1.0 Community Care Health Network Region 4

1.1 Title of Project

Community Care Network (CCN) services and healthcare resources, purchased under the authority of 38 United States Code (U.S.C.) § 8153, “Sharing of Health-care Resources.”

1.2 Scope of Work

The Contractor must provide a CCN per the requirements defined in this Performance Work Statement (PWS).

The Contractor must receive and maintain enrollment and eligibility information and Prior Authorizations provided by Department of Veterans Affairs (VA). The Contractor must establish and maintain a network of high performing licensed healthcare providers as well as healthcare practitioners to deliver patient-centered care. The Contractor must (i) provide exemplary customer service; (ii) monitor and manage quality outcomes; (iii) use data and performance metrics to improve services, and (iv) process and pay claims in order to enhance Veterans’ healthcare experiences. The Contractor must always deliver healthcare services through the use of tools and practices that drive efficiencies, cost savings, and a positive Veteran experience. The Contractor must always serve as a third-party administrator with responsibility to perform the requirements herein. The CCN must consist of licensed healthcare providers, as well as healthcare practitioners, to provide medical, surgical, Complementary and Integrative Health Services (CIHS), Durable Medical Equipment (DME), pharmacy, and dental services.

1.3 Background

The VA is committed to providing Veterans with timely, accessible, and high-quality care. VA intends to honor this commitment by improving performance, promoting a positive culture of service, increasing operational effectiveness and accountability, advancing healthcare innovation through research, and training future VA clinicians.

VA recognizes that while the healthcare landscape is constantly changing, VA’s unique population and broad geographic demands will continue to require community-based care for Veterans. A Veteran enrolled in the patient enrollment system of VA, established and operated under 38 U.S.C. § 1705, may receive services under this contract. Healthcare services will be provided in each state as defined in 38 U.S.C. § 101(20).

This contract will not be used to acquire services for inherently governmental functions as defined by Federal Acquisition Regulation (FAR) 7.503 or personal services as defined by FAR 37.104. The Contractor will not perform work reserved for performance by Federal employees, and the Government will manage the Contractor consistent with its responsibility to perform all inherently governmental functions and maintain control of its mission and operations in accordance with requirements of Office of Federal Procurement Policy Letter 11-01.

2.0 PROJECT MANAGEMENT

2.1 Post Award Meeting

Within two weeks after Contract award, the Contractor shall lead a Post Award meeting for the effort to be held with the Government and Contractor representatives. The purpose of the meeting is to do the following:

- Initiate the communication process between the Government and Contractor
  - Introduction of Contractor and Government personnel performing work related to this project,
  - Identification of stakeholders roles and responsibilities
- A brief overview of project administration and reporting
- Set expectations and discuss agenda for Kickoff meeting (section 2.2)

2.2 Kickoff Meeting

The Contractor must participate in a kickoff meeting within thirty (30) days after contract award. The Contractor must create a Kickoff Meeting Presentation describing the details of the approach, for all deliverables due at contract award, to delivering all services under this contract as defined in Section 2.2, in accordance with the expectations defined in the Schedule of Deliverables.

During the Kickoff Meeting the Contractor shall explain their approach to achieving the Start of Healthcare Delivery (SHCD) and full Healthcare Delivery (HCD) within the timelines specified. The Contractor shall explain their implementation strategy in detail such that VA stakeholders can provide meaningful feedback.

The Contractor shall present and be prepared to walk though in detail all the deliverables due at the Kickoff Meeting. Those deliverables that are due in draft form at kickoff (See Section 20.4, "Schedule of Deliverables" for details) shall be of sufficient detail to define the full approach such that the deliverables can be presented to and reviewed by VA Contractor Subject Matter Experts (SME) for them to provide real time feedback. The kickoff meeting may include breaking into multiple working groups of VA stakeholders for the various deliverables. The Contractor will coordinate the agenda and need for any working group sessions with the Contracting Officer's Representative (COR) ahead of time to ensure adequate SME participation to present, explain, and collect feedback on all the deliverables.

The Contractor must coordinate with the Contracting Officer (CO) to establish dates, location, and agenda for the kickoff meeting. The Contractor must take meeting minutes, which must be provided to VA in accordance with the Schedule of Deliverables.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Kickoff Meeting Presentation
B. Meeting Minutes

2.3 Project Management Plan (Project Plan)

The Contractor must always be responsible for project management and performance of the requirements of this contract. The Contractor must create a Project Plan to be approved by VA to capture all elements of managing the CCN. The Project Plan must be submitted in accordance with the Schedule of Deliverables. As part of the Project Plan, the Contractor must create an Integrated Master Schedule (IMS) that depicts the implementation and deployment of the CCN pursuant to the contract. For inclusion in the Project Plan, the Contractor must:

1. Create and maintain a Work Breakdown Structure (WBS) to a minimum of three (3)-levels to define the activities, tasks, and outcomes.

2. Identify and include all applicable project milestones in the IMS. The Contractor must always identify and document discrete events necessary to complete the project, identify and document the definition of the relationship between and among these events, and determine the expected duration of each event and resources required for each. The Contractor must then create a schedule that depicts this information as a cohesive whole in the IMS. The Contractor must deliver a detailed-level schedule, critical path depiction, and a what-if analysis, with breakouts of subsections for individual groups/teams. When data is provided/entered that creates overall critical path slippage, the Contractor must always notify VA Project Manager within one (1) business day. The notification should occur by email and phone.
3. Ensure that a fully resource-loaded and baselined schedule in Microsoft Project is in place as part of the submission of the initial Project Plan.
4. Generate schedule reports containing the planned versus actual program/project performance against the Project Plan and updated critical path information for the project. The Contractor's schedule reports must always include identification and documentation of project risks that may jeopardize any imminent milestones or the overall project timeline. The reports must always be provided to, and accepted by, VA.
5. Create and maintain a Change Control Process Plan. The Change Control Process Plan must always address any variance from the baseline plan. The Contractor must always obtain VA approval for all proposed changes to the IMS.
6. Deliver a Project-Level Communications Plan to outline the communications required to manage the overall CCN project. The Contractor must include, as part of the Project Level Communications Plan, an approach to communicating action items and issues that require immediate response.
7. Include reference to, and management approach for, the Continuity of Operations Plan requirements described in Section 18.2 "Continuity of Operations."

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Project Management Plan

2.3.1 Implementation Strategy

The CCN must meet HCD requirements no later than twelve (12) months after the contract award date. The Contractor must develop an Implementation Strategy to detail how the CCN will be implemented within the awarded CCN Region. The Implementation Strategy must be submitted in accordance with the Schedule of Deliverables. The Implementation Strategy must outline the strategy for management of the following:

1. VA's Data Access Service (DAS) Integration
2. The provider network, including identification of high performing providers
3. Provider education
4. Credentialing new and existing CCN providers
5. Data exchanges referenced in Section 19.0, "Data Analytics"
6. Claims processing
7. Invoicing for administrative services
8. Customer service
9. Technologies referenced in Section 18.0, "Technology"

In addition, the Implementation Strategy must contain a high-level phased implementation schedule to achieve full HCD within the first twelve (12) months. Acceptable strategies include, but are not limited to, SHCD no earlier than ninety (90) days after contract award but within one-hundred eighty (180) days of contract award, with HCD within twelve (12) months of contract award. For SHCD, the minimum schedule requirement includes full implementation of one (1) VA Urban Site and one (1)

VA Rural Site for CCN Region 4. VA will approve the selection of the Urban and Rural Site for SHCD. For HCD, the minimum schedule requirement includes full implementation of all sites within the awarded CCN Region. The list provided below is the potential list of sites the VA recommends for consideration for SHCD; this does not limit the proposal if other sites are proposed.

Region 4	
Urban	Rural
Portland (648)	Amarillo (504)
Spokane (668)	Fort Harrison (436)

Also, the Implementation Strategy must contain the Contractor's transition plan that includes, but not limited to:

1. Planned transition meetings and schedule
2. Transition execution steps with associated milestones ensuring continuation of healthcare delivery with minimal disruption to Veterans and the VA
3. What the Contractor will need from VA to effectively transition

Within the first fifteen (15) days of contract award, the Contractor must also provide a listing of its transition team members and team lead. This transition team must always be responsible for coordinating with VA and the incumbent Contractor(s) to identify the documentation, access to personnel (both VA and incumbent Contractor), and system access necessary to begin the process of reaching operating capability for SHCD and full HCD. The Contractor must provide a Twice Monthly Status Report on all activities related to implementation in accordance with the Schedule of Deliverables.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Implementation Strategy
B. Twice Monthly Status Reports (during implementation period)

2.3.2 CCN Deployment Plan

The Contractor must develop a CCN Deployment Plan describing the strategy and procedures associated with deploying the CCN in Region 4 by VA Facility, and VA Facility catchment construct identified in Attachment A, "VA Medical Center Catchment Area by CCN Region." The CCN Deployment Plan must be submitted in accordance with the Schedule of Deliverables.

The CCN Deployment Plan must contain details on the Contractor's method to:

1. Prepare for deployment of CCN
2. Participate in site readiness planning activities and deployment activities to ensure operational readiness and provider network adequacy
3. Complete training requirements
4. Identify and manage additional documentation proposed by the Contractor supporting CCN Deployment plans
5. Activate provider networks to achieve full HCD

6. Identify, monitor, and manage a series of risks and mitigation strategies specific to CCN deployment

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. CCN Deployment Plan

2.4 Risk Management Plan

The Contractor must create and adhere to a Risk Management Plan (RMP), which must consist of risk and issue management processes. The Contractor must always report risks and issues to VA for all CCN activities. In addition, the RMP must describe these impacts and describe measures to either minimize or eliminate the potential impact on the CCN. The Contractor must always submit updated risk responses and actions, to include mitigation strategies, in each Quarterly Progress Report (QPR). The RMP must be submitted in accordance with the Schedule of Deliverables.

The Contractor must always track and manage risks and issues and report them to VA in the Contractor Project Risk Register throughout the period of performance (PoP). In addition, the Contractor must always collaborate with VA to establish the priority, scope, bounds, and resources for managing project risks and issues, and/or assess the courses of action related to them. The Contractor must always inform VA of relevant deliberations and recommendations to mitigate and resolve project risks and issues as they are identified. The Project Risk Register must always be submitted in accordance with the Schedule of Deliverables.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Risk Management Plan
B. Project Risk Register

2.5 Operational Quality and Reporting Requirements

2.5.1 Quality Assurance Plan

The Contractor must establish and maintain a Quality Assurance Plan (QAP). The QAP must be submitted in accordance with the Schedule of Deliverables. The Contractor's QAP must demonstrate how the Contractor's performance will adhere to the Quality Assurance Surveillance Plan (QASP) (see Attachment B "Quality Assurance Surveillance Plan (QASP)" and Attachment BA, "QASP Performance Requirement Summary"). The Contractor must always meet performance targets established by the QASP. To provide for changing quality assurance and quality performance conditions, either VA or the Contractor may request changes to the components of QASP measurement and reporting. VA will utilize the QASP to monitor the quality of the Contractor's performance. The oversight provided for in the QASP will help to ensure that service levels reach and maintain the required levels throughout the contract term. The QASP will be finalized upon award and a copy provided to the Contractor after award. The QASP is a living document and may be updated by VA as necessary and executed upon bilateral agreement with the Contractor. The Contractor must always address all QASP performance metrics and whether the performance threshold missed, met and/or exceeded for each standard in a section entitled: "QASP Summary Report" within its Monthly Progress Report (MPR) (see Section 2.4.2, "Supplemental Project Management Reporting Requirements").

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Quality Assurance Plan

2.5.2 Supplemental Project Management Reporting Requirements

The Contractor must always establish and maintain QPRs. The Contractor must always provide the designated VA Project Manager and COR with QPRs in electronic form in Microsoft Word, Project, PowerPoint, or Excel formats as agreed upon with VA. The QPRs must always include:

1. Task Summary – This section includes a high-level summary narrative of the work that is being performed at all levels within the Project Plan.
2. QASP Summary Report – This section must always document the Contractor's performance against the performance metrics identified in the QASP during the reporting period.
3. High Level Schedule Summary – This section reports high-level summary of schedule elements that correspond with the reporting period.
4. Actual Activities for the Preceding Quarter – This section describes the activities performed in the preceding quarter.
5. Planned Activities for the Next Quarter – This section describes the activities planned for the following quarter.
6. High Level Risks and Issues Summary – This section includes the Risk Register, risk scores, probability, impact, and responses.
7. Corrective Actions and Improvements – This section lists the corrective actions and improvements that were executed during the reporting period.

These reports must always reflect data as of the last day of the preceding quarter and submitted in accordance with the Schedule of Deliverables. The Contractor must always participate in quarterly Program Management Reviews (PMRs) with VA at VA designated locations to support the presentation of information contained in the QPR. The Contractor must always utilize Attachment C, "QPR Template," to populate and submit the QPRs.

The Contractor must always create MPRs. The Contractor must always provide VA with an MPR in electronic form in Microsoft Word, PowerPoint, or Excel formats as agreed upon with VA. The Contractor must always utilize Attachment D, "MPR Template," to populate and submit the MPR. The MPR must always include:

1. Task Summary – This section includes a high-level summary narrative of the work that is being performed, both at the Indefinite Delivery/Indefinite Quantity (IDIQ) level and at the Task Order level.
2. QASP Summary Report – This section must always document the Contractor's performance against the performance metrics identified in the QASP during the reporting period.
3. Schedule Summary – This section reports summary of schedule elements that correspond with the reporting period.
4. Actual Activities for the Preceding Month – This section describes the activities performed in the preceding month.
5. Planned Activities for Next Month – This section describes the activities planned for the following month.
6. Risks and Issues Summary – This section includes the Risk Register, risk scores, probability, impact, and responses.
7. Corrective Actions and Improvements – This section lists the corrective actions and improvements that were executed during the reporting period.

The report must always identify any performance problems that arose and a description of how those problems were resolved. If problems have not been completely resolved, the Contractor must always provide an explanation, including its plan and timeframe for resolving the issue. The Contractor must

always keep in communication with VA so issues that arise are transparent to both parties to prevent escalation. The Contractor must always participate in *ad hoc* project related meetings with VA. The MPRs must always reflect the data as of the last day of the preceding month and be submitted in accordance with the Schedule of Deliverables. The MPRs must always identify the sources from which the data are pulled, and include notifications when updates to technical documents are made.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Quarterly Progress Reports
B. Monthly Progress Reports

2.6 CCN Communications Plan

The Contractor must develop a CCN Communications Plan to document the Contractor's approach to communicating with Community Care stakeholders as approved by VA. The plan must be delivered to VA in accordance with the Schedule of Deliverables.

Note: A comprehensive list of Community Care stakeholders will be provided for reference, and as applicable, at the kickoff meeting. Examples include but not limited to:

- *VA Executive Staff*
- *VA Community Care Staff*
- *VA Community Care Contractors (Per CCN Region)*
- *Veteran Community*
- *US Government Executive Staff*

The CCN Communications Plan must detail the key messages that must be articulated to the Community Care stakeholders, as well as the timing associated with the delivery of those messages. In addition, the CCN Communications Plan must contain the desired outcomes for the communications, as well as the vehicles for communications distribution.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. CCN Communications Plan

2.7 Accreditation

Except as described in Section 3.7.1, "Credentialing Requirements," healthcare delivery cannot commence until the CCN meets accreditation standards set forth herein. The CCN must always be accredited by a nationally recognized accrediting organization for the healthcare services that are within scope of an accreditation. The Contractor must always ensure that all services, facilities, and providers are in compliance with the accrediting organizations' standards or applicable Federal and State laws, where accreditation is not required and VA approves, for a service provider prior to serving Veterans under this contract. National certification, in lieu of accreditation, is insufficient to meet this requirement. In the event that this contract and the accrediting organization have different standards for the same activity, the more stringent standard must always apply for the services under this contract. A final determination of the more stringent standard will be made by the VA in any instance of uncertainty.

The Contractor must always maintain accreditation, where available, on the following components or programs of the CCN:

1. Provider Network or Health Network: Accredited prior to the SHCD. Documentation to be provided prior to SHCD.
2. Provider Network or Health Network Accreditation renewal: As renewals are processed
3. Credentialing Process: Documentation to be provided no later than date of award.
4. The CCN Contractor must also attest that they are capable of protecting the Government Furnished Information (VA data) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Security Rules.

The Contractor must always maintain documentation of all accreditation, certification, credentialing, delegation of credentialing, privileging, and licensing for its accredited components or programs and providers performing services under this contract. The Contractor must always provide a copy of its accreditation documentation in accordance with the Schedule of Deliverables. The Contractor must always notify VA if its accreditation is put on probation, suspended, or revoked within three (3) business days along with a corrective action plan (CAP). VA reserves the right to perform random reviews of the accreditation, certification, credentialing, delegation of certification agreements, privileging/competency measures, and licensing files for the accredited programs and providers within the CCN. The Contractor must always provide access to these files within five (5) business days of notification of such review.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Documentation of Accreditation

2.8 Service Organization Control Reporting (SSAE 18)

2.8.1 Service Organization Control Reporting Generally

The Contractor must engage an unaffiliated external auditing firm to conduct a Service Organization Controls (SOC) 1, Report on Controls at a Service Organization Relevant to User Entities Internal Control over Financial Reporting, Type 2 Report, in accordance with Statement on Standards for Attestation Engagements No. 18 (SSAE 18) or in accordance with the current guidance issued by the Auditing Standards Board and must always provide VA with a written copy of the SOC 1 Type 2 examination report (the "Prime Report"). The independent auditing firm must have prior experience in conducting SSAE audits. In addition, the Contractor must always provide a written copy of the SOC 1 Type 2 report, completed in accordance with SSAE 18, for any subservice organization (the "Subcontractor Report"). The Prime Reports and Subcontractor Reports must always address the specific services provided by the Contractor to VA under this contract. The current guidance for SSAE 18 was issued in April 2016. Reference: https://www.aicpa.org/Research/Standards/AuditAttest/DownloadableDocuments/SSAE_No_18.pdf. This guidance may be updated during the performance of the contract. The Contractor must always comply with updates to SSAE 18 and provide new reports as required by any changes to the updated SSAE guidance.

The Contractor must always engage an unaffiliated external auditing firm to conduct a SOC 2, Report on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality and Privacy, Type 2 Report, (the "Prime Report") in accordance with SSAE 18 and Trust Service Principles Criteria. The unaffiliated external auditing firm may be the same firm that provides the SOC 1 Type 2 report. The report must cover all trust principles to include: Security, Availability, Processing Integrity, Confidentiality and Privacy and ensure compliance with the HIPAA under those principles.

2.8.2 Service Organization Control Reporting Specifications and Deliverables SOC 1 and SOC 2 Reporting Specifications and Deliverables

VA's fiscal year begins October 1 and ends on September 30. The Contractor must submit an initial Prime Report and Subcontractor Report (SOC 1, Type 2 and SOC 2 Type 2) for current business and financial operations. The initial report must cover a minimum of nine (9) months from contact award in accordance with the Schedule of Deliverables. Any deviation to the initial report minimum must be approved by VA. Subsequent Prime Reports and Subcontractor Reports must always cover a minimum of 12 months; with a bridge letter covering the gap between the end date of the period covered by the Prime Reports and the end of VA's fiscal year and be submitted in accordance with the Schedule of Deliverables. Such subsequent reports must always cover the processes outsourced to the Contractor and that align to VA contractual requirements. When a SOC 1 and SOC 2 report covers only a portion of the Federal Government fiscal year (initial and subsequent reports), the Contractor must provide a bridge letter between the end date of the review period of the SOC 1 and SOC 2 and the end of the Federal Government fiscal year.

All Prime Reports and Subcontractor Reports must always clearly indicate the services, systems, and locations covered by the review, as well as the nature and type of control testing performed. The Contractor must always also account for controls over subservice organization (Subcontractor) services and performance. The Contractor must always include a cover letter on all Prime Reports and Subcontractor Reports clearly identifying that the Contractor that is performing services within the scope of the contract. The cover letter must be addressed to VA and must always summarize the results of the audit and the audit tests performed. The letter must always highlight unusual items, deficiencies, qualifications, and any inconsistencies with professional standards and provide an indication of actions being taken to address, remedy, or mitigate these or other weaknesses noted in the applicable report.

In the event a Prime Report or Subcontractor Report includes any deficiencies material to the Contractor's performance under this contract or relevant to VA's internal controls over financial reporting or operational controls to achieve the VA mission, as determined by VA in its sole discretion, VA will notify the Contractor in writing of the need for a CAP within thirty (30) days of receipt of the Prime Report. The Contractor must always submit the CAP to VA in accordance with the Schedule of Deliverables. The CAP must always describe, in detail, actions that will be taken by the Contractor to resolve the deficiencies and the timeline (begin and end dates) for completing each action. The Contractor must always implement recommendations as suggested by its auditor and the audit report within ninety (90) days from report issuance and must always cure any deficiencies to VA's satisfaction within a reasonable period, but no later than ninety (90) days from report issuance, and at no cost to VA.

The Contractor must always provide a bridge letter in accordance with the Schedule of Deliverables to cover the "gap" between the applicable Prime Report's and Subcontractor's Report period end date and VA's fiscal year end date (September 30).

The Contractor must always address the Bridge Letters to VA from Contractor senior management and must always specify the coverage begin and end dates. The letter must always include Contractor management's assertion that the processes and internal controls that were in effect during the period covered by the applicable Prime Report and Subcontractor Report remain in effect, and/or summarize any material changes in the control environment and the impact to VA. The Bridge Letter must

always provide an acknowledgement that it is not a replacement for the actual Prime Report or Subcontractor Report.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. SOC 1, Type 2 – Prime Report
B. SOC 2, Type 2 – Prime Report
C. SOC 1, Type 2 – Subcontractor Report
D. SOC 2, Type 2 – Subcontractor Report
E. SOC 1 and SOC 2 Bridge Letters as required
F. Corrective Action Plan

2.9 Transition

2.9.1 Reserved

2.9.2 Transition Out

The Contractor must facilitate the transition of contracted activities and services to the Government or to a follow-on Contractor at the end of the contract period of performance or as these activities are transitioned to the Government or to another Contractor. Transition activities must include, but are not limited to, the following:

1. Processing and finalization of all open healthcare claims inventories. The outgoing Contractor must always submit weekly status reports of claim inventories and phase-out activities to VA beginning the 20th calendar day after notification from the Contracting Officer.
2. Providing current inventory of all Government-owned assets used by the Contractor along with full support in the reconciliation of this inventory.
3. Providing "shadowing" and other knowledge transfer meetings and opportunities to facilitate the transfer of information, processes, and data needed to continue the services being performed by the Contractor.
4. Providing current and accurate program management documents.
5. Removal and purging of all non-public or other protected Government Furnished Information from any Contractor owned system, and certification thereof.
6. Active participation in transition management activities with a transition team comprised of VA and/or successor Contractor personnel.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Transition Out Plan
B. Weekly status report of claims inventories and phase-out activities

3.0 HIGH PERFORMING NETWORK

3.1 Network Establishment and Maintenance

The Contractor must provide a CCN. The CCN must always consist of a comprehensive network of qualified healthcare providers and practitioners to provide services set forth in Section 4.0, "CCN Health Benefit Package." Additional requirements for the Pharmacy component of the CCN are contained in Section 15.0, "Pharmacy." Additional requirements for the DME component of the CCN are contained in Section 16.0, "Durable Medical Equipment." Additional requirements for the Dental component of the CCN are contained in Section 17.0, "Dental." The Contractor must always

maintain a network of providers and practitioners that will extend across the entirety of the CCN Region and must always be sufficient in numbers and types of providers, practitioners, and facilities to ensure that all services will be accessible within the time frames outlined in this section. Network adequacy will be determined for each VA Facility located in the awarded CCN Region and by specific categories of care. The Contractor must always utilize two primary factors to achieve network adequacy: (i) geographic accessibility to a provider based on Drive Times, and (ii) Appointment Availability. Where access is inadequate (Drive Time or Appointment Availability) as determined by VA, the Contractor will be required to recruit providers and practitioners currently practicing in that area to participate in the CCN.

