance eligible
- Time eligibility is based on the following criteria:
 - VA cannot appointment within the wait time goals
 - Service is not available
- Distance eligibility is based on the following criteria:
 - Veterans who meet specific requirements due to geographic reasons

The contractor shall receive, process and store eligibility data based on information provided from VA

Contractor's enrollment system requirements:

- Contactor must enroll or load all Veteran eligibility information from VA into the Contractor's primary system(s) to manage the following:
 - Administer identification card process
 - Maintain and manage referral and prior authorization data in order to process claims
 - Process claims and pay providers
 - Manage coordination of benefits and other health insurance processes to ensure proper billing procedures
 - Support provider customer service process

Note: Enrollment for this purpose is not the same as VA enrollment. Separate process required by Contractor.

The contractor shall establish and maintain customer service capabilities to support VA staff and community provider inquiries

VA will provide customer service capabilities at the national, regional and local levels to support the following activities:

- Act as first point of contact for all Veteran customer service inquiries
- Answer all questions relating to:
 - eligibility determinations
 - referrals and prior authorizations
 - scheduling
 - medical management
 - medical record documentation and exchange

Contractor Customer Service Capabilities

To support VA

- Eligibility data inconsistencies
- Maintain a warm transfer process
 - Claim payment or denial questions
 - OHI questions
 - Questions regarding Veteran financial liability
- Supporting documentation for complaints and grievances
- Supporting documentation for Congressional responses

To support providers

- Eligibility verification
- Claim payment or denial questions
- Provider complaints and grievances
- Network participation process
- Network participation agreement questions
- Reimbursement rate questions

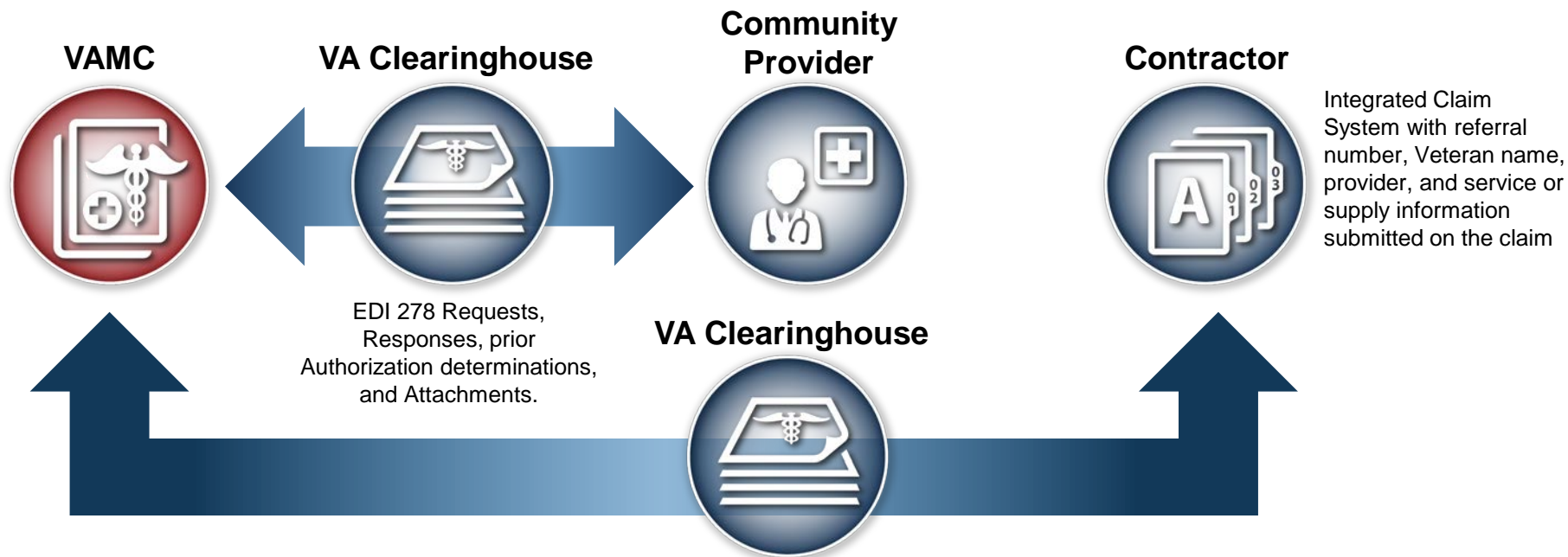
Note: Performance measures will be required for call center functionality, customer service technology, and reporting for complaints and grievances

Provide Veterans timely access to a community provider of their choice

The Contractor shall communicate with VA electronically through the VA clearinghouse for all referral and prior authorization determinations

Referral and Prior Authorization

VA will send all referral requests and prior authorization decision to community providers and the contractor. The proposed process is outlined below:



Contractor Referral and Prior Authorization Reports

- Requests by specialty, including the number of requests, denials, and approvals
- Referrals and prior authorizations with primary payer determinations for Veterans with OHI

**VA will maintain an alternate process when electronic transactions are not available.*

Medical Documentation Requirements

Definitions

- Initial medical documentation associated with the first appointment of an episode of care.
- Final medical documentation for the entire episode of care (as appropriate for the category of care) is provided at the end of the episode of care.