The CCN must always:

1. Include individual providers, practitioners, and institutional facilities
2. Coordinate with the care and services provided by VA
3. Monitor quality of care
4. Be adequate in size, scope, and capacity to ensure that Veterans receive timely access to care

The size, scope, and capacity of the CCN must always ensure timely access to care and must be set up in accordance with the minimum standards for each VA Facility catchment area found in Tables 1 and 2, except that minimum standards for: (i) CIHS practitioners are set forth in Section 3.2.2, "CCN CIHS Network," (ii) dental providers are set forth in Section 17.1, "Dental Network Adequacy," (iii) pharmacy providers are set forth in Section 15.2, "Urgent/Emergent Prescription Network Adequacy," (iv) Assisted Reproductive Technology (ART) service providers are set forth in Section 4.4, "CCN Assisted Reproductive Technology Services":

Table 1. Maximum Drive Times

Drive Times	
Primary	
Urban	Thirty (30) minutes
Rural	Forty-five (45) minutes
Highly Rural Location	Sixty (60) minutes
Specialty Care	
Urban	Forty-five (45) minutes
Rural	One hundred (100) minutes
Highly Rural Location	One hundred eighty (180) minutes

*Note: Drive Times calculations are in Section 3.6, "Network Adequacy Management."

Services from the following providers are excluded from Drive Time standards: telehealth, transplant, non-urgent neurosurgery, and cardiothoracic surgery. Contractor must always assure availability of these excluded services within each state of Region 4.

Table 2. Maximum Appointment Availability Times

Appointment Availability Emergent and Urgent		
	Emergent	Urgent

Urban	Twenty-four (24) hours	Forty-eight (48) hours
Rural	Twenty-four (24) hours	Forty-eight (48) hours
Highly Rural Location	Twenty-four (24) hours	Forty-eight (48) hours

Appointment Availability Routine		
	Primary Care	Specialty Care
Urban	Thirty (30) days	Thirty (30) days
Rural	Thirty (30) days	Thirty (30) days
Highly Rural Location	Thirty (30) days	Thirty (30) days

*Note: Appointment Availability calculations are in Section 3.6, "Network Adequacy Management."

Any deviations from these minimum standards, including requests to use telehealth capabilities to meet these standards, must always be requested in writing by the Contractor and submitted to the COR. Written requests must always include a detailed explanation of the circumstances that justify a deviation. Written requests will be reviewed by the COR, and a determination will be provided by the CO.

3.2 Provider Networks

The Contractor must always be responsible for identifying, contacting, negotiating, and contracting with hospitals, physicians, and other healthcare professionals and practitioners within the awarded CCN Region(s) (see Section 3.5, "CCN Regions"). The Contractor may use the prior fiscal year (FY) utilization data available to determine which providers and practitioners should be considered for CCN contracting. VA will provide additional Fiscal Year 2018 (FY18) utilization data after contract award. VA has attached FY15, FY16 and FY17 Summary Demand Data (see Attachment E, "Summary Demand Data") and FY17 Active Veteran counts by CCN Region (see Attachment F, "Projected Active Veterans"). Utilization data provided pursuant to this paragraph are not a guarantee of volume of purchases under this contract.

The Contractor must always identify providers by specialty and subspecialty type within the CCN provider listing.

Only VA providers will be delegated authority as Ordering Officials. CCN providers will not be delegated authority as Ordering Officials. For VA Providers ordering pharmacy services under this contract, the Contractor will need to have an Approved Referral.

3.2.1 CCN Healthcare Services Network

The CCN Healthcare Services Network must always be composed of a comprehensive network of licensed healthcare providers, unless licensure is not applicable to such providers, to deliver the services identified in Section 4.1, "CCN Healthcare Services," and to meet the network adequacy standards in Section 3.1, "Network Establishment and Maintenance." The Contractor must always make every reasonable attempt to include Tribal Health Services (THS), Academic Teaching Facilities and Federally Qualified Healthcare Centers (FQHC) as part of the CCN Healthcare

Services Network. VA will provide a list of THS and Academic Affiliate organizations to the Contractor within thirty (30) days after award. Contractor to annotate THS, Academic Affiliates, and FQHC on their provider listing.

The Contractor must always make every reasonable attempt to enroll providers that have and do currently accept Veteran referrals from VA.

The Contractor must always ensure the CCN Healthcare Services Network is accredited pursuant to Section 2.6, "Accreditation."

3.2.2 CCN Complementary and Integrative Healthcare Services Network

The Contractor must always provide access to a CCN CIHS Network. The CCN CIHS Network must always be composed of a comprehensive network of practitioners to deliver the services identified in Section 4.2, "CCN Complementary and Integrative Healthcare Services," and meet the minimum network adequacy standards for each VA Facility service area set forth in Tables 3 and 4.

Table 3. Maximum Drive Times

Drive Times	
Urban	Forty-five (45) Minutes
Rural	One Hundred (100) Minutes
Highly Rural Location	One Hundred Eighty (180) Minutes

*Note: Drive Times calculations are in Section 3.6, "Network Adequacy Management."

Table 4. Maximum Appointment Availability Times

Appointment Availability	
Urban	70% of Veterans have appointment availability within Thirty (30) days
Rural	70% of Veterans have appointment availability within Thirty (30) days
Highly Rural Location	70% of Veterans have appointment availability within Thirty (30) days

*Note: Appointment Availability calculations are in Section 3.6, "Network Adequacy Management."

Any deviations from these minimum standards, including rheumatology and dermatology services; or requests to use telehealth capabilities to meet these standards, must always be requested in writing by the Contractor and submitted to the COR. Written requests must always include a detailed explanation of the circumstances that justify a deviation. Written requests will be reviewed by the COR, and a determination will be provided by the CO.

The Contractor must include the CCN CIHS network adequacy in the Network Adequacy Plan that specifies the Contractor's specific processes and requirements for identifying and contracting with CCN CIHS Network practitioners to participate in the CCN CIHS Network in accordance with the applicable requirements set forth in this contract. The Network Adequacy Plan must identify each CCN CIHS Network practitioner type and the corresponding policies, regulations, and licensure and

certification requirements that will be used to define a CCN CIHS Network practitioner's scope of practice and determine whether to include a CCN CIHS Network practitioner in the CCN CIHS Network.

The Contractor must always confirm that CCN CIHS practitioners are credentialed in accordance with requirements set forth by national certifying boards or state certification and/or licensure.

3.3 Out-of-Network Providers

The Contractor must always instruct out of network providers to submit healthcare claims directly to VA, following VA claims submission procedures. Notifications to out-of-network providers must always include a reminder to have them submit supporting medical documentation with claims submission.

3.4 Identification of High-Performing Providers

The Contractor will assist VA with the development of CCN Healthcare Services Network Quality and Performance Criteria during implementation. Attachment G, "CCN Healthcare Services Network Quality and Performance Criteria Template" references quality and performance metrics the VA has prioritized; however, the thresholds and additional metrics will be determined during implementation based on the Contractors industry best practice and through further metric analysis by VA.

The Contractor must provide CCN providers with the Quality and Performance Criteria agreed to by VA in accordance with the Schedule of Deliverables. For purposes of identifying and designating a provider as described in this section, the Contractor may provide additional internal provider performance data along with publicly available performance data that are applicable to that provider. The Contractor must always monitor and review the performance of CCN Healthcare Services Network providers and take corrective action when necessary.

The Contractor must provide high performing provider quality and performance data to VA as specified by VA, but no less than quarterly.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. CCN Healthcare Services Network Quality and Performance Criteria Template
B. High Performing Provider Quality and Performance Data

3.4.1 Institutional Providers

The Contractor must always identify and designate high performing CCN Healthcare Services Network institutional providers as Centers of Excellence (CoE) in their provider file. Any designation of an institution as a CoE must always be based on the Healthcare Services Network Quality and Performance Criteria Thresholds as agreed to by VA, as referenced in Section 3.4, "Identification of High Performing Providers." The Contractor must always provide the CoE designation in all provider data transmitted to VA.

3.4.2 Group Practice Providers

The Contractor must always identify and designate CCN Healthcare Services Network group practice providers as high performing providers based on the combined group practice performance against the CCN Healthcare Services Network Quality and Performance Criteria Thresholds agreed to by VA, as referenced in Section 3.4, "Identification of High Performing Providers." The Contractor

must always provide the high performing provider designation in all provider data transmitted to VA, including in their provider file.

3.4.3 Individual Providers

The Contractor must always identify and designate CCN Healthcare Services Network individual providers as high performing providers based on the individual provider's performance against the CCN Healthcare Services Network Quality and Performance Criteria Thresholds agreed to by VA, as referenced in Section 3.4, "Identification of High Performing Providers." The Contractor must always provide the high performing provider designation in all provider data transmitted to VA.

The Contractor shall make available American Medical Association guidelines for assessing a patient's military experience and duty assignments. All high performing Veteran care providers will have access to accredited training developed by VA, including in their provider file.

3.5 CCN Region

For the purposes of this contract, the CCN Region 4 is as follows:

Table 5. VA CCN Region

CCN Region 4
Texas
New Mexico
Arizona
California
Nevada
Utah
Colorado
Wyoming
Idaho
Oregon
Washington
Montana
Hawaii

3.6 Network Adequacy Management

The Contractor must detail the approach for creating and maintaining an adequate CCN in a Network Adequacy Plan. The Contractor must always address all network adequacy requirements under the CCN; the CCN Healthcare Services Network, the CCN CIHS Network (per requirements in Section 3.2.2), dental, and pharmacy within the Network Adequacy Plan. The CCN must always be customized for each VA Facility catchment area per Attachment A, "VA Medical Center Catchment Area by CCN Region." The Contractor must obtain approval of the Network Adequacy Plan from VA in accordance with the Schedule of Deliverables.

The Contractor must always monitor CCN performance against the network adequacy standards set forth in Section 3.1, "Network Establishment and Maintenance," as part of the Network Adequacy

Plan. The Contractor must always provide Network Adequacy Performance Reports in accordance with the Schedule of Deliverables. The Contractor must always record performance, including any performance deficiencies, and submit the performance record as part of a Network Adequacy Performance Report to VA utilizing DAS. (see Attachment U, "Data Specification" (tab 1-Network Adequacy), see Attachment H, "Eligibility Verification and Enrollment Data Exchange"). Network adequacy performance is measured independently for Urban, Rural, and Highly Rural Location. The Network Adequacy Performance Reports must always include the following elements for the CCN Healthcare Services Network, CCN CIHS Network, dental, and pharmacy: (i) average Drive Time, calculated per claim received and calculated using Bing Maps or other geomapping utility approved by VA based on the distance between Veteran address and the rendering provider's physical address without factoring in allocations for traffic conditions; (ii) average Appointment Availability to evaluate wait times, calculated using the date the referral is sent to provider from VA and actual appointment date on the first claim associated with that referral; (iii) any further analysis that takes into consideration any rescheduled, cancelled, or missed appointments and/or Veteran or CCN provider complaint data received regarding Drive Time or Appointment Availability standards; (iv) any gaps in network adequacy for average Drive Time and Appointment Availability, categorized by healthcare service category and geographic location to include an Urban, Rural, or Highly Rural Location indicator; and (v) documentation of rescheduled, cancelled, or missed appointments. The Contractor must always develop and submit to VA a Network Adequacy CAP for Contractor resolution of any performance deficiencies identified by the Contractor or VA in accordance with the Schedule of Deliverables. The Contractor's Network Adequacy CAPs must always include the reason(s) for the performance deficiency and timeline for the Contractor to correct the deficiency. The Contractor's Network Adequacy CAP is to be submitted using DAS, and in accordance with the Schedule of Deliverables.

The Contractor must always conduct monthly network adequacy meetings with VA stakeholders at the direction of Veterans Integrated Service Network (VISN) leadership, with at least one meeting a quarter being face-to-face (at a location to be determined by VA). These meetings will focus on the evaluation of network performance, anticipated changes in network demand, and to review the deliverables listed in Section 3.6, "Network Adequacy Management." The Contractor must always prioritize VA capacity needs to meet network adequacy requirements. VA and the Contractor maintain the ability to request *ad hoc* meetings to discuss identified issues. Any such *ad hoc* meetings must always be unlimited until full HCD is reached; then limited to no more than two (2) times per month for each additional option period. VA and the Contractor may mutually agree to an alternate schedule of meetings once full HCD is achieved.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Network Adequacy Plan
B. Network Adequacy Performance Report
C. Network Adequacy CAP

3.7 Credentialing

3.7.1 Credentialing Requirements

The Contractor must always confirm that CCN Healthcare Services Network providers and facilities (medical, dental; not to include pharmacy and DME) are credentialed in accordance with the

requirements set forth by the nationally recognized accrediting organization for the Contractor's credentialing program unless the accrediting organization's standards are not applicable to such services, facilities and providers.

The Contractor must always confirm that all services, facilities, and providers are in compliance with all applicable federal and state regulatory requirements. Any provider on the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) exclusionary list must always be prohibited from network participation. See: http://oig.hhs.gov/exclusions/index.asp for further details.

In accordance with requirements outlined in the OIG's Compliance Program Guidance for Hospitals (https://oig.hhs.gov/compliance/compliance-guidance/index.asp), the Contractor must always confirm that all services, facilities, and providers, as applicable, have a compliance program in place that includes the seven (7) elements of an effective compliance program:

1. Conducting internal monitoring and auditing
2. Implementing compliance and practice standards
3. Designating a Compliance Officer or contact
4. Conducting appropriate training and education
5. Responding appropriately to detected offenses and developing corrective action
6. Developing open lines of communication
7. Enforcing disciplinary standards through well-publicized guidelines

The Contractor must always be responsible for ensuring that CCN providers, who have no national accrediting organization standards for their specialty requirement must provide the following minimum documentation:

1. Proof of identity by obtaining a government issued photo identification and I-9 documentation;
2. Education and training, if applicable (unskilled home health excluded);
3. Have an active, unrestricted license in the state in which the service is performed, if applicable (unskilled home health excluded);
4. Have a current National Provider Identifier (NPI) number, if applicable (unskilled home health excluded);
5. Tax Identification Number;
6. Maintain professional liability insurance in an amount in accordance with the laws of the state in which the care is provided;
7. Have a Drug Enforcement Agency (DEA) number, if they prescribe controlled substances;
8. Work History;
9. Criminal Background Disclosure;
10. Professional References; and
11. Operate within the scope of their license.

All documentation must be verified through primary sources and credentialing must be performed at a minimum of once every three years. The accreditation requirement may be waived at the direction of the VA, who will coordinate with the Contractor and facility for facilities that do not have a preexisting requirement for accreditation because of federal and/or state requirements. For cases in which this requirement is waived, the Contractor must always note the omission and submit proposed alternative qualification standards so as to ensure a like standard of quality to the CO and COR.

The Contractor must always ensure that all inpatient facilities maintain Joint Commission accreditation or accreditation by the Accreditation Association for Hospitals/Health Systems (AAHHS), when applicable. The Contractor must always ensure that rehabilitation facilities maintain accreditation with Commission on Accreditation of Rehabilitation Facilities (CARF), at a minimum. Rehabilitation facilities who maintain a Joint Commission accreditation are not required to maintain a CARF accreditation as well.

The Contractor must always confirm that all CCN CIHS Network practitioners are in compliance with all applicable federal and state laws, statutes, and regulatory requirements. The Contractor must always confirm if a CCN CIHS Network practitioner's practice area provides for certification and/or licensure. If so, then the CCN CIHS Network practitioner must always hold such certification and/or license.

If a provider is or has been licensed, registered, or certified in more than one state, the Contractor must always confirm that the provider certifies that none of those states has terminated such license, registration, or certification for cause, and that the provider has not involuntarily relinquished such license, registration, or certification in any of those states after being notified in writing by that state of potential termination for cause.

The Contractor must always notify VA and take necessary actions to remove any CCN Healthcare Services Network provider if any state in which the provider is licensed, registered, or certified, terminates such license, registration, or certification for cause. The Contractor must always notify VA of any action against the provider's state license immediately in writing.

The Contractor must always report in writing, as soon as possible, but not later than fifteen (15) days after the Contractor is notified, to the CO/COR (via email) and the Contractor's credentialing committee, the loss of or other adverse impact to a CCN Healthcare Services Network provider's certification, credentialing, privileging, or licensing. Loss of facility accreditation status must always be reported as soon as the Contractor is notified. The report must always contain information detailing the reasons for and circumstances related to the loss or adverse impact. The report must always be sent to the CO and COR. The Contractor may submit a request with supporting rationale for the re-listing of such provider/facility.

The Contractor must always provide an annual attestation, in accordance with the Schedule of Deliverables, certifying that all accreditation, certification, credentialing, privileging/competency measures, delegation of credentialing agreements and licensing requirements required under this contract are met for network providers performing services under this contract.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Documentation of Accreditation/Annual Attestation

4.0 CCN HEALTH BENEFIT PACKAGE

4.1 CCN Healthcare Services

The Contractor must always include the following CCN Healthcare Services as described in 38 Code of Federal Regulations (CFR) § 17.38 as part of the services provided under this contract:

Table 6. CCN Healthcare Services

Health Benefit	Coverage
Basic Medical Benefits Package, includes: • Preventive Care • Comprehensive Rehabilitative Services • Hospital Services • Ancillary Services • Behavioral Health (to include professional counseling) • Residential Care • Home Healthcare (Skilled and Unskilled) • Hospice/Palliative Care/Respite • Geriatrics (Noninstitutionalized extended care services, including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care) • Outpatient Diagnostic and Treatment Services (including laboratory services) • Inpatient Diagnostic and Treatment Services • Long Term Acute Care • Acupuncture • Maternity and Women's Health • Telehealth	All Eligible Veterans
Skilled Nursing Facility Care	Limitation of rehab services not to exceed 100 days per calendar year
Pharmacy	All Eligible Veterans; Contractor must always provide pharmacy services only for urgent and emergent prescriptions
Dental	Requires special eligibility (see Section 17.0, "Dental")
Emergent Care	Under certain conditions pursuant to 38 C.F.R. § 17.52(a)(3), 17.53, 17.54, and 17.120-17.132
DME, Medical Devices, Orthotic, and Prosthetic Items	Contractor must always provide DME, Medical Devices, Orthotic, and Prosthetic Items for only urgent and emergent prescriptions for eligible Veterans or otherwise specified in Section 16.0
Reconstructive Surgery	Under certain conditions pursuant to 38 C.F.R. § 17.38

Immunizations	Under certain conditions pursuant to 38 C.F.R. § 17.38
Implants	When provided as part of an authorized surgical or medical procedure
Urgent Care	Under certain conditions pursuant to 38 C.F.R. § 17.52(a)(3), 17.53, 17.54 and 17.120-17.132
Assisted Reproductive Technology services (ART)	Under certain conditions pursuant to 38 C.F.R. § 17.52(a)(3), 17.53, 17.54 and 17.120-17.132 Includes six (6) weeks after pregnancy is achieved and patient discharged from care

Note: CCN Healthcare Services must always include rehabilitative services/therapies provided by non-licensed practitioners (e.g., blind and low vision rehabilitation services, driver rehabilitation services, and recreational therapy).

4.1.1 CCN Healthcare Service Exceptions

CCN Healthcare Service Exceptions are services that are covered by VA Health Benefit Package pursuant to 38 C.F.R. § 17.38 or otherwise provided by VA, but must not be provided under this contract. The Contractor will not be reimbursed for the Administrative Fees or the Cost of Medical Care if any services for the following items are provided to an Active Veteran:

1. Beneficiary travel
2. Dialysis
3. Medical and rehabilitative evaluation for artificial limbs and specialized devices such as adaptive sports and recreational equipment
4. Nursing home care including state Veterans' Home per diem
5. Home deliveries Ambulance services (ambulance services must always be referred directly to VA for payment consideration)
6. Tai Chi, Yoga, Native American Healing and services included on CIHS Directive List 2
7. ART/ In-Vitro Fertilization (IVF) - cryopreservation and storage greater than three years

4.2 CCN Complementary and Integrative Healthcare Services

The Contractor must always provide the following CCN CIHS and require all practitioners to submit claims using the appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. If a CPT or HCPCS code is unavailable, the CCN CIHS Network practitioner must always use VA National Clinic List Codes identified in Table 7 as CPT codes or HCPCS codes.

Table 7. VA National Clinic List Codes

VA National Clinic List Code	Name	Coverage
BIOF	Biofeedback	Under certain conditions pursuant to 38 C.F.R. § 17.38
HYPN	Hypnotherapy	
MSGT	Massage Therapy	

RLXT	Relaxation Techniques (e.g., meditation, guided imagery)	

4.3 Excluded CCN Healthcare Services

Excluded CCN Healthcare Services are services not covered by the CCN Health Benefit Package pursuant to 38 C.F.R. § 17.38. The Contractor must always exclude the following healthcare services from the CCN Health Benefit Package:

1. Abortion or abortion counseling
2. Drugs, biologicals, and medical devices not approved by the Food and Drug Administration (FDA) unless used under approved clinical research trials
3. Gender alteration surgeries; however, medically indicated diagnostic testing or treatments related to gender alterations are covered benefits
4. Hospital and outpatient care for a Veteran who is either a patient or inmate in an institution of another Government agency if that agency has a duty to give the care or services
5. Membership in spas or health clubs
6. Out-of-network services

4.4 CCN Assisted Reproductive Techology Services

The Contractor must always include services for ART services, including IVF, for Veterans whom have a service-connected (SC) condition. Fertility services may include the following:

1. Stimulation of ovulation
2. Monitoring of ovulation stimulation
3. Ocyte retrieval laboratory studies
4. Embryo assessment and transfer
5. Luteal phase support
6. Embryo cryopreservation (three (3) years)
7. Cryopreservation of sperm, oocytes if medically indicated (three (3) years)

Table 8. ART Maximum Drive Times

	Drive Times
Urban	Within ninety (90) minutes
Rural	Within one hundred eighty (180) minutes
Highly Rural	Within one hundred eighty (180) minutes

*Note: Drive Times calculations are in Section 3.6, “Network Adequacy Management.”

Table 9. ART Maximum Appointment Availability Times

ART Appointment Availability	
Urban	Sixty (60) days
Rural	Sixty (60) days

ART Appointment Availability	
Highly Rural Location	Sixty (60) days

5.0 Reserved

6.0 CUSTOMER SERVICE

The Contractor must establish and maintain customer service capabilities in support of the CCN. These capabilities, detailed in Sections 6.1-6.8, must include:

1. Establishing and maintaining metrics for Contractor-maintained call center functionality for handling VA and Provider calls
2. Staffing and supporting call centers functionality in compliance with the standards established
3. Managing complaints and grievances based on established procedures
4. Providing monthly reporting to VA and maintaining communication between VA and the Contractor on performance in all areas of customer service
5. Managing correspondence, including Congressional and VA inquiries

6.1 Contractor VA Support Call Center Functions

The Contractor must establish and maintain a Contractor VA Support Call Center. The Contractor VA Support Call Center will address inquiries made by VA staff regarding information such as, but not limited to, provider availability, confirm receipt of Veteran referral/authorization status, retail pharmacy, claim status, Veteran Complaints and Grievances, and Congressional and VA inquiries. The Contractor VA Support Call Center must always manage calls received from VA staff and its representatives.

The Contractor VA Support Call Center must always include, at a minimum, toll-free telephone lines and access to customer service via electronic messaging. The call center must always operate from 8AM to 6PM, Monday through Friday, excluding Federal holidays, in all the local time zones within Region 4.

The Contractor must always provide an escalation process for VA Community Care Contact Centers to facilitate prompt resolution of customer service issues. The Contractor must always provide VA Community Care Contact Center employees access to appropriate staff who can resolve Veteran or provider issues that cannot be resolved without its support. This occurrence is considered an escalation of an issue. The Contractor must always provide VA a unique toll-free phone number, different from the toll-free line listed above, that connects directly to a Contractor representative bypassing any Interactive Voice Response (IVR), queue, or routing, so that VA Community Care Contact Center can Warm Transfer VA staff assisting a Veteran or a CCN provider immediately to the appropriate Contractor customer service representative. VA Community Care Contact Center staff will address Adverse Credit Reporting (ACR) and non Patient Centered Community Care (PC3)/Choice claim related inquiries for CCN Region 4.

The Contractor must have call center capabilities available for initial testing by VA no later than sixty days prior to the SHCD and demonstrate, at a minimum, that:

- Appropriate toll-free lines have been established
- A caller can call in to the lines and be routed to the correct call center representative
- Electronic messaging is available
- Website capabilities are available and functioning
- Support for English and Spanish speaking and hearing/vision impaired callers is available both telephonically and online
- Warm Transfer capabilities are available

Successful operation of VA Support Call Center must be complete and must be accepted by VA by thirty days prior to the SHCD. The Contractor must always develop training documents and response scripts and provide to VA for review and approval in accordance with the Schedule of Deliverables.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. VA Support Call Center Training Documents and Response Scripts

6.2 CCN Provider Call Center Function

The Contractor must establish and maintain a CCN Provider Call Center that includes, at a minimum, toll-free telephone lines and access to customer service via electronic messaging, and operates from 8AM to 6PM Monday through Friday, excluding Federal holidays, in the local time zones for all of Region 4, to respond to online and telephonic inquiries from CCN providers related to the following categories:

1. Claims Status
2. Claims Issues
3. Pharmacy
4. DME, Medical Devices, and Orthotic and Prosthetic Items
5. Provider Enrollment
6. Complaints
7. Benefits Issues

The Contractor's CCN Provider Call Center must always have a prompt on its provider call center number for Referrals that immediately routes to VA Community Care Contact Center.

The Contractor must always provide access to customer service via electronic messaging. Telephonic and electronic message inquiries must always be addressed in a timely, accurate, and consistent manner. Telephonic and electronic message services must always be fully accessible to callers including support for hearing-impaired and Spanish speaking persons.

The Contractor must have call center capabilities available for initial testing by VA no later than sixty (60) days prior to the SHCD and demonstrate, at a minimum, that:

- Appropriate toll-free lines have been established
- A caller can call in to the lines and be routed to the right call center representative
- Electronic messaging is available
- Website capabilities are available and functioning
- Support for English and Spanish speaking and hearing/vision impaired callers is available both telephonically and online
- Warm Transfer capabilities are available

Successful operation of the CCN Provider Call Center must be complete and must be accepted by VA thirty (30) days prior to the SHCD. The Contractor must develop training documents and response scripts and provide to VA for review and approval in accordance with the Schedule of Deliverables.

Deliverable: (See Section 20.4, “Schedule of Deliverables” for details.)

A. CCN Provider Call Center Training Documents and Response Scripts

6.3 Reserved

6.4 Contractor Customer Service Technology

The Contractor must always maintain a website/online service, in accordance with VA Directive and Handbook 6102, for VA personnel, and CCN providers related to, at a minimum, the following capabilities: access via a link to VA master provider directory search function (to include both VA and CCN providers as well as location, specialty, and name searches), claims, information on the appeals and grievance processes, and provider manual. The Contractor website services must be limited to data available in the Contractor data systems. Details for this requirement are described further in Section 18.8, “Contractor Self Service Website.” The Contractor must always educate the VA Community Care Provider to access the VA Community Care Provider Portal for Customer Service Inquiries related to Referral and Prior Authorization status.

The Contractor must always provide website Service Availability 99.9 percent of the time, measured monthly. The Contractor must always create and provide customer service technology availability statistics to VA monthly as part of the deliverable referenced in Section 6.8, “Call Center Operations and Customer Service Technology Performance Requirements and Metrics.” The Customer Service Availability statistics must always calculate the service’s unavailability for each calendar month. Calculation of service unavailability is the number of available minutes in a calendar month vs. the number of unavailable minutes, and will not include any time the service is unavailable due to scheduled maintenance.

The Contractor must always notify the CO and COR of scheduled system maintenance at least two (2) weeks in advance. The system maintenance notification must always include the system(s) affected, changes that will occur, and the date/time the changes will be in effect. The Contractor must always schedule system maintenance during the standard maintenance windows provided by VA. For unscheduled system maintenance, unscheduled downtime, unexpected interruption to web/online services, and call center functionality, the Contractor must always notify VA immediately (within one [1] hour of being alerted of an issue). Such notification must always be electronic via an agreed upon process with VA.

When unscheduled downtime occurs for more than one (1) cumulative hour in any given twenty-four (24) hour period, VA may request that the Contractor conduct a Root Cause Analysis. The Contractor must always complete such analysis and provide its findings and recommended corrective actions to the COR within ten (10) days of the request. The Contractor must always provide the COR with a schedule to resolve any identified issues within two (2) days of completion of the Root Cause Analysis.

6.5 Veteran Complaints and Grievances and Customer Service Procedure

The Contractor will develop a process to accept and report clinical grievances and appeals received

by Veterans.

The Contractor must always forward all Veteran disputes, complaints, grievances and appeals received to VA within two (2) business days of receipt. The Contractor must always provide VA relevant background information regarding the complaint or grievance within three (3) business days of the notification to VA.

VA reserves the right to request supplemental information relating to Veteran complaints and grievances and customer service at any time. When VA requests information from the Contractor, the Contractor must always confirm receipt of the request within one (1) business day. Notification of receipt can be accomplished electronically via an agreed-upon mechanism with VA. The Contractor must always provide the full written response within five (5) business days or within a timeframe as agreed to by the Contractor and VA. A full response must always consist of a description of the issue, actions taken to resolve the issue, and the final resolution to the issue. The written response must always include copies of any and all documentation on file with the Contractor.

Deliverable: (See Section 20.4, “Schedule of Deliverables” for details.)

A. CCN Veteran Complaints and Grievances Call Center Process

6.6 Congressional and VA Inquiries

The Contractor must establish a point of contact (POC) for Congressional inquiries and VA inquiries. The Contractor must always forward all inquiries received directly by the Contractor from a Congressional office, and a copy of the full written response back to the Congressional office, within five (5) business days of an inquiry.

VA reserves the right to request information relating to customer service at any time. When VA requests supplemental information from the Contractor, the Contractor must always confirm receipt of the request within one (1) business day. Notification of receipt can be accomplished electronically via an agreed-upon mechanism with VA. The Contractor must always provide the full written response within five (5) business days of VA’s request. A full response must always consist of a description of the issue, actions taken to resolve the issue, and the final resolution to the issue. The written response must always include copies of any and all responses to the Congressional representative, Veteran, or other involved party.

6.7 CCN Provider Satisfaction Surveys

The Contractor must always conduct CCN Provider Satisfaction Surveys in accordance with the Schedule of Deliverables. VA will provide the content and format for these surveys. At the end of each quarter, the Contractor must always survey all CCN providers who submitted a claim in that quarter. The initial CCN Provider Satisfaction Surveys must always be distributed at the end of the first quarter following SHCD. Subsequent CCN Provider Satisfaction Surveys must always be distributed quarterly thereafter. For each distributed set of CCN Provider Satisfaction Surveys, the Contractor must always report to VA the results of such surveys sixty (60) days following conclusion of the survey quarter. The CCN Provider Satisfaction Survey results are to be submitted electronically using DAS.

Deliverable: (See Section 20.4, “Schedule of Deliverables” for details.)

A. CCN Provider Satisfaction Survey Results

6.8 Call Center Operations and Customer Service Technology Performance Requirements and Metrics

The Contractor's customer service capabilities identified in Section 6.0, "Customer Service," must always comply with the following:

Table 10. Customer Service Capabilities

Customer Service Capabilities	
Metric	Performance Rate
Blockage Rate	less than 5%
Call Abandonment Rates	5% or less
Average Speed of Answer	Thirty (30) Seconds or less
First Call Resolution	85% or higher

The Contractor must provide a Contractor Call Center Operations and Customer Service Technology Performance Report in accordance with the Schedule of Deliverables. The report must always include detailed information in the following metrics:

1. Blockage Rates
2. Call Abandonment Rates
3. Average Speed of Answer
4. First Call Resolution
5. Acknowledgement to VA of Receipt of Inquiry
6. Veteran Complaints and Grievances Receipt and Notification
7. VA Inquiries Receipt and Response
8. Congressional Inquiries Receipt and Response
9. Customer Service Technology Availability Statistics

The Contractor must always provide a monthly report summarizing all call center inquiries, performance metrics, open issues, and trends. The Contractor must always also include, in each monthly report, summary information on all Veteran complaints and grievances received and responded to, all Congressional and VA inquiries received and responded to, results from all CCN Provider Satisfaction Surveys, and customer service technology availability statistics. The Contractor Call Center Operations and Customer Service Technology Performance Report is to be submitted electronically using DAS. (see Attachment U, "Data Specification" (tab 4-Customer Service)).

The Contractor must always meet with VA quarterly at VA designated locations as part of the established PMR referenced in Section 2.4.2 of the PWS. During these quarterly PMR meetings, the Contractor must always review contract performance metrics related to current customer services activities, call center performance metrics, and Veteran and CCN Provider Satisfaction Survey results to maintain an effective customer service relationship between the Contractor and VA. Additional meetings related to customer service activities may be requested at the discretion of VA, if needed.

Deliverable: (See Section 20.4, “Schedule of Deliverables” for details.)

A. Contractor Call Center Operations and Customer Service Technology Performance Report

7.0 REFERRALS AND PRIOR AUTHORIZATION

All services require an Approved Referral or task order from VA with limited exception as outlined below. (See Ordering Instructions for additional details) Approved Referrals from VA will authorize a specific Standardized Episode of Care (SEOC) as it relates to a specified number of visits and/or services related to a plan of care and will not be approved to exceed one (1) year. When Approved Referrals result in urgent and emergent prescriptions meeting the requirements in Section 15.0, “Pharmacy,” and urgent and emergent prescriptions for DME, Medical Devices, and orthotic and prosthetic items meeting the requirements in Section 16.0, “Durable Medical Equipment,” those supplies and services are also authorized as part of the Standard Episode of Care. VA will provide SEOC tables to the Contractor during contract implementation, and as material changes occur by the VA, but no less often than annually. The Contractor will have thirty (30) days to implement the updates to the revised SEOC tables provided by VA.

The Contractor must always maintain Approved Referral/authorization number in its system for claims adjudication and customer service report. VA will provide electronic access to the referral information as needed.

Veterans may seek initial outpatient behavioral health Services from a CCN Healthcare Network Services provider without an Approved Referral or Prior Authorization prior to the visit. Once the initial outpatient behavioral health visit has been established with the CCN Provider, the Contractor must always submit a Referral Request to the nearest VA Medical Center for additional behavioral healthcare services.

Veterans with a Service Connected (SC) disability, may seek treatment for ART & IVF. The Approved Referrals or Prior Authorizations may include both the Veteran and spouse. These spouses are referred to as collateral spouses. The collateral spouse can be either male or female and Veteran or non-Veteran.

Attachment I, “Prior Authorization List,” is a list of all medical services and procedures that require CCN providers to request Prior Authorization from VA when requesting directly. Attachment IA, “Dental Service Prior Authorization Exception List” identifies special guidance for dental services provided under this contract. Prior Authorization is the process of having the VA review and approve certain medical services to ensure medical necessity and appropriateness of care prior to a referral being authorized and the services being rendered. VA has provided Attachment I “Prior Authorization List” and Attachment IA “Dental Service Prior Authorization List”. The VA will provide updated Attachment I and IA to the Contractor during contract implementation, and as material changes occur by the VA, but no less often than annually. The Contractor will have thirty (30) days to implement the updates to the revised Attachment I and IA provided by VA.

The Contractor must always direct all Veteran or CCN provider Referral Requests that it receives for referrals, including urgent care, emergent care and behavioral health self-referrals or Prior Authorizations, to VA for appropriate disposition.

The Contractor must always communicate with VA through an Electronic Data Interchange (EDI)

transaction(s) for requests and responses through VA clearinghouse in accordance with the One VA Technical Reference Model (http://www.va.gov/trm/) and HIPAA. The Contractor must always also maintain the capability to send and receive referral information with VA and CCN providers via Direct Messaging, eHealth Exchange secure email, secure fax, telephone or through the Community Care Provider Portal (CCPP) provided by the VA.

The Contractor must always request the status of all Referral Requests and Prior Authorization requests via EDI 278 transaction once available. The Contractor must always inform CCN providers that they may request the status of all Referral Requests and Prior Authorization requests via direct messaging, secure email, eHealth Exchange, telephone requests or preferable once available VA's CCPP or EDI 278 transaction.

See Section 18.0, "Technology," for further detail.

7.1 Notification of Urgent, Emergent, or Behavioral Health Care

This contract includes the provision of outpatient urgent or emergent care and hospital admission due to emergent care furnished to any Veteran enrolled in the VHA Health Care System or otherwise entitled for VHA medical benefits as required under Title 38, Code of Federal Regulations, Section 17.37, who presents to an in-network emergency facility seeking emergent care. The Contractor must always educate its behavioral health providers, emergency care providers and urgent care providers to notify VA within 72 hours of the Veteran's self-presenting to an in-network urgent care clinic, emergency department, or behavioral health CCN provider. The Contractor must notify VA within seven (7) calendar days of admitting a Veteran to a hospital for routine care, treatment, or procedure, within the course of the SEOC. The notification can be via secure email, secure fax or EDI.

The VA Staff will determine the eligibility criteria and determine the authority in which they will pay if the Veteran is eligible. If the Veteran is eligible, VA will issue a retroactive Approved Referral for urgent or emergency services to the Contractor and Provider in which the Veteran self-reported. The Contractor shall reimburse that claim in accordance with the reimbursement rates identified by VA.

If the Contractor or providing facility fails to follow the steps identified above for urgent, emergent or behavioral health care, and the non-VA facility subsequently submits a Claim for consideration of payment, the Contractor must always pend the Claims that do not include an Approved Referral number. The Contractor can then submit the claims, and supporting documentation sufficient for VA to determine whether to issue a retroactive referral, to VA for review and consideration. VA will send a determination on the Referral Request to the Contractor. If the Veteran is not determined eligible by VA, under 38 USC 1728, the facility must submit the Claim within ninety (90) days of the encounter in the emergency department in order for the Veteran's claim to be considered under the Millennium Health Care Act 38 USC 1725.

In the event that VA issues denial of a retroactive authorization for urgent or emergency services claim to the Contractor, then the Contractor shall deny that claim. The Contractor must always instruct out-of-network emergency providers to submit healthcare claims directly to VA following VA claims submission procedures. In the event that care is not authorized by VA, the Contractor's provider may appeal, per guidance in Section 13.0 "Veteran Claim Appeals and Provider Reconsiderations."

The Contractor must always instruct providers to notify VA through direct messaging, secure email, secure fax, telephone, or preferably and once available, EDI 278. All notifications of admissions must always include: hospital name and location, admitting provider's NPI, admitting diagnosis, date of admission, and any services delivered to the extent that this information is available to the in-network provider. The Contractor must always store this information in its referral and Prior Authorization management system for claims adjudication as a post-service request approval by VA.

7.2 Referrals from VA to CCN Provider

The Contractor must always adhere to the process represented in Table 11:

Table 11. Referral Process and Actions (= capability under development but slated for readiness upon contract award)*

Step Number	Action
1	VA creates an Approved Referral, including attachments.
2	VA will send the referral information via Direct Messaging, secure email, secure fax, eHealth Exchange, EDI 278*, or preferably VA's Community Care Provider Portal*.
3	Services provided by Ancillary Providers are authorized under the Approved Referral if defined in the Standard Episode of Care and should be referred to the Ancillary Provider by the initial CCN provider.
4	VA will send a copy of the Approved Referral with the referral number to the Contractor.
5	The Contractor receives a copy of the Approved Referral and stores the referral information (e.g. medical codes, effective date, termination date, date generated) for claims adjudication and customer service support.

VA will provide the referral number for all services requiring a referral. VA will approve or deny all Referral Requests and Prior Authorization requests further described in Section 7.4.

7.3 Referrals Requested from a CCN Provider for VA Provided Care or Another CCN Provider

The Contractor must always adhere to the process represented in Table 12:

Table 12. Process for Transmitting Referrals from a CCN Provider to VA (= capability under development but slated for readiness upon contract award)*

Step Number	Action
1	Referring CCN provider creates a Referral Request (including any supporting medical documentation), providing the information requested and any supporting medical documentation.

2	Referring CCN provider sends a Referral Request via Direct Messaging, secure email, secure fax, eHealth Exchange, telephone request, or preferably once available VA's Community Care Provider Portal* or EDI 278*.
3	VA receives the Referral Request EDI 278 transaction, Direct Message, eHealth Exchange, secure online file exchange, secure email, secure fax, or telephone request including information requested and any supporting attachments (supporting medical documentation and or eligibility documentation).
4	VA sends the determination (and a referral number if approved) via Direct Messaging, secure email, secure fax, eHealth Exchange, EDI 278*, or VA's Community Care Provider Portal*. If the CCN provider requesting the referral is not the Veteran's Primary Care provider, a copy is also sent to the Primary Care provider.
5	Referred CCN provider receives determination from VA providing the determination and a referral number, if approved.
6	VA sends a copy of the determination to the Contractor.
7	Services provided by Ancillary Providers are authorized under the Approved Referral if defined in the Standard Episode of Care and should be referred to the Ancillary Provider by the initial CCN provider.
8	The Contractor receives a copy of the determination and stores it for claims adjudication and customer service support.

Table 13. Process for Transmitting Referrals from a CCN Provider to VA for Behavioral Health, Urgent Care or Emergency Services (= capability under development but slated for readiness upon contract award)*

Step Number	Action
1	Upon receipt of a claim for behavioral health, urgent care or emergency services from a CCN Provider that does not contain an Approved Referral, the Contractor must always submit an EDI 278 request for a referral for behavioral health, urgent care or emergency services to VA. If VA's EDI 278* capabilities are not available then VA will accept Direct Messaging or secure email.
2	If Contractor receives a claim for behavioral health, urgent or emergency services from an out of network provider, the Contractor must always deny the claim and instruct the out of network provider to submit the claim to VA for consideration and to include associated medical documentation. Automated alternatives to deny claims back to billing providers may be considered.
3	VA sends a determination on the Referral Request via EDI 278* to the Contractor. If the Referral Request is approved, the Approved Referral will contain the appropriate Contract Line Item Number (CLIN) number for payment purposes. In the event that care is not authorized by VA, the Contractor's provider may appeal, per guidance in Section 13.0 Veteran Claim Appeals and Provider Reconsiderations.

Table 14. Process for transmitting referrals to the Contractor for the Optional task of Appointment Scheduling and Comprehensive Care Coordination (= capability under development but slated for readiness upon contract award)*

Step Number	Action
1	VA creates an Approved Referral, including attachments.
2	VA sends an Approved Referral authorizing the service(s), including attachments, to the Contractor via the VA Community Care Provider Portal*. The Approved Referral will not contain a CCN provider name or an appointment date and time.
3	Contractor receives the Approved Referral and performs the tasks identified in Section 11.1 “Appointment Scheduling and Comprehensive Care Coordination”.
4	Contractor provides the CCN provider name and appointment date and time to VA in the Community Care Provider Portal so that VA can assign access to Veteran Health Record to CCN Provider.

5	Contractor notifies the CCN provider of the Approved Referral once the appointment date and time is confirmed. The VA will provide the assigned CCN Provider access to the Referral Information and necessary documentation through the VA Community Care Provider Portal* if available, otherwise VA will use Direct Messaging or secure email.

Table 15. Process for transmitting referrals to the Contractor for the Care Coordination Follow-up, Optional task of Comprehensive Case Management Program Administration, Comprehensive Disease Management Program Administration (= capability under development but slated for readiness upon contract award)*

Step Number	Action
1	VA creates an Approved Referral, including attachments.
2	VA sends an Approved Referral authorizing the service(s), including attachments, to the Contractor via the VA Community Care Provider Portal*.
3	Contractor receives the Approved Referral and performs the tasks identified in Section 11.2 “Care Coordination Follow-up”, Section 11.3 “Comprehensive Case Management Program Administration” or Section 11.4 “Comprehensive Disease Management Program Administration”.

VA will provide the referral number for all Approved Referrals, specifying the services authorized by the referral. VA will approve or deny all Referral Requests.

The Contractor must always inform all CCN providers of the following:

- Referrals are only valid for the service(s) specified, and the time period specified.
- Referral numbers must be forwarded to any Ancillary Providers by the referred CCN provider.
- Any additional services or extension of a treatment period will require an additional Referral Request.
- CCN providers treating Veterans under an Approved Referral may request that additional services by another provider (physician or Ancillary Provider) be authorized by submitting an additional Referral Request to VA.

7.4 Prior Authorizations

Attachment I, “Prior Authorization Lists,” contains a list of services that require Prior Authorization in order for claims to be reimbursed under this contract. The Contractor must always educate CCN providers of the fact that all Prior Authorization requests for CCN healthcare services, when required, are submitted to VA for all Veterans for whom services have been provided within its CCN Region. VA will provide online access to CCN providers and provide the Contractor with an updated electronic list of services requiring Prior Authorization and associated business rule guidance during the implementation phase. VA will update this list periodically. The Contractor

must always update the Prior Authorization List and associated business rule guidance in its claims adjudication system within thirty (30) days upon receipt of revisions from VA.

The Contractor must always advise all CCN providers to submit Prior Authorization requests via Direct Messaging, secure email, secure fax, eHealth Exchange, telephone request or preferably once available EDI 278 or VA's Community Care Provider Portal*. VA will approve or deny all Prior Authorization requests. *(* = capability under development but slated for readiness upon contract award)*

The Contractor must always ensure a copy of the Prior Authorization referral number and Prior Authorization information (medical codes, effective date, termination date, date generated) is stored electronically in the Contractor's referral and Prior Authorization management system for the purpose of paying claims.

VA will notify the Veteran, the CCN requesting provider, and the Contractor if the Prior Authorization request is denied and will advise the Veteran of their right to appeal in accordance with VHA Directive 1041, Appeal of VHA Clinical Decisions (https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3285).

8.0 SCHEDULING OF APPOINTMENTS

The Contractor is not responsible for scheduling or rescheduling appointments for Veterans under this contract. The Contractor must always educate its CCN providers that an Approved Referral is required when a Veteran self-schedules an appointment prior to rendering services, with the exception of behavioral health services, urgent and emergency services (see PWS Section 7.1), in order to be eligible to receive payment.

9.0 MEDICAL DOCUMENTATION

9.1 Medical Documentation Submission Process

The Contractor must always educate its CCN providers that medical documentation meets statutory and clinical requirements and is delivered by the CCN Healthcare Services Network provider or CCN CIHS Network practitioner, as applicable, directly to VA and the referring provider, if not VA.

The Contractor must provide a Medical Documentation Submission Plan to describe all processes, procedures, criteria, information and data collection activities for use in submitting medical documentation to VA.

The purpose of the medical documentation submission plan is to inform and educate the CCN providers and CCN CIHS Network practioners on the medical documentation submission process and encourage timely submission of all medical documenation directly to VA via secure electronic submission, where available. See Section 18.13, "Submission of Medical Documentation," for submission format requirements.

9.2 Medical Documentation Data Elements

The Contractor must always educate its CCN Providers that all medical documentation includes the following data when sent to VA:

1. Veteran Unique Identifier
2. Veteran's full name (including suffix)
3. Veteran's date of birth
4. Provider/Practitioner Authentication (including typed name and provider phone number)

All documents must always be authenticated by the submitting provider or practitioner. Authentication consists of a written signature, written initials, and/or electronic signatures.

9.3 Medical Documentation Submission Timeframes

The Contractor must always educate its CCN providers that medical documentation is to be delivered under the following timeframes. Initial medical documentation is medical documentation associated with the first appointment of a Standard Episode of Care. Final medical documentation is medical documentation that covers the entire Standard Episode of Care. Initial medical documentation for outpatient care must always be returned within thirty (30) days of the initial appointment. Final outpatient medical documentation must always be returned within thirty (30) days of the completion of the Standard Episode of Care. Medical documentation must always be returned within thirty (30) days for inpatient care and will consist, at a minimum, of a discharge summary. Any medical documentation requested by VA for appropriate urgent follow up, must always be provided to VA upon request.