Initial Findings

- Must be returned within 30 business days for inpatient care and consist of a Discharge Summary.
- Initial medical documentation for outpatient care shall be returned within 30 calendar days of the initial appointment and final medical documentation shall be returned within 30 calendar days of the completion of the episode of care.

Veteran Notification

- Veteran shall be notified of test results by the community provider within 14 calendar days of appointment date

Critical Findings

- Critical findings shall be reported to the Veteran and VA within 2 business days (verbal or written)

***Note:** Medical Documentation not required prior to claim payment

The contractor's training plan shall outline methods, schedules, role-specific training requirements, scope of training, and outcome measurements

Contractor training for VA (Web-based and virtual sessions):

- Contractor-Specific Systems
- Contractor deliverable: Interactive dashboard of reports
- Contractor deliverable: data repository

Contractor training for CCN providers:

- Customer service process
- Health benefit package
- Network participation
- Claims payment process
- Referral management process
- Pharmacy benefits management
- Dental eligibility requirements
- DME benefits

Contractor training for internal personnel:

- All requirements of the contract



Ensure Veterans get the right care at the right time and providers have the necessary information to ensure quality outcomes

Connecting Veterans with providers that meet their needs and preferences

Care Coordination Scheduling



- Veterans will have the option to schedule their own appointment
- For Veteran's who want assistance, VA will assist with the scheduling process

Develop pathways to ensure seamless transitions in care and optimize health outcomes

Transfer and Discharge Planning

Inpatient Transfer and Discharge Planning

- Must comply with VHA Directive 2007-015 Inter-Facility Transfer Policy
 - All patient transfers ensure maximum patient safety and compliance with EMTALA and all other applicable standards, for example:
 - Sending facility assumes responsibility during travel
 - An assigned designee is a credentialed provider
 - Standards for transferring patients with unstable medical conditions
- Contractor responsible for facilitating the hand off of information from the community provider to VA
- Contractor staff involved in discharge planning are not required to be co-located in VAMCs

Case and Disease Management

Optional Task: Distance Eligible Veterans Only

Case Management is a collaborative process of meeting the Veteran's and family's comprehensive health needs through communication and available resources.

Sample conditions for case management:

- high-cost conditions (e.g. IV therapy, chemo therapy, etc)
- specific disease (e.g. CHF, COPD)
- comorbid conditions which benefit from evidence-based clinical management and coordination

Disease Management utilizes analytic tools to promote health, identify at-risk individuals and populations, and treat specific diseases.

- The Contractor will demonstrate to VA its methods to engage Veterans, their family/caregivers, and their healthcare providers in appropriate care and treatment of these diseases.

**Support accurate and timely payment to
community providers**

The contractor shall receive, process and adjudicate claims electronically from Community Care Network providers for all services

Claims Processing

- Validate eligibility and enrollment data, referral and prior authorization data, and any other data needed to properly adjudicate claims using:
 - referral number
 - prior authorization number
 - name of Veteran
 - community provider information and
 - service or supply information submitted on the claim
- Process and adjudicate 98% of all Clean Claims within 30 days of receipt
- Deny claims for healthcare services that are submitted by providers outside of the timely filing limits set forth in federal law.

Note: EDI 835 and 837 HIPAA Standard information will be delivered to the VA daily

Claims Processing continued

- Deny claims for out of network providers that do not have an approved referral from VA
- Manage coordination of benefits and Other Health Insurance process
- Send explanation of benefits (EOB) to Veterans and remittance advice (RA) to providers to explain claim payment
 - Veterans may request a monthly summary instead of an EOB for each visit
- Provide monthly statistical reports of all claims received and processed

The contractor shall invoice VA for administrative service fees and use 837/835 EDI transactions as invoices for medical services

Contractor Invoicing

Medical Services Reimbursement

- VA will receive the EDI 835/837 HIPAA Standard Transaction from the Contractor as the invoice to VA daily for healthcare claims reimbursement

Administrative Fee Reimbursement

- The Contractor shall submit invoices monthly on an Active Veteran per member per month (PMPM)
- The Contractor shall propose a PMPM fee based breakdown based on the following categories:
 - Network Management
 - Eligibility and Enrollment
 - Referrals and Pre-Authorizations
 - Care Coordination
 - Customer Service
 - Claims Processing

Claims Audit, Improper Payments, and FWA

Prevailing industry standards will be followed for recovery of any improper payments for services rendered to Veterans or for persons who were not eligible to receive a benefit.

- The Contractor shall develop an Improper Payment Plan that includes a Healthcare Fraud Detection and Prevention Plan
- The Contractor is solely responsible and financially liable for reimbursing any claims that were adjudicated improperly
- In situations where VA is the secondary payer, the Contractor shall ensure the primary payer adjudicated the claim properly and VA is not held responsible if VA determines any identified OHI is primary payer and the claim was not processed accordingly.

Leverage technology and data analytics to improve the health of Veterans and experience of community providers and VA staff

Contractor will provide VA the following:

- Read only access to all systems used to support VA
 - Claims processing
 - Referral and prior authorizations
 - Utilization management, quality monitoring and customer service
- Reports
 - Daily claims reporting
 - Weekly claims performance report
 - Monthly network adequacy report
 - Quarterly claims audit reports
- Interactive Dashboard of all required reports
- Access to data repository of all VA data for ad hoc reports

Questions?