9.4 Medical Documentation Submission Format

The Contractor must always educate its CCN providers that VA prefers that medical documentation is submitted by CCN Healthcare Services Network providers and CCN CIHS Network practitioners directly to VA via secure electronic submission, where available. See Section 18.13, "Submission of Medical Documentation," for medical documentation submission format requirements.

9.5 Reserved

9.6 Critical Findings

The Contractor must always educate its CCN providers that Critical Findings must always be communicated by the CCN Healthcare Services Network provider or CCN CIHS Network practitioner, as applicable, to the Veteran, referring provider, and VA within the earlier of two (2) business days of the discovery or the timeframe required to provide any necessary follow-up treatment to the Veteran. Communications must always be either verbal or written.

9.7 Medical Documentation and Audit

Subject to the provisions of this Section, VA may audit the Contractor compliance with its obligations under this Agreement and the Contractor shall supply VA with access to information acquired or maintained by the Contractor in performing services under this Agreement. The

Contractor shall be required to supply only such information which is in its possession and which is reasonably necessary for the VA to administer the CCN Contract, provided that such disclosure is not prohibited by any third-party contracts to which the Contractor is a signatory or any requirements of law. VA hereby represents that, to the extent any disclosed information contains personally identifiable or health information about a Veteran, the Veteran has authorized disclosure to VA or VA otherwise has the legal authority to have access to such information.

VA shall give the Contractor prior written notice of its intent to perform such an audit and its need for such information and shall represent to the Contractor that the information which will be disclosed therein is reasonably necessary for the administration of the CCN Contract. All audits and information disclosure shall occur at a reasonable time and place and at the CNN Contractors expense.

VA may designate a representative acceptable to the Contractor to conduct or participate in the audit, or to receive access to such information provided, such that VA and the representative enter into a written agreement with the Contractor under which the representative agrees to use any disclosed information solely for purposes of administering the CCN Contract, to keep such information confidential and not to disclose the information to any other entity or person.

Any reports, information or documentation provided, made available, or learned by either of the parties to this Agreement which contain personally identifiable or health information about any Veteran or CCN Health Services provider or which contain information about either party's business or operations which is not available to the public, or which contain information which has been designated as proprietary or confidential by either party shall be held in the strictest confidence, used solely to perform obligations under this Agreement or to administer the CCN Contract, not be disclosed to any other entity or person, and maintained in accordance with the requirements of all applicable laws.

10.0 TRAINING – Contractor Processes, Systems, and Interfaces

The Contractor must develop and conduct an Annual Training Program Curriculum that must include training for CCN providers, Contractor personnel, and identified VA staff. The purpose of the training is to inform and educate on the Contractor’s processes, systems, interfaces with VA systems, as described in the following subsections.

10.1 Training Plan

The Contractor must provide a Training Plan that will include all training programs and activities as described in Section 10.0, “Training.” The Contractor’s Training Plan must outline:

- Description of the Contractor’s Training and Outreach and Education Program, including orientation and onboarding related to contract operations
- Learning Objectives and Course Content for each course
- Scope
- Dependencies and Assumptions

- Prerequisites
- How communications about training availability and delivery will be conducted
- Approach (audience, strategy, requirements/skills, delivery method, materials)
- Schedule of Training (including initial and refresher training as applicable)
- Deliverables
- Tools and Templates
- Target Results
- Evaluation Strategy (ensure effectiveness of the training with attendees and measure outcomes)
- Address Compliance with Section 508 of the Rehabilitation Act (29 U.S.C. 794d)
- Graphics Requirements
- Interactive Multimedia Instruction Level (i.e., Level 1 Passive, Level 2 Limited Participation, Level 3 Complex Participation, and Level 4 Real Time Participation)
- Estimated Time to Develop Course(s)

The Contractor must submit the Training Plan and any updates thereto in accordance with the Schedule of Deliverables. The Contractor must review the Training Plan with the appropriate points of contact for the program-level VA Community Care Training Plan, Change Management Plan, and Communications Plan (as well as portfolio- or project-level plans as deemed necessary), and incorporate input required to ensure alignment among activities.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Training Plan

10.1.1 Training Program for Contractor CCN Providers, Contractor Personnel, and VA Staff Training Program

The Contractor must develop and conduct an Annual Training Program Curriculum that must include training for CCN providers, Contractor personnel, and identified VA staff. The purpose of the training is to inform and educate on the Contractor's processes, systems, interfaces with VA systems, and other areas of interest in the following areas:

1. Contractor VA Support Call Center Operations, including business processes, services, escalation procedures, metrics, points of contact for each target audience, and systems.
2. CCN Provider Call Center Operations, including business processes, services, escalation procedures, metrics, points of contact for each target audience, and systems.
3. Contractor systems, systems interfaces, and systems access.
4. CCN Providers and CCN CIHS Network Practioners must be informed that it is impermissible to charge Veterans for not keeping a scheduled appointment.
5. Any other areas identified by VA or the Contractor related to services required under this contract. The Contractor must provide training at least sixty (60) days prior to the SHCD and provide updated training consistent with the implementation of any system changes that impact VA's ability to use the system.

The Contractor must always review and update the Annual Training Program Curriculum in accordance with the Schedule of Deliverables.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Annual Training Program Curriculum

10.1.2 Contractor CCN Provider and Contractor Personnel Outreach and Education Program

The Contractor must develop and implement an initial on-boarding and ongoing outreach and education program for CCN providers and personnel to execute the requirements under this contract. The Contractor's outreach and education program, including specific training, must always be documented in the Training Plan that outlines the methods, schedule, role-specific training requirements, scope of training, and outcome measurements to be provided. The purpose of this program is to ensure that the CCN provider and Contractor personnel have the information necessary to successfully perform the requirements outlined in this PWS. Subject matter not directly under the Contractor's services will be supplied by the VA as indicated below. The Contractor's outreach and education program must include, at a minimum:

1. VA program requirements, policies, and procedures related to the requirements under this contract
2. How to sign up for the Network (Note: If appropriate, separate training may be provided for sign-up procedures versus procedures for working with the Contractor as an existing provider.)
3. Veterans' healthcare benefits that are administered through this contract referenced in Section 4.0, "CCN Health Benefit Package"
    - Pharmacy Benefits
    - Dental Eligibility and Benefits
    - DME Benefits
4. Customer Service Process
5. Network participation requirements (e.g. compliance with VA Opioid Safety Initiative) (supplied by VA)
6. Making available American Medical Association and VA guidelines for assessing a patient's military experience and duty assignments for all high performing Veteran care providers (supplied by VA)
7. Referral and Prior Authorization processes (including emergency claims and referrals back to VA) (supplied by VA)
8. Claims submission and payment processes
9. Compliance with medical documentation submission requirements set forth in this contract
10. Expected timeframes for processes
11. Escalation procedures for certain operations
12. Resources and points of contact
13. How to keep aware of any program changes
14. Any other areas identified by VA or the Contractor related to services required under this contract

10.1.3 Contractor-Provided VA Staff Training Sessions

The Contractor must always provide training of specific services and systems. The number of trainees is provided for estimation purposes. The Contractor must conduct the following training sessions for VA staff:

1. Customer Service (50 trainees)
   The Contractor must always provide training to VA staff of its operations for Customer Service Support. The purpose of this training is to inform how to utilize the Contractor's system. The Contractor must always "Train the VA Trainer," who in turn will train VA Customer Service Personnel. The Contractor must always provide job aids, such as a quick reference guide, that provide VA Customer Service Personnel with immediate information. The training delivery method must always be in accordance with the VA approved training plan. The Contractor must always provide follow-on training and counsel for new releases and upgrades to the customer service system.
2. Contractor-Specific Systems Training for designated VA data analytics users (50 trainees)
   The Contractor must always provide training on its systems for designated VA data analytic users. The purpose of this training is to educate the data analyst on how to effectively access and interpret contract data for analysis and evaluation of the program. The training delivery method must always be in accordance with VA approved training plan. The Contractor must always provide follow-on training and counsel for new releases and upgrades to the Contractor-specific systems.

10.2 Contractor Training Materials

The Contractor must always deliver Training Materials that are compliant with the commercial standard Shareable Content Object Reference Model (SCORM) to VA to facilitate all required training in accordance with the Schedule of Deliverables. The Contractor must always utilize VA terms in its Training Materials or provide a glossary to allow trainees to understand the meaning of terms. The Contractor must always obtain VA approval of all Training Materials prior to the execution of the Training Sessions referenced in Section 10.1.3, "Contractor-Provided VA Staff Training Sessions."

The Contractor must always review all training materials annually to determine what materials need to be retired or updated, and provide a Review of Training Materials Report to VA based on such review in accordance with the Schedule of Deliverables. The content of the Review of Training Materials Report, and approved activities out of it, will include the Contractor's recommendations to VA and provide an input for updates to the overall training plan.

Training Materials may include but are not limited to:

- Class handouts
- Manuals
- Student exercises
- User and Quick Reference Guides
- Job Aids
- Online modules

- Course Evaluation Surveys

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Training Materials
B. Review of Training Materials Report

10.3 VA Provided Training

VA will provide the Contractor appropriate user guides and orientation material to facilitate the use of VA web based systems.

Training developed on VA Community Care systems, tools, and processes in SCORM compliant eLearning courses are developed using Articulate 360. Creation of supplement training materials would require compatibility with this software.

11.0 MEDICAL ADMINISTRATIVE MANAGEMENT

The Optional Tasks described in this section may be ordered by VA in accordance with the procedures stated in Section B.14, 1.0.

VA will use the VA Community Care Provider Portal to the maximum extent possible during the execution of the optional task; however, VA in collaboration with the contractor will use other systems and technologies as they become available or are needed to support the Optional Tasks. The Contractor shall provide support for both English and Spanish speaking callers and hearing/vision impaired Veterans both telephonically and online for all optional tasks identified in this section.

Each VA Medical Center will determine the need for services described in this section, including:

- Appointment Scheduling and Comprehensive Care Coordination
- Care Coordination Follow-up
- Comprehensive Case Management Program Administration
- Comprehensive Disease Management Program Administration

11.1 Optional Task: Appointment Scheduling and Comprehensive Care Coordination

The Contractor must develop an Appointment Scheduling and Comprehensive Care Coordination Plan, including plans to support Veteran self-scheduling. The plan must include details on how the Contractor will provide Appointment Scheduling and Comprehensive Care Coordination activities co-located at a VA facility, a Contractor facility or a combination of both within the region. The Contractor's approach must allow for customization at the individual VA facility level.

VA will use the workflow capability within the VA Community Care Provider Portal as the means of transmitting the Approved Referral and relevant medical documentation to support the Standard Episode of Care in the Approved Referral. VA will collaborate with the Contractor to use other systems and technologies as they become available to support these optional tasks. The contractor must have an Appointment Scheduling and Comprehensive Care Coordination Implementation Plan

which allows services to begin within the following timeframes:

Contractor site:

- Urban – Fully operational no later than 120 days after optional task is exercised
- Rural – Fully operational no later than 120 days after optional task is exercised
- Highly Rural Location – Fully operational no later than 160 days after optional task is exercised

VA Facility:

- Urban – fully operational no later than 90 days after optional task is exercised
- Rural – Fully operational no later than 90 days after optional task is exercised
- Highly Rural Location – Fully operational no later than 160 days after optional task exercised

The contractor must always meet the milestones contained within its Appointment Scheduling and Comprehensive Care Coordination Implementation Plan for each individual VA Facility. The contractor must obtain approval of its Appointment Scheduling and Comprehensive Care Coordination Implementation Plan in accordance with the Schedule of Deliverables.

The Appointment Scheduling and Comprehensive Care Coordination Plan at a minimum must include a quality assurance component (performance and quality measures, staffing (e.g., capabilities, minimum qualifications, attrition, location, specialization based upon complexity of cases)). The comprehensive care coordination component of the plan at a minimum must include pertinent care coordination quality and outcome measures.

VA will issue an Approved Referral with the optional task CLIN 16C "Appointment Scheduling and Comprehensive Care Coordination" using the VA Community Care Provider Portal or other systems and technologies determined in collaboration with the Contractor. The Approved Referral will indicate the Standard Episodes of Care. The Contractor must identify for the CCN Provider the appropriate medical documentation relevant to the Approved Referral for inclusion in the referral package to facilitate scheduling.

The Contractor must always contact the Veteran to obtain the Veteran's provider and appointment preferences to include the Veteran's desire to self-schedule or have the Contractor assist in the scheduling process. The Approved Referral may specify the preferred provider if indicated by the Veteran. The Contractor must always schedule the Veteran's routine care first appointment in the Episode of Care with a CCN Provider in five (5) business days or less, from the date the Contractor received the VA Approved Referral. The Contractor must always ensure the first appointment in the Episode of Care is completed within thirty (30) days of the Care Indicated Date by VA on the Approved Referral unless the Veteran indicates a desired appointment date or a specific provider whose first available appointment is outside of those requirements. The Contractor must always adhere to the geographic accessibility requirements listed in Sections 3.1 Network Establishment and Maintenance (Table 1, Maximum Drive Times); 3.2.2 CCN Complementary and Integrative Healthcare Services (CIHS) Network (Table 3, Maximum Drive Times); 4.4 CCN Assisted Reproductive Techology Services (Table 8, ART Maximum Drive Times) and Section 17.1 Dental Network Adequacy (Table 17. Dental Network Access Standards). The Contractor must always

notify VA of the CCN Provider in order to allow the VA to provide the CCN Provider the ability to view the Veterans EHR using the VA Community Care Provider Portal. The Contractor must always use the VA Community Care Provider Portal, or other systems and technologies determined in collaboration with the VA, to link an appointment created to the Approved Referral and document prior business day data status of routine appointment scheduling activities and comprehensive care coordination activities with a CCN provider, specifically:

- Date appointed
- Appointment date and time
- Date care delivered
- Name of CCN provider
- Appointment dates and times for Veteran scheduling own appointment

The Contractor must always send a communication to the Veteran identifying the Veteran's appointment date, time, provider name and address, toll-free phone number (maintained by the Contractor, so the Veteran can contact the scheduling team, as needed). Furthermore, the Contractor must always provide the Veteran a single customer service number that will be routed through the appropriate customer support, using consistent standards and customer service scripts. Additionally, the Contractor must always be able to answer scheduling questions for Veterans whom they've been assigned to schedule.

11.1.1 Contractor Schedules

For each Approved Referral issued by VA to the Contractor for Appointment Scheduling and Comprehensive Care Coordination, the Contractor must always contact the Veteran to obtain scheduling preference and CCN Provider preference, and to schedule the needed appointment.

The Contractor must always comply with the following scheduling timeline:

- Business Day 0-2: Contractor accepts the Approved Referral loaded in the VA Community Care Provider Portal or other systems and technologies determined in collaboration with the Contractor. The Contractor must always return an Approved Referral not meeting Section B.14 requirements in this timeframe with the specific reason for return. The business day the VA uploads the Approved Referral is considered day zero (0).
- Business Day 11: Contractor must always return the Approved Referral to VA if the Veteran has not responded to the Contractor's scheduling efforts including a no contact letter sent to the Veteran from the Contractor.
- Business Day 11 – If contact has been made with Veteran and the Veteran has elected to self-schedule, the contractor must notify the VA through the VA CCPP of the Veteran's choice, and requirements of 11.1.2 (i.e. 90 day validity) will then apply to that Approved Referral.

The Contractor must always use an appropriate return reason code in Attachment AI, "CCN Scheduling Return Reason Codes" for Approved Referrals returned to VA.

The Contractor must always communicate with VA to resolve any questions during the scheduling process (e.g., community provider request for additional documentation, request for additional services to be performed prior to scheduling, etc.). When a Veteran No-shows or cancels their appointment, the Contractor must always attempt to contact the Veteran to reschedule. If after 10

business days the Contractor is unable to contact the Veteran, the Contractor must always return the Approved Referral using the appropriate return reason code.

11.1.2 Veteran Self-Schedules

The Contractor must address its approach to support, and facilitate Veterans desiring to Self-Schedule their appointment in the Appointment Scheduling and Comprehensive Care Coordination Plan. For Veterans who elect to Self-Schedule, the Contractor must always educate the Veteran of options and provide guidance to support the Veteran scheduling their appointment with CCN Providers, including all the capabilities of the VA master provider directory search function. The Contractor must always document whether the Veteran has scheduled an appointment. This information is required to ensure the VA can grant the CCN Provider access to the VA Community Care Provider Portal to view the Veteran's EHR. The Contractor must always return Approved Referrals when the Veteran has informed the Contractor of their preference to Self-Schedule and there has been no appointment activity for 90 days from date of acceptance or when the validity period has expired.

The Contractor must always monitor CCN appointment scheduling and comprehensive care coordination performance against the standards set forth in Section 11.1 "Appointment Scheduling and Comprehensive Care Coordination" and Attachment BA, "QASP Performance Requirement Summary." The Contractor must always provide Appointment Scheduling and Comprehensive Care Coordination Adequacy Performance Report to VA in accordance with the Schedule of Deliverables. The Contractor must always develop and submit to VA an Appointment Scheduling and Comprehensive Care Coordination Adequacy Corrective Action Plan (CAP) for Contractor resolution of any performance deficiencies identified by the Contractor or VA in accordance with the Schedule of Deliverables. The Contractor's Appointment Scheduling and Comprehensive Care Coordination Adequacy CAP must always include the reason(s) for the performance deficiency and timeline for the Contractor to correct the deficiency.

11.1.3 Comprehensive Care Coordination

As part of the Appointment Scheduling and Comprehensive Care Coordination Plan, the Contractor must develop a detailed approach and plan to administer Comprehensive Care Coordination that includes at a minimum:

1) Obtain appointment dates and times for Veterans scheduling their own appointments.
2) Identify barriers to the Veteran that impact attending a scheduled appointment.
3) Follow up to ensure the Veteran attended a scheduled appointment and any supplemental activities, such as but not limited to labs, follow-up appointments, etc. required from the appointment.
4) Support discharge planning to both VA and CCN provider.
5) Document status of Veteran appointment, including cancellation, no show, or appointment kept. Contact the Veteran to determine reason for cancellation or no show, and document the reason.
6) If applicable, reschedule Veteran appointment and document new appointment details.
7) If applicable assist the Veteran in scheduling additional care approved within the Approved Referral's Standard Episode of Care.

8) Administer a discharge planning program for Veterans receiving care under the comprehensive care coordination optional task:
   a. The contractor must always ensure the transfer in and out of VA medical facilities of inpatients and patients in the emergency department (ED)/urgent care center (UCC) are to be accomplished in a manner that ensures both maximum patient safety and compliance with the intent of transfer provisions of Emergency Medical Treatment and Labor Act (EMTALA) and its implementing regulations.
   b. The Contractor must submit a Discharge Planning Plan to include the program design for managing inpatient discharges. The Contractor must submit the Discharge Planning Plan to VA in accordance with the Schedule of Deliverables.
   c. The Contractor must establish Discharge Planning Liaison positions to facilitate the transfer of information from the Contractor to VA or CCN Provider to VA. The Contractor's Discharge Planning Liaisons are not required to be co-located in VA Facilities; however, specific contact information for each Discharge Planning Liaison must be provided to VA.
   d. The Contractor must always contact the VA once a clinical determination has been made that a Veteran is stable for transfer. The Contractor must always ensure VA has 24 hours from contact to accept first right of refusal to transfer Veterans to a VA facility.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Discharge Planning Plan

11.1.4 Daily Appointment Scheduling and Comprehensive Care Coordination reporting

The Contractor must always document all attempts to contact the Veteran and all communications with the Veteran and CCN Provider. The Contractor must always provide a Daily Appointment Scheduling and Comprehensive Care Coordination Report to VA in accordance with the Schedule of Deliverables. The Contractor must always transmit the data using the schema identified in Attachment W, "Data Repository Schema" with Scheduling Care Coordination. VA regional scheduling volume estimates can be found in Attachment AH, "Appointment Scheduling and Comprehensive Care" Estimated Volumes.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Appointment Scheduling and Comprehensive Care Coordination Plan
B. Appointment Scheduling and Comprehensive Care Coordination Implementation Plan
C. Appointment Scheduling and Comprehensive Care Coordination Adequacy Performance Report
D. Appointment Scheduling and Comprehensive Care Coordination Adequacy CAP
E. Daily Appointment and Scheduling Comprehensive Care Coordination Report

11.2 Optional Task: Care Coordination Follow-up

The Contractor must develop and administer a Care Coordination Follow-Up Plan in accordance with the Schedule of Deliverables. The goal of the Care Coordination Follow-Up Plan is for the Contractor to describe the approach to support the Veteran after the appointment is made. The Care Coordination Follow-Up Plan must include, at a minimum, the first six (6) items identified in Section 11.1.3 "Comprehensive Care Coordination" and a discharge planning liaison to support VA discharge planning staff.

The Contractor must propose a Care Coordination Follow-Up Plan thirty (30) days after this optional task is exercised. The Care Coordination Follow-Up Plan must include outcome and monitoring measures for each of the processes.

The Contractor must always document all attempts to contact the Veteran and all communications with the Veteran and CCN Provider. The Contractor must always provide a Daily Care Coordination Follow-Up Report to VA in accordance with the Schedule of Deliverables. The Contractor must always transmit the data using the schema identified in Attachment W, "Data Repository Schema."

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Care Coordination Follow-Up Plan
B. Daily Care Coordination Follow-Up Report

11.3 Optional Task: Comprehensive Case Management Program Administration

The Contractor must always administer a Comprehensive Case Management Program that follows a similar program as identified in Attachment K, "Case Management Standards of Practice," for all Eligible Veterans.

The Comprehensive Case Management Program Administration is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the Veteran's healthcare needs. Comprehensive Case Management includes advocacy, communication, and resource management and promotes high quality and cost-effective interventions and outcomes. VA's goal for the Comprehensive Case Management program is to ensure that Veteran's reach their optimum level of wellness, self-management, and functional capability through a coordinated and personalized approach specific to each referred Veteran's health status, ability to participate in their own healthcare decisions, and other factors assessed by the referring provider.

The Contractor must always use a multi-disciplinary and continuum-based system to Assist VA in identifying populations or individual Veterans with, or at risk for, chronic medical conditions with the goal of improving overall health status. For each Approved Referral VA assigns to the contractor for Comprehensive Case Management, VA will load the Approved Referral as workflow and will include the appropriate optional task CLIN for Case Management. The Contractor must propose a Comprehensive Case Management Plan, in accordance with the Schedule of Deliverables. Contractor personnel performing the services in this section must always possess a nationally recognized Case Management Certification as recognized by nationally recognized accrediting organization for the healthcare services that are within scope of an accreditation. The Contractor's plan must include the methodology of reporting Veteran progress in Case Management to VA. The Contractor must include in its plan outcome and monitoring measures for each of the programs, in accordance with the Schedule of Deliverables. The contractor must always submit a Comprehensive Case Management Progress Report, in accordance with the Schedule of Deliverables.

The Contractor must always submit an individual Veteran summary report on the Case Management progress. The report must be submitted using the VA Community Care Provider Portal and linked to the Approved Referral.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Comprehensive Case Management Plan
B. Comprehensive Case Management Progress Report

11.4 Optional Task: Comprehensive Disease Management Program Administration

The Contractor must establish Comprehensive Disease Management Program Administration that includes understanding the course, clinical implications, and trajectory of specific diseases; identifying and targeting patients likely to benefit from intervention; focusing on prevention of complications; optimizing clinical management; and working toward resolution of resource-intense problems. Conditions that should be included in the Comprehensive Disease Management Program Administration include any or all of the following: asthma, chronic obstructive pulmonary disease, complex pain management, diabetes, congestive heart failure, coronary heart disease, end-stage renal disease, depression, high-risk pregnancy, hypertension, and arthritis; however, the Comprehensive Disease Management Program Administration is not limited to such conditions. The Contractor must always utilize an evidence-based practice guideline approach to educate Veterans provided with Comprehensive Disease Management Program Administration as well as ensure collaboration between the Veteran's Primary and Specialty care providers. For each Approved Referral VA assigns to the Contractor for Comprehensive Disease Management, VA will load the Approved Referral as workflow and will include the appropriate optional task CLIN for Comprehensive Disease Management. The Contractor must propose a Comprehensive Disease Management Plan to VA, in accordance with the Schedule of Deliverables.

The Contractor's plan must include the methodology of reporting Veteran progress in Disease Management to VA. The Contractor must include in its plan outcome and monitoring measures for each of the programs. The contractor must always submit a Comprehensive Disease Management Progress Report to VA, in accordance with the Schedule of Deliverables.

Contractor personnel performing the services in this section must always possess a nationally recognized Case Management Certification or have Disease Management Certification as recognized by a nationally recognized accrediting organization for the healthcare services that are within scope of an accreditation.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Comprehensive Disease Management Plan
B. Comprehensive Disease Management Progress Report

12.0 CLAIMS PROCESSING AND ADJUDICATION FOR CCN HEALTHCARE SERVICES RENDERED

The Contractor must always receive, process, and adjudicate claims for all services provided

pursuant to this contract. The Contractor will be reimbursed in accordance with the Schedule of Services solely for claims paid in accordance with Section 12.1.1, "Claims Adjudication and Payment Rules."

12.1 Claims Processing System Functions

The Contractor must always utilize an existing automated claims processing system to process and adjudicate claims. The Contractor's claims processing system must always determine if a claim is ready for processing by ensuring the claims processing system contains all the standard requirements of all standard EDI transaction types as well as those fields required for VA claims processing. The Contractor must always process claims in accordance with all applicable federal and state statutes and regulations. The Contractor must always use tables created by VA that outline referral (Standard Episode of Care) parameters (provided during implementation) and must always incorporate those tables in its claims adjudication system. The Contractor's claims processing system must always accept electronic claims in EDI 837P, EDI 837I, and EDI 837D format transactions, as appropriate, and create the EDI 835 remittance transaction.

The Contractor must always ensure claims not processed to completion and any associated supporting documentation will be retrievable by Veterans name, Electronic Data Interchange Patient Identifier (EDIPI), and Internal Control Number (ICN).

VA will notify the Contractor at least sixty (60) days prior to any change to the clearinghouse VA uses, and the Contractor is responsible to adjust claims routing to the new clearinghouse.

The Contractor's claims adjudication system must always validate Referral and Prior Authorization, and any other data needed to properly adjudicate claims. The Contractor must always develop rules to apply the correct fee schedule based upon information provided on the referral from VA. The Contractor must always ensure that correct payment schedules are used to pay providers. The Contractor must always deny claims that are not within the period of authorization listed in the referral. The Contractor may advise network providers to submit Referral Requests prior to claims submission.

The Contractor's claims adjudication system must always validate that the Approved Referral number, Prior Authorization number, period of authorization, name of Veteran, provider, NPI number, and service or supply information submitted on the claim are consistent with the care authorized and that the care was accomplished within the authorized time period.

12.1.1 Claims Adjudication and Payment Rules

The Contractor must deliver a Claims Processing Data Dictionary in accordance with the Schedule of Deliverables that includes all capabilities for auto-adjudication, rejection, return, and denial of a claim. The Contractor's claims processing system must always include standard business rules and edits in its Claims Processing Data Dictionary. The Contractor's claims processing system must always be capable of adding rules and edits based on information from VA, to include the application of VA Fee Schedules. When VA requests a change, the Contractor must always

implement the change within thirty (30) days, or as mutually agreed upon by the parties. When industry changes occur that require planning, testing, implementation, and compliance readiness dates, system change orders will be made in accordance with industry standards. The Contractor's claims processing system must always include adjudication rules for the following requirements:

2. Administrative Charges: The Contractor's claims processing system must always classify as non-covered and deny, any administrative charges imposed by the provider related to completing and submitting the applicable claim form or any other related information.
3. Duplicate Claims: The Contractor's claims processing system must always deny, as a duplicate claim, any claim that was previously submitted by a provider for the same service provided to a particular individual on a specified date of service.
4. Benefits: The Contractor's claims processing system must always deny, as not being a covered benefit, any claims submitted for a medical service that is not included as part of the Veteran's medical benefits package. The Contractor must always deny any claim submitted for care that is not within the scope of the referral.
5. Claim Forms: The Contractor must always reject any claims submitted on unapproved claim forms. When an unapproved claim form is submitted, the Contractor must always notify the claimant in writing that in order to be considered for payment the claim must always be submitted on approved claim forms and that any additional information, if required, must always be submitted and received by the Contractor within the timely filing deadline. See Section 12.2, "Paper Claims."
6. Urgent or Emergency Services: The Contractor shall pend claims for urgent or emergency services that do not include an Approved Referral number and submit the claims, and supporting documentation sufficient for VA to determine whether to issue a retroactive referral, to VA for review and consideration. In the event VA issues a retroactive referral for urgent or emergency services claim to the Contractor, the Contractor shall reimburse that claim in accordance with the reimbursement rates identified by VA. In the event that VA issues denial of a retroactive authorization for urgent or emergency services claim to the Contractor, then the Contractor shall deny that claim. The Contractor must always instruct out-of-network emergency providers to submit healthcare claims directly to VA following VA claims submission procedures. Urgent/Emergent prescriptions that result from urgent, emergent, or behavioral health services that do not have an Approved Referral shall not be dispensed by any pharmacist; for any resulting pharmacy prescriptions the Contractor must always inform the Veteran of the VA's out of pocket reimbursement process.
7. Out-of-Network Providers: The Contractor must always instruct out of network providers to submit healthcare claims directly to VA following VA claims submission procedures.
8. NPI Claims: The Contractor must always use the NPI to process claims from covered entities with the exception of number eight (8) below. The Contractor must always deny claim transactions received that do not include a valid NPI.
9. Non-NPI Claims: The Contractor must always use Tax Identifier Number (TIN) to

process claims for providers who are not eligible to receive an NPI. The Contractor must always deny claim transactions received from providers without their TIN.

10. Referrals and Prior Authorizations: The Contractor must always deny, for lack of referral number, any claim for care that is not emergent or urgent that does not contain a valid referral and any required Prior Authorization number. The Contractor must always deny claims for lack of valid referral number if the referral and/or Prior Authorization number are missing, incorrect, or inconsistent with the exception of in-network behavioral health claims.
11. Timely Filing Deadline: The Contractor must always deny claims not submitted within one hundred eighty (180) days from the date of service or date of discharge for passing the timely filing deadline.
12. Secondary Payer: The Contractor must always grant additional time to the claims filing deadline requirements for Veterans with Other Health Insurance (OHI) when the provider first submitted the claim to the primary payer, and the adjudication occurred past the VA filing deadline. The Contractor must always ensure claims for services denied by another insurer include the Explanation of Benefits (EOB) or Remittance Advice (RA) statement indicating the dates of service, amount of the claim, and reason(s) for denial. The Contractor must always deny all OHI claims submitted beyond ninety (90) days from the date of the other insurer's adjudication.
13. Co-Pay Calculations: The Contractor must always exclude any co-pay calculations from the claims adjudication rules.
14. VA Fee Schedule: The Contractor must always use the applicable payment fee schedule provided by VA to determine and apply reimbursable amounts associated with the authority with which the claims are authorized as determined by VA. VA will provide, in the referral, a reference (to a program) that will allow the Contractor to identify the appropriate VA fee schedule the Contractor must always use to pay claims. VA will provide the Contractor with all current VA Fee Schedules.
15. Claim Adjustment: The Contractor's claims processing system must always identify a request for a payment adjustment (positive/negative) to a prior payment for healthcare services by appending the original claim number with a suffix sufficient to identify and document the number and order of adjustment requests received and processed on the original claim. All claim adjustments must be completed within twelve (12) months from the original payment date.

The Contractor must always retain all claims and claims processing information to allow processing to completion. VA reserves the right to audit all claims. The Contractor must always retain the claims and sufficient information on all claims to permit audits pursuant to the record retention requirements contained in HIPAA privacy regulations (45 C.F.R. § 160, 162 and 164).

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Claims Processing Data Dictionary

12.2 Paper Claims

Prior to submission to VA, paper claims received by the Contractor must always be converted to standard EDI transactions to be consistent with the most recent Centers for Medicare and Medicaid Services (CMS) approved claims formats, specifically to include EDI transactional data requirements referenced in Section 18.12, "Submission of EDI Transactions." The VA cites as reference the November 2011 National Uniform Claim Committee 1500 Claim Form Map to the X12N Healthcare Claim: Professional 837.

The Contractor must establish a billing and claims adjudication process using the following fields of the CMS-1500 claim form for CIHS claims:

1.	Field 1:	Medicare, Medicaid, Tricare, Civilian Health and Medical Program of Uniformed Service (CHAMPUS), Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Group Health Plan, Federal Employee's Compensation Act Black Lung, or Other Identification Number
2.	Field 1a:	Insured's Identification Number
3.	Field 2:	Patient's Name
4.	Field 3:	Patient's Date of Birth and Sex
5.	Field 4:	Insured's Name
6.	Field 5:	Patient's Address
7.	Field 6:	Patient's Relationship to Insured
8.	Field 7:	Insured's Address and Telephone Number with Area Code
9.	Field 8:	Patient Status
10.	Field 9:	Other Insured's Name
11.	Field 9a:	Other Insured's Policy or Group Number
12.	Field 9b:	Other Insured's Date of Birth and Sex
13.	Field 9c:	Employer's Name or School Name
14.	Field 9d:	Insurance Plan Name or Program Name
15.	Field 10a:	Is Patient's Condition is Related to: Employment
16.	Field 10b:	Is Patients Condition Related to: Auto Accident
17.	Field 10c:	Is Patients Condition Related to: Other Accident
18.	Field 10d:	Reserved for Local Use
19.	Field 11:	Insured's Policy Group or Federal Employee Compensation Act Number
20.	Field 11a:	Insured's Date of Birth and Sex
21.	Field 11b:	Employer's Name or School Name
22.	Field 11c:	Insurance Plan Name or Program Name
23.	Field 11d:	Is There Another Health Benefit Plan
24.	Field 12:	Patient's or Authorized Person's Signature
25.	Field 13:	Insured's or Authorized Person's Signature
26.	Field 14:	Date of Current of Illness
27.	Field 15:	If Patient Has Had Same or Similar Illness Give First Date
28.	Field 16:	Dates Patient Unable to Work in Current Occupation
29.	Field 17:	Name of Referring Provider or Other Source
30.	Field 17a:	Other ID#
31.	Field 17b:	NPI#

32. Field 18: Hospitalization Dates Related to Current Services
33. Field 19: Reserved for local use
34. Field 20: Outside Lab Charges
35. Field 21: Diagnosis or Nature of Illness or Injury
36. Field 22: Medicaid Resubmission and/or Original Reference Number
37. Field 23: Prior Authorization Number
38. Field 24A: Date(s) of Service
39. Field 24B: Place of Service
40. Field 24C: Emergency (EMG)
41. Field 24D: Procedures, Services or Supplies
42. Field 24E: Diagnosis Pointer
43. Field 24F: Charges
44. Field 24G: Days or Units
45. Field 24H: Early and Periodic Screening, Diagnostic and Testing/Family Planning
46. Field 24I: Identification Qualifier
47. Field 24J: Rendering Provider Identification Number
48. Field 25: Federal Tax Identification Number
49. Field 26: Patients Account No.
50. Field 27: Accept Assignment
51. Field 28: Total Charge
52. Field 29: Amount Paid
53. Field 30: Balance Due
54. Field 31: Signature of Physician or Supplier Including Degrees or Credentials
55. Field 32: Service Facility Location Information
56. Field 32a: NPI#
57. Field 32b Other ID#
58. Field 33: Billing Provider Information and Telephone Number
59. Field 33a: NPI#
60. Field 33b: Other ID #

12.3 Signature Requirements

12.3.1 Signature on File Procedure

The Contractor must submit to VA, in accordance with the Schedule of Deliverables, its Signature on File Procedure for providers to indicate providers are authorized to submit a claim on behalf of the Veteran.

Deliverable: (See Section 20.4, “Schedule of Deliverables” for details.)

A. Signature on File Procedure

12.3.2 Network Provider Signature on Claims

The Contractor must always follow its normal business operations to verify signature of providers on all claim submissions for services provided under this contract.

12.4 Claims Submission and Processing Timeframes

The Contractor must always process and adjudicate ninety-eight percent (98%) of all Clean Claims, including resubmissions, within thirty (30) days of receipt. The Contractor must always return claims, other than Clean Claims, to the provider with a clear explanation of deficiencies within thirty (30) days of original receipt. The term 'adjudicate' in this section includes the expectation that the Contractor has issued payment within thirty (30) days.

The Contactor must always confirm the actual date of receipt is entered into the ICN and all required claims aging and inventory controls are applied for all claims. The Contractor must always count the actual date of receipt as day one.

The Contractor must always process all "other than clean" claims and notify the provider/supplier filing such claims of the determination within forty-five (45) days of receiving such claims. This is consistent with the Social Security Act, section 1869(2). [42 U.S.C. 1395ff]

12.5 Issuance of EOB

The Contractor must always issue an EOB to Veterans. The EOB must always be available through electronic means, including but not limited to a web-based portal. The EOB must always be mailed in hard copy, unless the Veteran has provided verbal or written agreement to receive the EOB electronically. EOBs must always be available in a paper monthly summary upon the Veteran's request. The EOB must always comply with the requirements of 38 U.S.C. § 7332, 38 C.F.R. § 1.460-1.496, and VHA Handbook 1605.1, Privacy and Release of Information. For further information, see the following:

1. VHA Directive 1605.1, Privacy and Release of information: https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3233
    a. For VHA Directive 1605, VHA Privacy Program; Transmittal Sheet, dated September 1, 2017, see: https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5456
2. 38 U.S.C. § 7332, 38 C.F.R. § 1.460-1.496 (as applicable);
    a. 38 C.F.R. § 1.460-1.461: https://www.gpo.gov/fdsys/pkg/CFR-2015-title38- vol1/pdf/CFR-2015-title38-vol1-sec1-460.pdf.
    b. 38 C.F.R. § 1.461-1.464: https://www.gpo.gov/fdsys/pkg/CFR-2015-title38- vol1/pdf/CFR-2015-title38-vol1-sec1-461.pdf.

The EOB must always include language describing the process for the Veteran to appeal a claim that is denied in whole or in part.

12.6 Issuance of Remittance Advice

The Contractor must always provide an 835 RA to all providers via EDI when available. Where providers do not currently use EDI, 835 transactions must always be created, printed, and mailed to providers. Paper RAs will contain all information available on the EDI 835 transaction.

The Contractor must always transmit a daily HIPAA-compliant EDI 835 Transaction File of all

claims processed that day for VA in accordance with the Schedule of Deliverables.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. EDI 835 Transaction File

12.7 Coordination of Benefits

12.7.1 VA designation of Primary or Secondary Payer of Healthcare Services

The Contractor must always adjudicate all claims for Veterans where the referral indicates the services are related to a service connected disability and/or special authority with VA as the primary payer, or services related to a Non-service connected disability with VA as primary. VA will provide the Contractor with information to determine when VA is primary or secondary payer in the Approved Referral. The Contractor must develop systems to ensure that payment made to CCN Providers is in accordance with VA designation of primary or secondary payer. Notwithstanding any other provision in this contract, VA retains the right to bill third-parties for services rendered to Veterans under this contract to the fullest extent permitted under applicable federal laws (including but not limited to 38 USC § 1729 et. seq. and 38 CFR Part 17). When VA exercises such right to bill third-parties, VA shall be the primary payer.

In situations in which VA indicates it is the secondary payer the Contractor must:

1. Develop and execute a program to coordinate benefits for CCN healthcare services determined by VA to not be related to a service connected disability and/or special authority for Veterans with OHI (see 12.7.2). The Contractor must develop a National Association of Insurance Commissioners compliant Coordination of Benefits (COB) Plan and submit it to VA in accordance with the Schedule of Deliverables.
2. Obtain a copy of the OHI RA from the CCN provider and submit the OHI RA in addition to healthcare claim reimbursement invoices. This includes cases where there will be no additional payment required as the secondary payer by the Contractor to the CCN provider.
3. Deny any claims when an Eligible Veteran who has OHI is receiving medical care for services that are determined by VA to not be related to a service connected disability and/or special authority and the Veteran's OHI is not invoiced by the provider prior to the Contractor invoicing VA. Upon completion of OHI invoicing, the Contractor must always submit, with every healthcare EDI claim to VA, an RA for services determined by VA to not be related to a service connected disability or special authority care. The healthcare and OHI prior payment information, including payments made by the Veteran, must always be submitted to VA with each claim. This includes all claims that have been satisfied and/or paid in full by the OHI primary insurance. The Contractor must always provide VA the amounts paid by the Veteran at the point of service.

The Contractor must ensure that Veterans are held harmless and may not be invoiced for any services associated with an Approved Referral, even if the claim is denied.

The Contractor must always identify and correct any situation in which OHI is invoiced by the CCN Provider for care provided on an Approved Referral when VA was marked as primary payer. The Contractor must always educate CCN providers on the process for identifying Approved Referrals marked VA primary and VA secondary.

The Contractor must always educate its CCN providers that VA is to be notified in all circumstances when any CCN healthcare services related to or associated with any claim involving subrogation against: (i) workers' compensation carrier, (ii) an auto liability insurance carrier, (iii) Third-Party tortfeasor (e.g. medical malpractice), or (iv) any other situation where a third-party is responsible for the cost of CCN healthcare services. Whenever the Contractor is aware of potential Third-Party liability, e.g., Workman's Compensation, automobile insurance liability insurance, etc., through the normal course of business, the Contractor will notify the COR in writing of such potential Third-Party liability within thirty (30) days of identifying the event.

The Contractor must always educate its CCN providers that payment to the provider under this contract is deemed as payment in full.

In situations where VA would be a secondary payer, the Contractor must always receive, process, and store a service connected disability and/or special authority determinations. The service connection and non-service connection determinations will be sent with each referral and the information must always be used by the Contractor's system to adjudicate claims in accordance with the claims adjudication requirements in Section 12.0, "Claims Processing and Adjudication for CCN Healthcare Services Rendered."

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Coordination of Benefits Plan

12.7.2 Other Health Insurance

Without direct contact to the Veteran, the Contractor must always use available OHI data sources to: (i) validate Veteran OHI provided by VA to the Contractor as part of the Approved Referral when VA is secondary payer; and (ii) update as necessary the Veteran's OHI insurance information.

The Contractor must always electronically transmit OHI data that they have collected to VA weekly through VA DAS (see Attachment U, "Data Specification" (tab 21-OHI Data Update)). The Contractor must always submit to VA each business day all files containing EDI 837P, 837I, and 837D transactions received each day. For those Veterans whose OHI cannot be confirmed through available data, the Contractor may obtain such information from the Veteran only in accordance with a process pre-approved by VA.

The Contractor must always ensure that when an Eligible Veteran is receiving Non-service Connected Care and the Approved Referral indicates VA is a secondary payer, the Veteran's OHI is invoiced by the provider prior to the Contractor invoicing VA. Upon completion of OHI invoicing, the Contractor must always determine whether additional payment is required to fulfill the reimbursable Standard Episode of Care up to negotiated rates. Upon completion of OHI billing and

supplemental payment (if needed), the Contractor must always submit to VA a post-payment EDI 837 transaction that includes all payment and OHI associated activity RA. The Contractor must always provide care to Service Connected Care Eligible Veterans and bill VA for services rendered within the Approved Referral up to VA allowed amount using a post-payment EDI 837 transaction RA.

The Contractor must develop an OHI Verification and Retrieval Plan in accordance with the Schedule of Deliverables.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. OHI Verification and Retrieval Plan
B. OHI Report

12.8 Claims for Services Rendered to Veterans Assigned to Other CCN Region

The Contractor must always receive, process, and adjudicate claims for all services provided pursuant to this contract by CCN providers and practitioners in the Contractor's CCN Region network.

12.9 Claims Auditing

The Contractor must always ensure that fraud, waste, and abuse (FWA) detection analytics are inherent in its claims processing system. The Contractor must always share information when FWA is substantiated for any payments which they were reimbursed by VA. The Contractor must always make every reasonable attempt to recover all improper payments for services rendered to Veterans or for persons who were not eligible to receive a benefit.

Abuse is defined as, and Contractor analytics systems must always apply rules to identify, provider practices that that are inconsistent with sound medical practices, business practices, fiscal practices, and may result in unnecessary costs to VA. Business rules will identify services provided that were not medically necessary or fail to meet professional standards for health care.

Fraud is recognized as the intentional deception or misrepresentation made by a person with the intent that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State law. The Contractor must always demonstrate business analytics rules that may identify fraudulent activity. The Contractor must always apply and be able to demonstrate rules to identify potentially fraudulent claims.

The Contractor must always create a Quarterly Cost Avoidance and Recovery/Recoupments Report to include patient level as well as summarized key elements (see Attachment U, "Data Specification" (tab 18-Qtrly Cost Avoidance)), in accordance with the Schedule of Deliverables, within thirty (30) days following the last day of each quarter. The report will include the cost avoidance and recoveries/recoupments achieved as a result of improper payment reviews conducted by the Contractor. Each Quarterly Cost Avoidance and Recovery/Recoupments report must always contain but not be limited to:

- A summary of errors by reason category to include number of cases and dollar value.
- Trending of overpayments from inception and suggested corrective action.
- A detailed narrative with graphical and statistical information.
- Overpayments Established – This component of the report will: a) present the number of cases on which the Contractor has performed its initial assessment, b) indicate if the Contractor has requested and received additional documentation from VA and the timeframes associated with those documentation requests, and c) indicate the date the case was established and the date the Contractor is prepared to move on to the collection phase.
- Overpayments Collected – Collected amounts must only be included in this report if the amount has been successfully collected by the Contractor. Collected amounts must always be shown in a way that allows relation of the collected amount to a specific claim or invoice.
- Underpayments Identified – Indicate the number of cases that have been identified as having been underpaid and, if available, the estimated value of the underpayments.
- Overpayments Adjusted – During the course of the audit, there may be situations where the overpayment amount needs to be adjusted. This report will present any of those situations where adjustments have been required and the associated date of those adjustments.
- The number of reviews completed during each month of the quarter.
- Variance analysis for any reporting category with a greater than 15% increase or decrease from the current quarterly report to the previous report, to include any unusual activity even if it does not exceed the percentage.

Each Quarterly Cost Avoidance and Recovery/Recoupments Report for the final quarter of the applicable contract year must always include an annual analysis of the full PoP. The report for the final quarter must always include summarized information in presentation format (Microsoft Word, Excel, or PowerPoint) in laymen's language to facilitate conveying this information to senior VHA Community Care Leadership and to VA management. The report for the final quarter must always include lessons learned and will reflect unusual activity that persists throughout all four quarters. The report will include suggestions for improvements, implemented corrective action, and roll-up summaries from the quarterly reports.

Financial adjustments needed based on the findings in the Cost Avoidance and Recovery / Recoupment report, both overpayment and underpayment will be made upon acceptance of the report by VA. Audit *ad hoc* reports are responses to a current need for specific information in a specified format to support a VA audit. VA will request any *ad hoc* report by email to the Contractor's POC. The Contractor must always provide *ad hoc* reports, in accordance with the Schedule of Deliverables, three (3) business days after the request. Requests for *ad hoc* reports will not exceed eight (8) per year, and must always be requested by the COR.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Quarterly Cost Avoidance and Recovery/Recoupments Report

B. Audit *Ad Hoc* Reports

12.10 Reserved

12.11 Reserved

12.12 Claims Reporting

The Contractor must always transmit (non-clearinghouse file transfer) to VA through DAS a daily file containing all EDI 837 claims received from CCN Providers, including those that are in a pre-payment status, in accordance with the Schedule of Deliverables.

The Contractor must always provide Weekly Claims Processing Reports (see Attachment U, "Data Specification" (tab 19-Weekly Claims Processing)) through VA DAS, in accordance with the Schedule of Deliverables, that summarizes all claims activity. The Contractor must commence sending Weekly Claims Processing Reports at the start of claims processing. The Contractor must always run the Weekly Claims Processing Reports and include all claims activities from Sunday through close of business on Saturday, for the submission to be received by VA no later than 11 PM Eastern Time each Sunday. The Contractor must always include totals for open claims, pended claims, rejected claims, newly received claims, adjustments, transfers, claims processed, adjustments processed, closing of pending claims, denied claims, and closing of adjusted claims at the CCN level, and at the NPI or TIN level. The Contractor must always include the following categories by the age of the claim, and provide a total for each category: 0-10, 11-30, 31-60, 61-90, and 90+ days.

The Contractor must always provide Quarterly Claims Audit Reports (see Attachment U, "Data Specification" (tab 20-Quarterly Claims Proc)) through VA DAS in accordance with the Schedule of Deliverables.

The Contractor must always provide *ad hoc* reports, standardized reports, and special reports that satisfy request requirements within mutually agreed upon timelines, but no later than five (5) business days from date of request. VA can request a maximum of twenty-four (24) ad hoc reports during each period of performance. The Contractor must always have search capabilities built into its systems to quickly and easily accommodate such requests.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. EDI 837 Transaction File
B. Weekly Claims Processing Reports
C. Quarterly Claims Audit Reports

12.13 Federal Codes and Regulations

The Contractor must always ensure the claims processing system and any associated business rules and processes incorporate and maintain VA statutory and regulatory authorities, including any subsequent changes thereto.

12.14 Improper Payments Elimination and Recovery Improvement Act

On July 22, 2010, the Improper Payments Elimination and Recovery Act of 2010 [Public Law 111-204, (IPERA)], was signed into law. This legislation, and its predecessors and subsequent amendments (Improper Payments Information Act of 2002 [Public Law 107-300], Improper Payments Elimination and Recovery Improvement Act of 2012 [Public Law 112-248], and Federal Improper Payments Coordination Act of 2015 [Public Law 114-109], collectively referred to as IPERA in this document, requires agencies to review annually all programs and activities, identify those that may be susceptible to significant improper payments, estimate annual improper payments in the susceptible programs and activities, and report the results of its improper payment activities. IPERA also requires agencies to conduct payment recapture audits. The Fraud Reduction and Data Analytics Act (Fraud Act) of 2015 [Public Law 114-186] was approved on June 30, 2016 and requires agencies to improve financial and administrative controls and procedures to assess and mitigate fraud risks, and to improve development and use of data analytics for the purpose of identifying, preventing, and responding to fraud, including improper payments. VA has determined that Community Care is a program susceptible to significant improper payments.

12.14.1Payment Accuracy

The Contractor is fully responsible for ensuring VA is invoiced in accordance with the contract pricing and payments guidelines and only for services authorized through an Approved Referral. VA will pay the Contractor the applicable price for healthcare services in accordance with the Schedule of Services unless the invoice is for less than the Schedule of Services. For all instances where the Contractor submits a Healthcare invoice for less than the Schedule of Services, the rate billed is accepted as a “one-time” automatic adjustment to the negotiated contract rates and will not result in the identification or correction of any underpayments during audits, reviews, or attestation engagements. For all instances where the Contractor submits a Healthcare invoice for less than the Schedule of Services, the Contractor may request VA reconsideration for Healthcare invoice in accordance with Section B.15.

12.14.2Accounting and Access to Records

The Contractor must always maintain an accurate accounting of payments and Standard Episodes of Care and make those documents available to VA or another Federal Partner. The VA may use the services of a support Contractor (s) to assist in assessing Contractor compliance with the healthcare invoicing / medical claims processing requirements within the contract. To that end, the support Contractor (s) may require access to the Contractor’s business records or other proprietary data to review such business records regarding contract compliance. All support Contractors conducting this review on behalf of the VA will be required to sign an “Information Protection and Non-Disclosure and Disclosure of Conflicts of Interest Agreement” to ensure the Contractor’s business records or other proprietary data reviewed or obtained in the course of assisting the VA in assessing the Contractor for compliance are protected to ensure information or data is not improperly disclosed or other impropriety occurs. The Contractor must always cooperate fully and make available any records as may be required to enable the VA to assess Contractor compliance with healthcare invoicing / medical claims processing requirements. The documents must always be

provided to the requestor within forty-five (45) calendar days from the date of request.

The Contractor must always aggregate data using the format found in Attachment U, "Data Specification" (Quarterly Audit & Root Cause) and submit the Quarterly IPERA Audit and Root Cause report through VA DAS in accordance with the Schedule of Deliverables. VA uses this information to determine accuracy of payments (to include eligibility and Approved Referrals) and that services were received. This data will be available to VA in the performance of audits / reviews to determine accuracy of billing and incentives / disincentives calculation.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details).

A. Quarterly IPERA Audit & Root Cause

12.14.3Agreed-Upon-Procedures

The Contractor must hire a third-party auditor who is a member with the American Institute of Certified Public Accountants (AICPA); is in good standing with AICPA; and complies with AICPA's Code of Ethics standards 1.2000.001 and 1.110.010. The auditor must be independent and have no affiliation with the Contractor and its subsidiaries that could cause conflicts of interest or be motivated to skew the results of the procedures to benefit the Contractor. See CLIN 15 for additional details regarding pricing for this service.

The auditor will conduct an Agreed Upon Procedures review of the complete universe of healthcare service payments, which the Contractor submits to VA for reimbursement (CLIN01; CLIN02; CLIN03; CLIN04A; CLIN04B; CLIN06; CLIN07; CLIN08; CLIN09; CLIN10; and CLIN15) from VA to the Contractor in order to determine the percentage and dollar amount of improper payments (to include payments made subject to fraud) in the program as well as recoveries for overpayments that result in a loss to VA. The review will utilize a statistical sampling plan approved by VA in advance of the review to ensure it complies with Office of Management and Budget (OMB) Circular A-123, Appendix C, "Requirements for Effective Estimation and Remediation of Improper Payments," October 20, 2014. Guidance for the performance of such engagements can be found in Attestation Standards (AT) Section 201 of the American Institute of Certified Public Accountants (AICPA) Professional Standards, described more fully below. The Contractor must submit the auditor's Annual Auditing Plan, for approval by VA, that describes the approach for the following year's review in accordance with the Schedule of Deliverables.

The Contractor must always ensure the third-party auditor provides the Independent Auditor Quarterly Report in accordance with the Schedule of Deliverables, concurrently to the Contractor and VA, with the report for Quarter four (4) of the previous year provided to VA by June 1. The Contractor must always ensure the independent auditor provides the Annual Independent Auditor Statistical Projection of Improper Payments in accordance with Schedule of Deliverables to the VA and Contractor by June 1. The independent third-party auditor will provide the Contractor and VA the annual statistical projection of improper payments and all reporting requirements for improper payments as required by OMB Circular No. A-123, Appendix C "Requirements for Effective Estimation and Remediation of Improper Payments," October 20, 2014, and OMB Circular A-136,

"Financial Reporting Requirements," August 4, 2015. The auditor will also perform an extrapolation of root cause errors that resulted in a loss to VA for recovery purposes. The extrapolation process will include only claims that are subject to the identified error based on a statistically valid method attributed to the universe of claims for the audit period.

The review will ensure that the definition of improper payments applied during the review aligns with the definition included in OMB Circular A-123, Appendix C, "Requirements for Effective Estimation and Remediation of Improper Payments," October 20, 2014. The Circular requires the identification of all improper payments to include those that are a loss to VA based on the initial payment without consideration of supplemental adjustments in payment (i.e. the wrong amount was paid or the care was not authorized) as well as those that are administratively incorrect (i.e. documentation is unavailable to fully determine that the invoice should have been paid). If supplemental payments on a claim initially paid in error are identified by the Contractor, the Contractor must submit a detail report identifying all such adjustments for each such claim in order to request a reduction in the total overpayment amount extrapolated from the audit results. If a claim is selected for audit and the Contractor cannot produce the claim or other pertinent supporting documents or the documents are not auditable, a payment error based on the total unsupported amount will be assessed. The review must always ensure the most current published CMS, VA fee schedule and other applicable contract payment schedules which correspond to the period the services were rendered are utilized when determining if a payment was accurate. The Contractor must always provide evidence that the pricing schedule was obtained from certified sources. During the audit, the auditor will validate the proper configuration of the Contractor's payment system. Any variance in pricing caused by the use of different pricing sources by the Contractor and the auditors will be identified and addressed by the Contractor and auditor. If the variance is caused by the differences in payment schedules used but are otherwise correct then the vendor calculations will be considered accurate. If the variance is caused for some other reason, the vendor calculations will be considered inaccurate.

If new guidance is issued or laws/regulations are changed, the Contractor must always ensure the definition is adjusted and applied in accordance with the new guidance/laws/regulations.

The Contractor must always provide the independent auditor's Post Audit Findings and Recovery Report in accordance with the Schedule of Deliverables. The report is to be transmitted to VA utilizing DAS.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details).

A. Annual Auditing Plan
B. Independent Auditor Quarterly Report
C. Annual Independent Auditor Statistical Projection of Improper Payments
D. Post Audit Findings and Recovery Report

12.14.4Error Determination Rebuttals.

The Contractor must submit rebuttals of audit error findings to the auditor and VA within thirty (30)

calendar days of the date of the Post Audit Findings and Recovery Report. Rebuttals not submitted within thirty (30) calendar days of the report will be excluded from further consideration. The auditor will have thirty (30) calendar days to make a final determination on the rebuttal. The auditor will provide rebuttal decisions to VA for review. VA will make the final determination regarding whether a payment is in error or not. Once the errors are finalized, the auditor will extrapolate those errors that resulted in a loss to VA for recovery.

12.14.5Additional Reviews.

The VA or its authorized third-party may conduct an audit of the accuracy of payments in accordance with Generally Accepted Accounting Principles or regulatory guidance quarterly at its cost. Nothing in this section removes the right of any Government oversight entity to review payments for accuracy.

12.14.6Recoveries.

The results of errors resulting in a loss to VA of the Agreed Upon Procedures review will be extrapolated across all the medical claims submitted during the procedures period that meet the same identified error, e.g. category of care, to determine the total overpayment of the medical claims population sampled. The Contractor must complete the extrapolation of the samples within fourteen (14) days of the completion of Agreed Upon Procedures. The Contractor must then identify all invoices subject to those errors to identify all overpayments within sixty (60) days of the completion of Agreed Upon Procedures (after the error determination rebuttal period). The Contractor must provide VA a complete listing of all invoices requiring adjustment in order to ensure all errors have been identified and corrected at the end of the sixty (60) day period in order to ensure that VA receives a credit for all overpayments. Audits resulting in the identification of overpayments to the Contractor requiring recovery will be provided to VA in the Overpayments Electronic File in a structure to allow VA to identify the specific error that resulted in the overpayment, (e.g., coding error, pricing error, improper bundling, eligibility error, etc.) and the corresponding individual claim number(s) that resulted in the overpayment that were identified as included in the extrapolation and overpayment calculation.

Payments made by the Government to the Contractor for less than the negotiated contract rate based on the Contractor invoice that are found in the review are not used to offset overpayment adjustments as underpayments (see “Payment Accuracy”). In addition to the Contractor reimbursing VA for the projection of improper overpayments resulting in a loss to the Government, the Contractor must complete a review of all payments within the universe of healthcare service payments which the Contractor submits to VA for reimbursement (CLIN01; CLIN02; CLIN03; CLIN04A CLIN04B; CLIN06; CLIN07; CLIN08; CLIN09; CLIN10; and CLIN15) that align with root causes improper payments identified in the attestation engagement within three (3) months of all payments made to identify improper payments and ensure root causes are corrected. If the full review identifies additional improper payments, the Contractor must always adjust each claim subject to the identified error and submit as a corrected invoice.

Deliverable: (See Section 20.4, “Schedule of Deliverables” for details).

A. Overpayments Electronic File

12.14.7 Reduction of improper payment performance goals.

VA will establish a payment accuracy performance threshold. The accuracy of payments will be calculated via the independent audit for identification and reporting of improper payments and measured against the performance thresholds established in Attachment T, "Incentive Plan" (e.g., annual performance threshold is identified at 95.0% accuracy). If the independent audit results conclude a 94% accuracy, the Contractor is assessed a 2% disincentive.

Adjustments are in addition to the Government's rights under FAR 52.212-4. At any time or times, the Contracting Officer may have the Contractor's invoices or vouchers and statements of cost audited. "Audits", includes audits on statically valid samples.

13.0 VETERAN CLAIM APPEALS AND PROVIDER RECONSIDERATIONS

13.1 Veteran Appeals

In the event that the Contractor denies a claim and the Veteran has a financial liability (e.g., denied emergency service claims) for that denied claim, the Contractor must always provide a notice of the denial to the Veteran with a description of the Veteran's right to appeal such denial to VA. The Contractor must always include "VA Form 4107VHA" (http://www.va.gov/vaforms/va/pdf/VA4107VHA.pdf) with the notice of denial to the Veteran.

13.2 Practitioner and Provider Reconsiderations

The Contractor must establish and always maintain a provider reconsideration process for all claims that are denied, either in whole or in part. The Contractor must always notify the CCN Healthcare Services Network provider or CCN CIHS Network practitioner in writing, of any such denial, the reason for the denial, and the provider's right to request reconsideration. The Contractor must always ensure all CCN Healthcare Services Network provider or CCN CIHS Network practitioner requests for reconsiderations are submitted to VA within ninety (90) days from the date of denial.

The Contractor must create and submit a description of the Provider Claims Denial Reconsideration Process in accordance with the Schedule of Deliverables.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Provider Claim Denial Reconsideration Process

14.0 CLINICAL QUALITY AND PATIENT SAFETY MONITORING

The Contractor must take the necessary steps, as directed by VA, to safeguard Veterans when the Contractor or VA identifies a patient safety issue where Veterans are, or could be, at risk.

When VA identifies clinical quality or patient safety concerns regarding a Veteran's care, the Contractor must conduct a clinical quality and patient safety review and case investigation, as directed by VA, and report their findings to VA.

14.1 Clinical Quality Monitoring Plan (CQMP)

The Contractor must develop and submit a written Clinical Quality Monitoring Plan (CQMP) to VA in addition to documentation of national accreditation status (see Section 2.6, "Accreditation") for certain elements of the CQMP not covered by accreditation status. The CQMP must include but not be limited to the following:

1. A description of the quality monitoring activities for patient safety, clinical quality assurance, clinical quality improvement, and clinical quality peer review
2. A detailed description of the purpose, methods, proposed goals, and objectives designed to ensure the highest quality of clinical care under this contract
3. A description of the process to educate providers regarding VHA clinical practice guidelines
4. A description of the process to work with the VHA Office of Community Care (OCC) to align clinical quality monitoring activities with the VHA OCC Quality and Patient Safety Improvement Program Description
5. A description of a committee/committee structure and its activities that provides executive oversight of quality and patient safety monitoring and improvement for Veteran's Care
6. Identification of authorized Quality and Patient Safety representatives aligned to each VISN be available to participate in established VHA VISN Quality and Patient Safety Meetings
7. A description of the process to ensure that supplied performance results are accurate, complete, and reliable
8. A description of the process to comply with federal, state, and local privacy regulations during the reporting, review and/or investigation of records related to quality and patient safety reporting
9. A description of the process to comply with the performance reporting schedule described in the CCN Quality and Patient Safety Measure Specifications Manual
10. The Contractor will conduct a minimum of three (3) Quality and Patient Safety Improvement Initiatives per year. The initiatives will be mutually agreed upon between Contractor and VA. The Contractor's CQMP must include a written description of the three (3) quality and patient safety improvement initiatives and their expected results/impact. The Contractor must evaluate and update the quality and patient safety improvement initiatives at least annually.
11. The Contractor's CQMP must include a Clinical Quality and Patient Safety Improvement Program (CQPSIP) component
12. Provide documentation for how Clinical Quality Peer Reviews will be conducted including committee structure and membership, oversight, scoring, and reporting of findings. The Contractor must describe the clinical quality peer review committee's composition, qualifications, and quorum of voting members to conduct clinical quality peer review, and frequency of the meetings. The Contractor must detail the framework of review, analysis, education presentations, and oversight used to ensure responsible quality improvement participation by network physicians and affiliated practitioners.

13. Provide documentation for how the Contractor allows VA staff, as mutually agreed upon between Contractor and VA, to actively participate as non-voting members on the Contractor's CQPSIP committees, clinical quality management committees, patient safety committees, clinical quality peer review committees, and credentialing committees for the CCN Region covered under this contract. The Contractor must include how reports form automated data sources, focused studies, and other elements are used in the practitioner evaluation step of the credentialing and privilege process.

The Contractor must provide a copy of its CQMP to VA in accordance with the Schedule of Deliverables.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Clinical Quality Monitoring Plan

14.1.1 Reserve

14.1.2 Clinical Quality and Patient Safety Improvement Component of the CQMP

The Contractor's CQMP must include a Clinical Quality and Patient Safety Improvement Program component, defined as a set of related activities designed to achieve measurable improvement in processes and outcomes of clinical care. The Contractor's CQPSIP component must be designed to achieve improvements: (i) through activities that target healthcare providers, practitioners, plans, and Veterans; (ii) by addressing administrative processes, Veteran health, error reduction and safety improvement, Veteran functional status, Veteran and provider satisfaction, and program-related issues; and (iii) for Veterans who are high-risk or high-volume users of services. The Contractor's CQPSIP component must be structured with appropriate elements, including clearly defined sample sizes and inclusion and exclusion criteria, and developed using relevant and rigorous scientific methodology. The data is to be transmitted to VA utilizing DAS.

The Contractor must appropriately document the CQPSIP with the following common elements:

1. Description and purpose of the activity and specific question(s) for study
2. Description of the population
3. Rationale for selection of the CQPSIP baseline data
4. Description of relevant data collection and data sets
5. Goals and time frames for achieving these goals
6. Action plans and interventions
7. Periodic measurements and outcomes

The Contractor will adhere to the processes described in the VHA OCC Patient Safety Guidebook to manage adverse events and close calls involving VA beneficiaries. The Contractor will provide a patient safety event reporting process available to Veterans and network staff for reporting adverse events and close calls.

14.2 Clinical Quality and Patient Safety Issues Identification

Identification of quality issues applies to medical, dental and ancillary care services. The Contractor must identify, track, trend, and report interventions to resolve any Potential Quality Issues (PQI), Potential Safety Issues (PSI), Identified Quality Issues (IQI), or Identified Safety Issues (ISI) using performance metrics such as the National Quality Forum (Serious Reportable Events, CMS Hospital Acquired Conditions, and Agency for Healthcare Research and Quality Patient Safety Indicators). The Contractor must always adhere to processes identified in VA Guidance (e.g., VHA OCC Patient Safety Guidebook, VHA Patient Safety Handbook 1050.01).

The Contractor must always apply appropriate medical judgment, evidence-based medicine, and best medical practices when identifying, evaluating, and reporting on all PQI, PSI, IQI, and ISI. The Contractor must always process to completion ninety-five (95) percent of all PQI, PSI, IQI, and ISI within ninety (90) days from date of identification and ninety-nine (99) percent within one hundred eighty (180) days of identification. For patient safety events requiring an investigative analysis or quality improvement initiative, the analysis must be completed within forty-five (45) days of identification, and associated corrective actions must be implemented within ninety (90) days for ninety-five (95) percent of all PQI, PSI, IQI, and ISI. The Contractor must always prepare a Quarterly Clinical Quality and Patient Safety Issues Report (see Attachment U, “Data Specification” (tab 12-Clinical Quality)) for VA with aggregated PQI, PSI, IQI, ISI, VHA provider complaints, and Veteran complaints data, (See Section 6.1, “Contractor VA Support Call Center Functions”) which must always be submitted in accordance with the Schedule of Deliverables.

The Contractor must always implement appropriate IQI and ISI interventions using evidence-based medicine and best medical practices to address and resolve each identified quality and patient safety issue. When the Contractor confirms an IQI, ISI, or determines there is deviation in the standard of practice or care, the determination must always include assignment of an appropriate severity/probability score and describe the actions taken to resolve the quality or patient safety problem.

Deliverable: (See Section 20.4, “Schedule of Deliverables” for details.)

A. Quarterly Clinical Quality and Patient Safety Issues Report

15.0 PHARMACY

The CCN Healthcare Services Network must always include a Pharmacy component. The Pharmacy component must always provide pharmacy benefits to Veterans through the use of a Pharmacy Benefits Management (PBM) function that has a retail pharmacy network to provide prescription fulfillment services for urgent/emergent prescriptions from CCN providers and VA providers. The Contractor must always require all routine/maintenance prescriptions to be forwarded to VA pharmacy for processing and fulfillment.

The Contractor must always educate its CCN providers and confirm that the following information is required from the prescribing CCN provider for each routine/maintenance prescription for fulfillment:

1. Provider Name (Family, Given, Middle Suffix) Provider Name Suffix (e.g., Sr., Jr., II., III.)
2. NPI of the Provider
3. TIN of the Provider
4. Provider's PERSONAL DEA Number and Expiration Date (not a generic facility number)
5. Provider's Office Address
6. Providers Office Phone and Additional Phone Number
7. Provider's Fax Number (if applicable)
8. Provider's Discipline (e.g., physician, physician assistant, nurse practitioner, etc.)

VA will transmit a list through VA DAS of all VA providers who are eligible to prescribe prescriptions to Veterans within thirty (30) days of contract award date pursuant to 18.15.2. The Contractor must always have a process in place where new VA providers may be active to prescribe prescriptions as quickly as possible. When VA communicates the deletion of VA provider from the network, the change must always occur within one (1) business day of being provided the information.

The Contractor must always ensure that the CCN pharmacist dispenses prescriptions in accordance with VA Pharmacy program's mandatory generic substitution policy, VHA Handbook 1108.08 (https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3291). The Contractor must always prohibit CCN providers from dispensing any pharmaceutical samples to Veterans. The Contractor must always require all CCN providers be registered with its own states' prescription monitoring programs.

The Contractor must always support e-prescribing for retail network prescriptions, in accordance with commercial standards. The Contractor must manage and publish all data files required to support commercial e-prescribing practices. The Contractor must always maintain all electronic formularies administered under this contract and publish updates to the commercial e-prescribing hub, monthly. At a minimum, formularies must be updated quarterly.

15.1 Urgent/Emergent Prescriptions

The Contractor must establish a retail pharmacy network to fill urgent/emergent prescriptions received from CCN providers and VA providers for prescription fulfillment. An urgent/emergent prescription is available for a maximum fourteen (14) day supply of medication without refills (or shorter supply of opioid medication if required by state law). The Contractor must always have retail pharmacies covering all geographic areas of the CCN Region and meet the adequacy standards described in Section 15.2, "Urgent/Emergent Prescription Network Adequacy."

The Contractor's retail pharmacies must always follow established clinical protocol for registration of new patients to determine a Veteran's allergy and previous drug history. The Contractor must provide training on pharmacy benefits and requirements, under this contract, to its network providers. This must include web-based and virtual trainings as well as written training materials.

The Contractor must establish procedures that include instructions for prescribing a maximum fourteen (14) day supply of medication without refills (or shorter supply of opioid medication if

required by state law), when it is determined medically appropriate by the CCN provider or VA provider and associated with an Approved Referral. The Contractor's procedures must instruct the Veteran to go to a local pharmacy in the retail pharmacy network established by the Contractor's PBM.

The Contractor must always provide to its PBM all applicable Veteran eligibility information and network prescribing provider information to facilitate Veterans' receipt of their urgent/emergent prescriptions through the participating retail pharmacies. The retail pharmacies must always provide Veterans the same quality of services provided to beneficiaries of other commercial clients, to the extent allowed by federal regulation and this contract.

The Contractor must always ensure that all pharmacy documents, and the receipt of the medication by the Veteran or the individual authorized by the Veteran, are in accordance with all applicable state and federal laws. The Contractor must always ensure that network pharmacies have procedures to reasonably assess the validity of prescriptions ordered by fax, telephone, and e-prescribing.

The Contractor must require all CCN providers to generate a second prescription for medications, when clinically needed for continued treatment beyond the urgent/emergent fourteen (14) day supply, and submit the prescription to the authorizing VA facility's pharmacy by fax or other agreed-upon electronic method. Incomplete prescriptions will not be processed and will be returned to the prescribing provider to resubmit to the authorizing VA facility's pharmacy for processing once completed. The Contractor must require its CCN providers to check with its state's prescription monitoring program for any controlled substance utilization prior to writing any controlled substance prescription for a Veteran to ensure appropriate opioid/controlled substance use.

The Contractor must instruct and mandate its CCN providers to use VA Urgent Emergent National Formulary (subject to routine updates) (Attachment M, "Urgent and Emergent Drug Formulary"). When CCN or VA providers are unable to comply with the VA Urgent/Emergent Formulary, the Contractor must ensure that its PBM communicates to the retail pharmacy the applicable Urgent/Emergent National Formulary alternatives. If a medication from the VA Urgent/Emergent National Formulary is not acceptable, the Contractor must next offer an alternative from the VA National Formulary (Attachment AE, "VA National Formulary"). The Contractor must develop a Prior Authorization process that conforms with VA's non-formulary request process, referenced in VHA Handbook 1108.08, "VHA Formulary Management Process" (http://www.va.gov/VHAPUbLICAtIons/ViewPublication.asp?pub_ID=3291).

The Contractor must always perform clinical reviews for all Prior Authorization, non-formulary medications, recommending formulary alternatives that are in compliance with the posted Criteria for Use (CFU) on VA PBM website. When a CFU is not available, the Contractor must always utilize a generic Prior Authorization template that requires strict adherence to only FDA approved indications. For unlabeled uses or other clinical exceptions, the Contractor must always contact the Veteran's VA medical center pharmacist for assistance on making an approval determination. No

prescriptions for topical compounded products are considered urgent/emergent. The Contractor must submit a Monthly Electronic Prior Authorization Report in accordance with the Schedule of Deliverables. The Monthly Electronic Prior Authorization Report must always use the National Council for Prescription Drug Programs (NCPDP) format with two additional columns. The headings of the two additional columns must state "Approve or Disapprove" and "Justification." Entries under "Justification" could be as follows:

1. *"Urgent/Emergent Need as Determined by Provider"*
2. *"Non-Formulary for Urgent/Emergent Need as Determined by Network PBM with CFU"*
3. *"Non-Formulary for Urgent/Emergent Need as Determined by Network PBM with generic Prior Authorization"*
4. *"Non-Formulary for Urgent/Emergent Need as Determined by VA staff"*

The Contractor must establish a PBM process that will automatically reject a retail network pharmacy's attempt to renew a Veteran's prescription if it is for the same drug and strength within thirty (30) days of the original fourteen (14) days prescription. Approved Prior Authorizations include continuation of pain or antibiotic therapy; otherwise, the Contractor must always contact the Veteran's VA medical center pharmacist for assistance. The monthly Electronic Prior Authorization Report must always use the NCPDP format with the two additional columns noted above ("Approve or Disapprove" and "Justification."), including a section for continuation of pain or antibiotic therapy. Entries under "Justification" could be as follows:

1. *"Urgent/Emergent Need for Continuation of Pain or Antibiotic Therapy as Determined by Provider"*
2. *"Urgent/Emergent Need for Continuation of Therapy as Determined by VA staff"*

The Contractor must provide, in accordance with the Schedule of Deliverables, a Monthly Electronic Urgent/Emergent Prescription Report in NCPDP format, as a flat, tab delimited file, to VA including the following information on each prescription filled:

1. Pharmacy name, store #, address, and phone number
2. Pharmacy prescription number
3. National Drug Code number of the drug that was used to fill the prescription
4. Text description of drug
5. Number of days' supply, quantity, and date dispensed
6. Average Wholesale Price (AWP) including % off AWP, AWP at time of charge, and dispensing fee
7. Prescribing provider, who prescribed the medication, including the NPI and DEA numbers (if required for prescription)
8. Patient's last four digits of Social Security Number (SSN)
9. Provider status (i.e., CCN Provider or VA Provider)
10. VISN
11. Facility ID
12. Referral Number

This monthly report must always provide details on urgent/emergent fill performance metrics, as referenced in Section 15.2, "Urgent/Emergent Prescription Network Adequacy."

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Monthly Electronic Urgent/Emergent Prescription Report
B. Monthly Electronic Prior Authorization Report (to include Continued Need Justifications)

15.2 Urgent/Emergent Prescription Network Adequacy

The Contractor must always ensure that a retail pharmacy network is established and in place, and that it's adequate in size, scope, and capacity to ensure that Eligible Veterans receive timely access to urgent/emergent prescription services in accordance with the following standards, at a minimum, for each VA Facility service area:

Table 16. Network Pharmacy Minimum Access Standards

	Average Drive
Urban	Network pharmacy 90% of Veteran have access within five (5) miles of a Veteran's residence
Rural	Network pharmacy 70% of Veterans have access within fifteen (15) miles of a Veteran's residence
Highly Rural	Network pharmacy 70% of Veterans have access within thirty (30) miles of a Veteran's residence

Any deviations from these minimum standards must always be requested in writing by the Contractor and submitted to the COR. Written requests must always include a detailed explanation of the circumstances that justify a deviation. Written requests will be reviewed by the COR and a determination will be provided by the CO.

The Contractor must submit the Pharmacy Adequacy Plan to VA in accordance with the Schedule of Deliverables.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Pharmacy Adequacy Plan

15.2.1 Urgent/Emergent Prescription Performance Metrics

The Contractor must always report performance toward the defined performance metric goals for all urgent/emergent prescriptions handled by the retail pharmacy network monthly. These goals and metrics are:

1. 95 percent overall conformance with VA Urgent/Emergent Formulary for CCN Providers
2. 90 percent generic dispensing for VA Urgent/Emergent prescriptions for CCN Providers

The Monthly Urgent/Emergent Prescription Performance Metrics Report must always be submitted in accordance with the Schedule of Deliverables and include the ability to drill down to prescribing provider level, including contact information and retail pharmacy location utilizing DAS.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Monthly Urgent/Emergent Prescription Performance Metrics Report

15.3 Routine/Maintenance Prescriptions

VA healthcare benefits include providing Veterans with prescription medications, medical/surgical supplies, and nutritional products. The Contractor's CCN providers may prescribe medications to be processed by the VA pharmacy only where the Veteran is enrolled for care as part of the authorized CCN healthcare services under this contract.

The Contractor must always instruct and mandate its CCN providers that prescriptions must always be prescribed in accordance with VA's National Formulary, which includes provisions for requesting non-formulary drugs (see http://www.va.gov/VHAPUbLICAtIons/ViewPublication.asp?pub_ID=3291).

In addition to the online formulary, an online formulary search tool is available at: http://www.pbm.va.gov/apps/VANationalFormulary/. This application provides formulary alternatives to non-formulary drugs in the same VA drug class. The Contractor must always instruct its CCN providers to utilize this application in order to prescribe appropriate formulary medications. All Prior Authorizations or non-formulary prescriptions received by the VA Pharmacy must be reviewed in coordination with the CCN provider and authorized by VA Pharmacy before dispensing.

Prescriptions must always be transmitted by secure fax or other agreed-upon electronic method to VA for processing. Incomplete prescriptions will not be processed and will be returned to the prescribing provider to re-submit to VA for re-processing once completed.

Seasonal flu vaccine are authorized to be administered by the CCN retail pharmacies in accordance with VA Vaccination recommendations (http://www.publichealth.va.gov/vaccines.asp) and the Centers for Disease Control and Prevention immunization protocols governing its use, found at http://cdc.gov/vaccines. VA will provide to the Contractor during contract implementation and with each option period award thereafter, a SEOC listing of approved vaccinations and CPT/billing codes that will be reimbursed without further authorization from VA. The Contractor must always ensure its Pharmacy providers verify eligibility prior to dispensing a flu vaccination.

Veterans are required to present a valid identification (e.g. State driver's license) and a VA issued identification card. All other vaccinations require prior authorization.

15.4 Contingency Plan for Disaster Response

In the event the VHA Undersecretary for Health or his/her designee initiates VA's continuity of operations plan (COOP) in response to a disaster, the Contractor must always make available its retail pharmacy network to Veterans affected by such disaster. VA will provide to the Contractor a list of Veterans affected by the disaster who are eligible to access the Contractor's retail pharmacy network. The Contractor must always make available its retail pharmacy network service to those Veterans on the list within twelve (12) hours of receiving the list from VA. The Contractor must always allow a maximum of thirty (30) days of fill for each prescription medication at the retail

network pharmacy in accordance with the Veteran's CCN or VA provider prescription. The Contractor's retail pharmacy may also call VA Pharmacy to transfer the disaster response prescription(s).

The Contractor must provide, utilizing DAS, an Electronic Disaster Response Prescription Report, in accordance with the Schedule of Deliverables and following the NCPDP format, on a monthly basis during the period for which the service is provided and for ninety (90) days following the end of the service.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Electronic Disaster Response Prescription Report

16.0 DURABLE MEDICAL EQUIPMENT

The Contractor must always provide urgent and emergent DME, Medical Devices, orthotic, and prosthetic items (hereinafter referred to as "DME and Medical Devices") to Eligible Veterans.

16.1 Urgent/Emergent Prescriptions for DME and Medical Devices

The Contractor must always provide DME and Medical Devices to Eligible Veterans for an urgent or emergent condition requiring DME and/or Medical Devices as determined by a CCN provider. Urgent or emergent condition for DME and Medical Devices is a medical condition of acute onset or exacerbation manifesting itself by severity of symptoms including pain, soft tissues symptomatology, bone injuries, etc. Urgent or emergent DME or Medical Devices may include, but are not limited to: splints, crutches, canes, slings, soft collars, walkers, and manual wheelchairs. All other (i.e., non-urgent or non-emergent) DME and Medical Device prescriptions must always be submitted to VA for the prescribed item(s) to be purchased and provided by VA. Failure to plan or coordinate with VA in advance of a scheduled procedure or patient discharge for instances in which the need for DME and/or Medical Devices can be reasonably anticipated, does not constitute an urgent or emergent condition for DME and/or Medical Devices. The Contractor must always ensure that CCN providers assess cost effectiveness of a rental option for an urgent/emergent DME/Medical Devices, if available. If a rental option is selected, the rental period may not exceed thirty (30) days. The Contractor must always ensure that CCN providers submit any longer term need of urgent/emergent DME/Medical devices to VA for fulfillment.

The Contractor must always provide DME or Medical Devices to Veterans receiving care in the community for urgent or emergent conditions at the time of healthcare service delivery or soon thereafter.

16.2 Routine Prescriptions for DME and Medical Devices

The Contractor must always ensure that CCN providers submit all prescriptions for routine DME and Medical Devices for Eligible Veterans to VA for fulfillment. The Contractor must always require all DME and Medical Device prescriptions contain the following information:

1. Date of Request

2. Patient's Full Name
3. Patient's Date of Birth
4. Patient's Last four (4) Digits of SSN
5. Patient's EDIPI
6. Prescribing Provider's Full Name
7. Prescribing Provider's Address
8. Prescribing Provider's Phone Number
9. Prescribing Provider's Fax Number
10. Diagnosis and International Classification of Diseases (ICD)-10 Code(s)
11. Description and HCPCS Code for Each Prescribed Item
12. Detailed Information (brand, make, model, part number, etc.) and Medical Justification for Each Prescribed Item (if a specific brand/model/product is prescribed)
13. Item Delivery Location/Address and Expected Delivery Date

The Contractor must always ensure that all DME and Medical Device prescriptions are submitted using VA-provided order forms or templates. All VA forms and templates for DME and Medical Devices, along with instructions for use, will be provided to the Contractor during the implementation phase. A sample DME and Medical Devices form is attached and will be updated during the implementation phase (Attachment N, "VHA Request Form for CCN DME, Medical Device, Orthotic, and Prosthetic Items"). The Contractor must always notify CCN providers that VA reserves the right to issue comparable, functionally equivalent DME and Medical Devices to what is prescribed by the CCN provider.

The Contractor must always require that all prescriptions for hearing aids are submitted to VA for review and fulfillment. For hearing aids, the Contractor must always provide initial testing results related to potential hearing aid needs to VA. Hearing aids cannot be purchased or provided under this contract by the Contractor or the CCN providers. The VA will provide information for the hearing aid manufacturers that have current contracts with VA.

The Contractor must always require that all requests for home oxygen are submitted to VA for review and fulfillment. For home oxygen, the Contractor must always provide definitive testing results related to potential home oxygen needs and detailed home oxygen prescriptions. Home oxygen equipment or supplies cannot be purchased or provided under this contract by the Contractor or the CCN providers. The Contractor must always inform the CCN Providers that the need for home oxygen must always be planned sufficiently in advance of the procedure or patient discharge to avoid delay in fulfilling the prescription.

The Contractor must always require CCN Providers to be responsible for all necessary follow-up care, including patient education, training, fitting, and adjustment for the prescribed item. VA will procure and send the prescribed item to the prescribing CCN provider location, unless specified otherwise, for the prescribing CCN provider to provide follow-up care and the item(s) to the Veteran.

16.3 RESERVED

16.4 Oral Appliance Therapy (OAT) for Obstructive Sleep Apnea (OSA)

The Contractor must always provide the capability for Eligible Veterans to receive Oral Appliance Therapy (OAT) for obstructive sleep apnea through the Dental Network established in Section 17.0. OAT is classified as medical treatment for a medical disorder, obstructive sleep apnea, which is provided by a licensed dentist.

17.0 DENTAL

The Contractor must establish and maintain a network of dental providers to provide outpatient dental care to all Eligible Veterans who also satisfy the dental eligibility requirements of 38 U.S.C. § 1710(c) and 1712 and 38 C.F.R. § 17.93 and 17.160-17.166.

17.1 Dental Network Adequacy

The dental network must always include both general and specialized dental care. Specialized dental services include all recognized American Dental Association (ADA) specialties except for pediatric dentistry.

Minimum network standards for Veteran access are as follows:

Table 17. Dental Network Access Standards

Minimum Network Standards for Access to General Dentistry	
Urban	Thirty (30) minutes
Rural	Forty-five (45) minutes
Highly Rural Location	Sixty (60) minutes
Minimum Network Standards for Access to Specialized Dentistry	
Urban	Forty-five (45) minutes
Rural	One hundred (100) minutes
Highly Rural Location	One hundred eighty (180) minutes

Appointment Availability Emergent and Urgent for General and Specialized		
	Emergent	Urgent
Urban	Twenty-four (24) hours	Forty-eight (48) hours
Rural	Twenty-four (24) hours	Forty-eight (48) hours
Highly Rural Location	Twenty-four (24) hours	Forty-eight (48) hours

Appointment Availability Routine (General and Specialized)		
	General Dental Care	Specialized Dental Care
Urban	Thirty (30) days	Thirty (30) days
Rural	Thirty (30) days	Thirty (30) days

Highly Rural Location	Thirty (30) days	Thirty (30) days

Any deviations from these minimum standards must always be requested in writing by the Contractor and submitted to the COR. Written requests must always include a detailed explanation of the circumstances that justify a deviation. Written requests will be reviewed by the COR and a determination will be provided by the CO.

17.2 Dental Network Provider Credentialing

The Contractor must always confirm that CCN Dental Network providers are credentialed in accordance with the requirements set forth in Section 3.7 of this contract, and by a nationally recognized accrediting organization for the Contractor's credentialing program unless the accrediting organization's standards are not applicable to such services, facilities and providers.

If a provider is or has been licensed in more than one state, the Contractor must always confirm that the provider certifies that none of those states has terminated such license for cause, and that the provider has not involuntarily relinquished such license in any of those states after being notified in writing by that state of potential termination for cause.

17.3 Dental Network Compliance

The Contractor must always ensure CCN providers comply with the most current version of the Code on Dental Procedures and Nomenclature published in the ADA's Current Dental Terminology (CDT) manual throughout the PoP.

17.4 Dental Care Referrals and Prior Authorization

The Contractor's processes must always require that, except as described in the following paragraph, after an initial authorized dental referral is completed, all recommended treatment plans be reviewed and approved by VA prior to the Veteran receiving care.

VA will provide the Contractor an initial list of dental services as part of Attachment IA, "Dental Service Prior Authorization Exception List" in advance of dental treatment. Upon the receipt of an updated Dental Services Prior Authorization Exceptions List and associated business rule guidance from VA, the Contractor must always communicate and distribute the updated Dental Services Prior Authorization Exceptions List to dental providers within the CCN within thirty (30) days of receipt.

The Contractor must always have a referral for all dental services to be provided under the contract in advance of treatment. Attachment IA, "Dental Service Prior Authorization Exception List" defines specific services that may be performed after the referral is established without further clinical review or prior authorization by VA. All dental services not listed in the attachment require prior authorization by VA.

17.5 Return of Dental Records

The Contractor must always educate its CCN providers that CCN Dental Network providers are to return dental records of completed care, including supplemental images/radiographs, to VA within forty-five (45) days upon completion of the dental treatment plan. The Contractor must always educate its CCN providers that requested documentation is submitted by CCN Dental Network providers directly to VA via secure electronic submission, where available. See Section 18.13, "Submission of Medical Documentation," for submission format requirements.

17.6 Dental Clinical Quality Management

The Contractor must establish and always maintain a process for dental clinical quality management as detailed in Section 14, "Clinical Quality and Patient Safety Monitoring". The Contractor must always follow the processes for Appeals and Grievances as represented in Section 13.1, "Veteran Appeals," of this document.

18.0 TECHNOLOGY

The Contractor must leverage its existing Information Technology (IT) systems, with enhancements as necessary, to perform the requirements outlined within the PWS. The Contractor must always keep its systems in line with evolving industry standards and the Contractor must always plan future system enhancements, as appropriate, to support CMS and the Office of the National Coordinator (ONC) Electronic Health Record (EHR) Meaningful Use Stage 3, and related 2015 EHR certification criteria providing consistent, standards-based workflow, and building on open specifications including health Level 7's Fast Healthcare Interoperability Resources (FHIR), the Data Access Framework (DAF), OAuth, and other VA approved specifications, such as those developed under Argonaut.

18.1 Contractor Software Configuration Management Requirements

The Contractor must always utilize a solution to support the requirements herein that is configurable to allow for changes to be tested, accepted, and implemented. When VA requests a change to the solution, the Contractor must always implement the change by the mutually agreed upon date.

18.2 Continuity of Operations

The Contractor must develop a Continuity of Operations (COO) Plan (COOP) that demonstrates the process for the continuous operation of its IT systems, data availability, and organizational support of the CCN. The Contractor's COOP must be submitted to VA in accordance with the Schedule of Deliverables. The COOP must include user access and authentication processes. The Contractor must provide the current COOP annually thereafter. The COOP must include information specific to all actions that will be taken by the Contractor in order to continue operations should an actual disaster be declared for its CCN Region. The COOP must describe the process for managing temporary system unavailability and the communication method that will be used to ensure minimal process disruption. The Contractor's system and associated data shall be available at all times even in the event of hardware, software, and/or communications failures.

The Contractor must always notify VA (CO and COR) in writing, the scheduled system maintenance at least two (2) weeks in advance. The system maintenance notification must always include the system(s) affected, changes that will occur, and the date/time changes will be in effect. The Contractor must always schedule system maintenance only during the standard maintenance windows provided by VA. For unscheduled system maintenance, the Contractor must always notify the CO and COR via email (within one [1] hour of being alerted of an issue).

The COOP must address the following categories:

1. Process for Continuous Operations
2. System Maintenance (Scheduled and Unscheduled)
3. Hardware/Software System Failures
4. Temporary System Unavailability
5. Availability Performance
6. Disaster Recovery

The COOP must always meet the operational and availability standards, including a downtime process for all systems provided under this contract, as set forth below:

Table 18. Operational/Availability Standards

Hours of Operation	Availability*	Return to Operations
24/7	99.9%	12 hours

* Excluding agreed upon downtime

When unscheduled downtime occurs for more than one (1) cumulative hour in any given twenty-four (24) hour period, VA may request that the Contractor conduct a Root Cause Analysis. The Contractor must always complete such analysis and provide its findings and recommended corrective actions to the COR within ten (10) days of the request. The Contractor must always provide the COR with a schedule to resolve any identified issues within two (2) days of completion of the Root Cause Analysis.

The Contractor must submit a COO Report in accordance with the Schedule of Deliverables. The COO Report must always include system downtime (planned and unplanned) recorded that month (total hours and minutes), functional capabilities impacted by the system down time, cause/reason for the system downtime, updates/changes made to the system during downtime (or steps taken to remediate if no changes), and a summary of any analysis and corrective actions reported to the COR during the reporting period.

Deliverables: (See Section 20.4, “Schedule of Deliverables” for details.)

A. Continuity of Operations Plan
B. Continuity of Operations Report

18.3 Contractor System Access

The Contractor must always provide VA and Contractors serving on the behalf of VA that have appropriate security and privacy agreements in place, with real-time, read-only access to the Contractor's system(s) that provide the functionalities required under this contract:

Table 19. Contractor Systems (Users per CCN Region)

Functionality	Users per CCN Region
Customer Service	750
Claims Processing	750
Data Repository	60
Contractor's Self Service Website (18.8)	Unlimited

The Contractor must always include user access control and user authentication information of the Contractor's systems as part of the implementation plan. The user access control and user authentication information must include defined roles and permissions, and the process for setting up and managing user accounts. The Contractor must always provide access via Application Programming Interfaces (API) for future use in VA application read-only access to the data required under this contract.

18.4 VA System Integration Requirements

The Contractor is required to integrate with VA's Data Access Service (DAS) to provide a standard interface for data access and storage of structured and unstructured data. For this DAS connection, the Contractor must enter into an Interconnection Security Agreement (ISA) with VA per the terms found in Attachment O "Interconnection Security Agreement with MOU." The Contractor must always be responsible for all documentation to certify its system meets all the requirements for information security, system certifications, and privacy in order to connect to all VA necessary systems. DAS is the approved gateway for sharing data between external and VA entities. The Contractor must always provide the details for its systems integration with DAS and an integration timeline in the implementation plan (see Attachment P Q R - DAS Gateway and Electronic Create Read Update Delete Service Information).

In the future, as further technology capabilities become available (i.e. Argonaut project mature, FHIR standards and API, for exchanging electronic health records), these more sophisticated methods will be adopted by VA in collaboration with the Contractor.

18.5 Veteran Demographic and Administrative Data

The VA will send the Contractor Veteran data through the DAS interface. VA will share updated data with the Contractor through DAS when pertinent Veteran demographic and/or administrative information is updated/changed. The interface will use secured connections (Hypertext Transfer Protocol Secure (HTTPS)) between Contractor servers and DAS servers. See Attachment H, "Eligibility Verification and Enrollment Data Exchange," and Section 18.4 for more information.

18.6 IT Customer Service

The Contractor must always provide customer service support to assist VA users with access to Contractor's systems and data as defined in this contract. IT Customer Service support must always be available via toll-free telephone and email Monday through Friday from 8AM and 6PM (excluding federal holidays) in all local time zones in the Contractor's assigned CCN Region

18.7 VA Community Care Provider Portal

VA will establish a Community Care Provider Portal that will allow the CCN provider to view a Veteran's EHR (capability available today) as well as the capability to track referral workflow and exchange data/documentation between VA and CCN providers (will be available by contract award). The type of data/documentation that could be exchanged through the portal includes referral information, medical documentation, DME/Medical Device prescriptions and Prior Authorization requests. In addition to providing network provider information, the Contractor must provide the VA a list of administrative and clinical support staff associated with each Network Provider that will require access to the VA Community Care Provider Portal (see section 18.15.1 Contractor Provider Data).

18.8 Contractor Self Service Website

The Contractor must provide a secure, role-based website (a single HTTPS) with functionalities for CCN providers, and VA Personnel. This Contractor-provided website will be separate and unique from the portal to be established by VA. The Contractor Self Service Website must always provide access to machine readable data as well as provide the capabilities as described in Section 6.4, "Contractor Customer Service Technology," and other parts of the PWS.

For CCN providers, the Contractor Self Service Website must always display (specific to Veterans they are authorized to care for): Veterans benefits, access to the VA Master provider directory search function, claims, information on the appeals and grievance processes, and provider manual.

For VA Personnel only, the Contractor Self Service Website must always provide access to the following: all submitted claims, and access to reporting capabilities that includes the ability to drill down to the Veteran level, as required in this PWS.

For VA Personnel and CCN Providers, the Contractor Self Service Website also must always provide access to real-time pharmacy dispensing data from the Contractor's PBM in order to prevent medication errors and maintain clear communication with network providers and patients. Pharmacy data required per Veteran with prescriptions filled by the PBM are:

- National Drug Code
- Drug Name
- Strength
- Quantity
- Dispensed and/or Adjudicated Date

18.9 Contractor Reporting and Data Submission

The Contractor must always make all reports, as required in this PWS, available to view and download as described in Section 18.8, "Contractor Self Service Website," Where required within the PWS, data elements/files must always be transmitted to VA in a nightly data extract, transform, load (ETL) (see Section 19.4, "Nightly Data Extract") via VA DAS described in Section 18.4.

18.10 Email Communication

The Contractor must always use a VA approved secure encrypted email when exchanging protected health information and personally identifiable information with VA through email communication.

18.11 Reserved

18.12 Submission of EDI Transactions

If available, the Contractor must always exchange all EDI transactions as required in this PWS. The Contractor must always transmit these EDI transactions in the current HIPAA-compliant standard format as required by HHS, which are listed for reference below:

1. The ASC X12 Standards for EDI TR3 - Health Care Services Review-Request for Review and Response (278), May 2006, ASC X12N/005010X217, and Version 5010 to Health Care Services Review-Request for Review and Response (278), ASC X12 Standards for EDI TR3, April 2008, ASC X12N/005010X217E1, as referenced in § 162.1302.
2. The ASC X12 Standards for EDI TR3 - Health Care Claim: Dental (837), May 2006, ASC X12N/005010X224, and Version 5010 to Health Care Claim Dental (837), ASC X12 Standards for EDI TR3, October 2007, ASC X12N/ 005010X224A1, as referenced in § 162.1102 and § 162.1802.
3. The ASC X12 Standards for EDI TR3 - Health Care Claim: Professional (837), May 2006, ASC X12N/005010X222, as referenced in § 162.1102 and § 162.1802.
4. The ASC X12 Standards for EDI TR3 - Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, and Version 501600 to Health Care Claim: Institutional (837), ASC X12 Standards for EDI Technical Report Type 3, October 2007, ASC X12N/ 005010X223A1, as referenced in § 162.1102 and § 162.1802.
5. The ASC X12 Standards for EDI TR3 - Health Care Claim Payment/Advice (835), April 2006, ASC X12N/005010X221, as referenced in § 162.1602.
6. The ASC X12 Standards for EDI TR3 – Additional Information to Support a Health Care Claim or Encounter (275), 2007, ASC X12N/005010X210.
7. American National Standards Institute (ANSI) ASC X12N/005010X279 270/271 Technical Report Type 3 (TR3) for Health Care Eligibility Benefit Inquiry and Response and its associated Errata 005010X279A1.

The EDI 275 transaction file must always include a Trace Number segment that contains the Provider Attachment Control Number. The EDI 837 transaction file must always include a Paperwork segment that contains the Attachment Control Number.

When additional accompanying EDI Standard Transactions are adopted and mandated by CMS for use at a future date, the Contractor must always comply with those EDI Standard Transactions by the compliance dates as specified by HHS.

18.13 Submission of Medical Documentation

The Contractor must always educate its CCN Healthcare Services Network Providers and CCN CIHS Network practitioners to submit medical documentation to VA via an accepted modality as outlined in Attachment S, "CC Data Flow Diagram", and in order of preference according to the list of preferred documentation listed below. If using Direct Messaging or eHealth Exchange, the file format must always be in Portable Document Format (PDF) format or use a Consolidated Clinical Document Architecture (CCDA) template. Initially, the Continuity of Care Document (CCD) is acceptable, but the ultimate template for receipt of findings from a referral is the Consultation Note CCDA.

Preferred Documentation Exchange Methods (* = will be available by contract award)

1. Community Care Provider Portal*
2. VA Health Information Exchange
3. Secure, Encrypted Email (Direct Messaging, Virtru Pro)
4. EDI 275 Attachments*
5. Secure Fax

18.14 Submission of OHI

The Contractor must always submit the OHI Report in Section 12.7.2 weekly through the DAS (see Section 18.4).

18.15 Provider Data Transfer

18.15.1 Contractor Provider Data

The Contractor must create and deliver a Network Provider File in accordance with the Schedule of Deliverables. The Contractor must submit an initial full Network Provider File (see Attachment U, "Data Specification" (tab 16-Master Provider File)) in accordance with the Schedule of Deliverables. After the initial delivery, the Contractor will submit weekly files thereafter until health care delivery is met. The government anticipates the need for delivery of the Network Provider Change File every two (2) to four (4) weeks after health care delivery. The contractor will be notified of the desired delivery frequency by the CO in writing. The Contractor must submit the Network Provider Change File (see Attachment U, "Data Specification" (tab 16-Master Provider File)) in accordance with the Schedule of Deliverables. Both the initial and change file submissions will utilize the DAS (see Section 18.4).

The Contractor must provide, at the kickoff meeting, a summary report of the network providers that identifies their listed locations and specialties.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Network Provider File
B. Network Provider Change File

18.15.2VA Provider Data

The Contractor must always use its copy of VA provider data to ensure VA providers have the ability to write prescriptions pursuant to Section 15.0, “Pharmacy.” VA will provide a copy of the detailed provider data daily as identified in Attachment U, “Data Specification” (tab 16-Master Provider File). VA will provide the Provider File format during the Kickoff Meeting. VA will transmit such provider data utilizing the DAS (see Section 18.4).

18.16 Section 508 – Electronic and Information Technology (EIT) Standards

On August 7, 1998, Section 508 of the Rehabilitation Act of 1973 was amended to require that when Federal departments or agencies develop, procure, maintain, or use Electronic and Information Technology (EIT), that they shall ensure it allows Federal employees with disabilities to have access to and use of information and data that is comparable to the access to and use of information and data by other Federal employees. Section 508 required the Architectural and Transportation Barriers Compliance Board (Access Board) to publish standards setting forth a definition of electronic and information technology and the technical and functional criteria for such technology to comply with Section 508.

These standards have been developed and are published with an effective date of December 21, 2000. Federal departments and agencies shall develop all Electronic and Information Technology requirements to comply with the standards found in 36 CFR 1194.

The Section 508 standards established by the Architectural and Transportation Barriers Compliance Board (Access Board) are incorporated into, and made part of all VA orders, solicitations and purchase orders developed to procure EIT. These standards are found at: https://www.access-board.gov/guidelines-and-standards/communications-and-it/about-the-section-508-standards/section-508-standards and https://www.section508.gov/content/learn. A printed copy of the standards will be supplied upon request. The Contractor shall comply with the technical standards as marked:

§ 1194.21 Software applications and operating systems
X § 1194.22 Web-based intranet and internet information and applications
§ 1194.23 Telecommunications products
§ 1194.24 Video and multimedia products
§ 1194.25 Self-contained, closed products
§ 1194.26 Desktop and portable computers X § 1194.31 Functional Performance Criteria
X § 1194.41 Information, Documentation, and Support

18.16.1Equivalent Facilitation

Alternatively, offerors may propose products and services that provide equivalent facilitation, pursuant to Section 508, subpart A, §1194.5. Such offerors will be considered to have provided equivalent facilitation when the proposed deliverables result in substantially equivalent or greater

access to and use of information for those with disabilities.

18.16.2 Compatibility With Assistive Technology

The Section 508 standards do not require the installation of specific accessibility-related software or the attachment of an assistive technology device. Section 508 requires that the EIT be compatible with such software and devices so that EIT can be accessible to and usable by individuals using assistive technology, including but not limited to screen readers, screen magnifiers, and speech recognition software.

18.16.3 Acceptance And Acceptance Testing

Deliverables resulting from this solicitation will be accepted based in part on satisfaction of the identified Section 508 standards' requirements for accessibility and must include final test results demonstrating Section 508 compliance.

Deliverables should meet applicable accessibility requirements and should not adversely affect accessibility features of existing EIT technologies. The Government reserves the right to independently test for Section 508 Compliance before delivery. The Contractor shall be able to demonstrate Section 508 Compliance upon delivery.

Automated test tools and manual techniques are used in the VA Section 508 compliance assessment. Additional information concerning tools and resources can be found at http://www.section508.va.gov/section508/Resources.asp.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Final Section 508 Compliance Test Results

19.0 DATA ANALYTICS

19.1 Data Specification

VA has provided, in Attachment U, "Data Specification," a compilation of data fields for each report called out in this PWS. Contractors are invited to propose the use of additional data elements for use in reports for consideration by VA. The fields, their type, and definition will be used by all Contractors in order to provide all parties with a uniform understanding of meaning for data fields and the reports. VA has provided VA Identity Management data specification for those data fields that VHA Identity Management has developed for use in VA Master Veteran Index (MVI). All data reports and data repositories and interactive dashboards must always incorporate these fields in the manner specified by VHA Identity Management, as shown in Attachment V, "MVI Identity Management Data Specifications."

19.2 Data Repository and Data Repository Relational Database Schema

It is the intention of VA to standardize all data elements to be used by VA and all Contractors by providing a data specification for fields to be used in reporting, repositories, and dashboards. It is the intention of VA to have all Contractors use the same relational database schema from which

reports will be derived.

VA has provided, in Attachment W, "Data Repository Schema," a proposed relational database repository schema to be used in the creation of a data repository by all Contractors. VA invites Contractors to propose additional fields for use in the schema. Contractors may propose additional tables. VA will standardize the report format, the report data column headers, the report data column field definitions, and the relational database schema for all Contractors within thirty (30) days of award.

The Contractor must create a Data Repository that reflects data the Contractor has collected on Veterans based on the VA provided schema, in accordance with the Schedule of Deliverables. The data repository must always allow VA-designated personnel to access the Contractor's data information system/data repository, permitting VA to extract a copy of the Contractor's data. This requirement does not require direct access to the Contractor's production system(s). The Contractor must always make available sixty (60) user accounts per CCN region to be assigned at the discretion of VA. The Contractor must always manage the list of user accounts based on approved users provided by VA COR throughout the PoP.

All Contractor data contained in the Contractor data repository must always be current and updated with new data no less frequently than daily and must always be accessible to all VA-designated personnel.

The Contractor's data repository must always provide the user the capability to download and retrieve automated and *ad hoc* data to VA in a format that is in Excel and/or acceptable to Structured Query Language (SQL) tables. VA access to the Contractor's data analytics application will be mutually agreed upon by the Contractor and VA and will be included as part of the implementation plan. The Contractor must develop and provide a Data Definitions Dictionary. VA will review all Data Definitions and approve one Contractor Data Definitions Dictionary for use by the Contractor. The Contractor must always use the Data Definitions Dictionary approved by VA. The Contractor must always provide initial and ongoing training for accessing the Contractor's repository. Web-based training is an acceptable training method.

Deliverables: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Contractor Data Repository
B. Data Definitions Dictionary

19.3 Reserved

19.4 Nightly Data Extract

The Contractor must always provide, in accordance with the Schedule of Deliverables, a nightly data ETL to VA that includes updates to the relational database and is acceptable for upload into a SQL database. VA will provide the Contractor with access to DAS. DAS is a VA approved secure data transfer system. VA will approve file names to be used for each ETL so that VA DAS can properly route the ETL to the appropriate VA database. The Contractor must always format the

nightly data extract based on the Relational Database Schema (Attachment W, "Data Repository Schema."

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Nightly ETL's of specified data

19.5 Data Integrity

A data integrity issue is identified when an ETL thru DAS is rejected at the receiving VA database. VA will notify the Contractor of the ETL failure when it is noted by VA staff which will normally be the next business day. VA reserves the right to identify data integrity issues with physical or logical properties. ETL's to VA DAS that are rejected for non-compliance with the VA provided specification must be corrected within two (2) business days of notification by VA. Any other data integrity issue identified by VA must be corrected within thirty (30) days of observation and notification of the Contractor by VA.

The Contractor must always clean and validate data stored in the data repository and data to be transmitted to VA daily so that it conforms to the agreed upon data specification for each field. The Contractor must always provide a Monthly Data Integrity report to VA in accordance with the Schedule of Deliverables. The Data Integrity report must always include all open data integrity issues found by the Contractor and issues reported by VA. The Data Integrity report must always include the data issue description, date identified, action to fix, resolution status, and resolution date. The Contractor must always resolve data integrity issues identified by Contractor or VA within two (2) business days of notification.

Deliverable: (See Section 20.4, "Schedule of Deliverables" for details.)

A. Monthly Data Integrity Report

20.0 DELIVERABLES

The Contractor must always be prepared to comply with requests for information, including those originating from Congress, using company letterhead, complete sentences, and professional English. The Contractor must always comply with the request of Government and independent auditors during audits of this contract and all associated contract documentation, including but not limited to, invoices and medical records.

20.1 Delivery Address

Deliverables must always be submitted to the COR designated in the COR appointment letter, unless otherwise specified in the PWS.

20.2 Method of Delivery

Electronic copies must always be delivered using Microsoft Office suite of tools (for example, Word, Excel, PowerPoint, Project, or Access format) unless otherwise specified in the PWS or by the CO/COR.

20.3 Government Acceptance

The COR will have ten (10) business days after receipt to review deliverables, notate deficiencies, or make other comments. The Contractor must always have five (5) business days after receipt of returned deliverables to make corrections. Upon receipt of the resubmitted deliverables, the COR will have five (5) business days for final review prior to acceptance or providing documented reasons for rejection for failure to comply with Contract requirements.

In the event of a rejected deliverable, the Contractor will be notified in writing by the COR of the specific reasons for rejection. The Contractor must always have five (5) business days to correct the rejected deliverable and return it per delivery instructions.

20.4 Schedule of Deliverables

Monthly deliverables must always be delivered on the 10th day after the end of the previous month, unless otherwise specified in the PWS.

Quarterly deliverables: VA's fiscal year begins October 1 and ends on September 30. The initial quarterly deliverable will be delivered on the 15th day of VA Fiscal quarter following SCHD.

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
1	2.2	A	Kickoff Meeting Presentation	Five (5) days before scheduled kickoff meeting	VA Program Manager (PM), COR, CO
2	2.2	B	Meeting Minutes	Five (5) days after kickoff meeting	VA PM, COR, CO
3	2.3	A	Project Management Plan	At the kickoff meeting and updated monthly thereafter	VA PM, COR, CO
4	2.3.1	A	Implementation Strategy	At the kickoff meeting	VA PM, COR, CO
5	2.3.1	B	Twice Monthly Status Reports	15th and 30th (or 31st) of month following start of transition through implementation	VA PM, COR, CO

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
6	2.3.2	A	CCN Deployment Plan	At the kickoff meeting and updated monthly thereafter until completion of deployment	VA PM, COR, CO
7	2.4	A	Risk Management Plan	At the kickoff meeting and updated monthly thereafter	VA PM, COR, CO
8	2.4	B	Project Risk Register	At the kickoff meeting and updated as needed	VA PM, COR, CO
9	2.5.1	A	Quality Assurance Plan	At the kickoff meeting and updated annually thereafter	VA PM, COR, CO
10	2.5.2	A	Quarterly Progress Reports	First report due at the end of the federal fiscal quarter following award and then quarterly thereafter	VA PM, COR, CO
11	2.5.2	B	Monthly Progress Reports	Monthly, by the 10th day of each month	VA PM, COR, CO
12	2.6	A	CCN Communications Plan	At the kickoff meeting and updated as needed thereafter	VA PM, COR, CO
13	2.7	A	Documentation of Accreditation	At time of award or upon receipt, as applicable, and upon renewal thereafter	VA PM, COR, CO

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
14	2.8.2	A, B, C, D	Initial: SOC 1, Type 2 – Prime Report SOC 2, Type 2 – Prime Report SOC 1, Type 2 –Subcontractor Report SOC 2, Type 2 –Subcontractor Report	Must cover a minimum of nine (9) months from contract award and be submitted NLT July 31st of the first year of performance	VA PM, COR, CO
15	2.8.2	A, B, C, D	Subsequent SOC Reporting: SOC 1, Type 2 – Prime Report SOC 2, Type 2 – Prime Report SOC 1, Type 2 – Subcontractor Report SOC 2, Type 2 – Subcontractor Report	Must cover a minimum of 12 months and be submitted NLT July 31 of each performance year after initial report, except as directed by VA in the implementation year	VA PM, COR, CO
16	2.8.2	E	SOC 1 and SOC 2 Bridge Letter	Fifteen (15) days after the end of the VA fiscal year	VA PM, COR, CO
17	2.8.2	F	Corrective Action Plan	Seven (7) business days after written notification that the CAP is required	VA PM, COR, CO
18	2.9.2	A	Transition Out Plan	One hundred eighty (180) days after award	VA PM, COR, CO
19	2.9.2	B	Weekly status report of claims inventories and phase-out activities	Weekly following end of contract and start of transition to either VA or new Contractor	VA PM, COR, CO
20	3.4	A	CCN Healthcare Services Network Quality and Performance Criteria Template	Throughout the PoP	VA PM, COR, CO
21	3.4	B	High Performing Provider Quality and Performance Data	Thirty (30) days after SHCD and updated quarterly thereafter	VA PM, COR, CO

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
22	3.6	A	Network Adequacy Plan	At the kickoff meeting and VA requires a minimum of thirty (30) days for review and approval	VA PM, COR, CO
23	3.6	B	Network Adequacy Performance Report	Thirty (30) days after SHCD and quarterly thereafter	VA PM, COR, CO
24	3.6	C	Network Adequacy CAP	Within ten (10) days of discovery of performance deficiencies	VA PM, COR, CO
25	3.7.1	A	Documentation of Accreditation/Annual Attestation	At time of award or upon receipt, as applicable, and upon renewal of accreditation thereafter. Annual attestation due date to be determined during the contract kickoff meeting.	VA PM, COR, CO
26	6.1	A	VA Support Call Center Training Documents and Response Scripts	Fourteen (14) days prior to implementation	VA SME identified by VA
27	6.2	A	CCN Provider Call Center Training Documents and Response Scripts	Fourteen (14) days prior to implementation	VA SME identified by VA
28	6.5	A	CCN Veteran Complaints and Grievances Call Center Process	Thirty (30) days prior to SHCD	VA PM, COR, CO
29	6.7	A	CCN Provider Satisfaction Survey Results	60 days following the conclusion of the survey quarter	VA PM, COR, CO
30	6.8	A	Contractor Call Center Operations and Customer Service Technology Performance Report	Monthly after SHCD	VA PM, COR, CO

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
31	10.1	A	Training Plan	Fifteen (15) days after kickoff meeting and updated annually after HCD and thirty (30) days prior to the effective date of any material change	VA PM, COR, CO
32	10.1.1	A	Annual Training Program Curriculum	Sixty (60) days after kickoff and annually thereafter and updated thirty (30) days prior to the effective date of any material change	VA PM, COR, CO
33	10.2	A	Training Materials	Ninety (90) days after kickoff and annually thereafter and thirty (30) days prior to the effective date of any material change	VA PM, COR, CO
34	10.2	B	Review of Training Materials Report	Ninety (90) days after HCD and annually thereafter and thirty (30) days prior to the effective date of any material change	VA PM, COR, CO
35	11.1.3	A	Discharge Planning Plan	Thirty (30) days prior to execution	VA PM, COR CO
36	11.1.4	A	Appointment Scheduling and Comprehensive Care Coordination Plan	Thirty (30) days after contract award	VA PM, COR CO
37	11.1.4	B	Appointment Scheduling and Comprehensive Care Coordination Implementation Plan	Thirty (30) Days after this optional task is exercised	VA PM, COR, CO

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
38	11.1.4	C	Appointment Scheduling and Comprehensive Care Coordination Adequacy Performance Report	Monthly	VA PM, COR, CO
39	11.1.4	D	Appointment Scheduling and Comprehensive Care Coordination Adequacy CAP	Within ten (10) days of discovery of performance deficiencies	VA PM, COR, CO
40	11.1.4	E	Daily Appointment and Scheduling Comprehensive Care Coordination Report	Daily	VA PM, COR, CO
41	11.2	A	Care Coordination Follow-Up Plan	Within thirty (30) days after the optional task is exercised	VA PM, COR, CO
42	11.2	B	Daily Care Coordination Follow-Up Report	Daily	VA PM, COR, CO
43	11.3	A	Comprehensive Case Management Plan	Within thirty (30) days after the optional task is exercised	VA PM, COR, CO
44	11.3	B	Comprehensive Case Management Progress Report	Monthly	VA PM, COR, CO
45	11.4	A	Comprehensive Disease Management Plan	Within thirty (30) days after the optional task is exercised	VA PM, COR, CO
46	11.4	B	Comprehensive Disease Management Progress Report	Monthly	VA PM, COR, CO
47	12.1.1	A	Claims Processing Data Dictionary	Thirty (30) days after kickoff meeting and updated at least thirty (30) days prior to the effective date of any material change	VA PM, COR, CO

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
48	12.3.1	A	Signature on File Procedure	At the kickoff meeting and updated thirty (30) days prior to any effective change	VA PM, COR, CO
49	12.6	A	EDI 835 Transaction File	Daily after payment of first claim	VA PM, COR, CO
50	12.7.1	A	Coordination of Benefits Plan	At the kickoff meeting and updated at least thirty (30) days prior to the effective date of any material change	VA PM, COR, CO
51	12.7.2	A	OHI Verification and Retrieval Plan	At the kickoff meeting and updated thirty (30) days prior to the effective date of any material change	VA PM, COR, CO
52	12.7.2	B	OHI Report	Weekly after SCHD	VA PM, COR, CO
53	12.9	A	Quarterly Cost Avoidance and Recovery/Recoupments Report	Ninety (90) days after payment of first claim and quarterly thereafter within thirty (30) days following the last day of each quarter	VA PM, COR, CO

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
54	12.9	B	Audit *Ad hoc* Reports	VA will request any *Ad hoc* report by email to the contract POC. The Contractor must always provide *Ad hoc* reports three (3) business days after the request. Requests for *Ad hoc* reports will not exceed eight (8) per year.	VA PM, COR, CO
55	12.12	A	EDI 837 Transaction File	Daily	VA PM, COR, CO
56	12.12	B	Weekly Claims Processing Reports	Weekly after payment of first claim	VA PM, COR, CO
57	12.12	C	Quarterly Claims Audit Reports	Thirty (30) days after the end of the first quarter following the SHCD, and within thirty (30) days after the end of each quarter thereafter	VA PM, COR, CO
58	12.14.2	A	Quarterly IPERA Audit & Root Cause	Quarter 1 of Year 1 is due July 31 of Year 2, then each subsequent report is due quarterly on September 30th, December 31st, March 31st, July 31st for the PoP	VA PM, COR, CO
59	12.14.3	A	Annual Auditing Plan	March 31 in the year prior to the review	VA PM, COR, CO

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
60	12.14.3	B	Independent Auditor Quarterly Report	Quarter 1 of Year 1 is due July 31 of Year 2, then each subsequent report is due quarterly on September 30th, December 31st, March 31st, July 31st for the PoP	VA PM, COR, CO
61	12.14.3	C	Annual Independent Auditor Statistical Projection of Improper Payments	June 1st	VA PM, COR, CO
62	12.14.3	D	Post Audit Findings and Recovery Report	Ten (10) days after the stated audit cycle	VA PM, COR, CO
63	12.14.6	A	Overpayments Electronic File	Ten (10) days after the stated audit cycle	VA PM, COR, CO
64	13.2	A	Provider Claim Denial Reconsideration Process	At the kickoff meeting and updated thirty (30) days prior to the effective date of any material change	VA PM, COR, CO
65	14.1	A	Clinical Quality Monitoring Plan	At the kickoff meeting and updated thirty (30) days prior to the effective date of any material change	VA PM, COR, CO
66	14.2	A	Quarterly Clinical Quality and Patient Safety Issues Report	Ninety (90) days after SHCD and Quarterly thereafter	VA PM, COR, CO

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
67	15.1	A	Monthly Electronic Urgent/Emergent Prescription Report	Thirty (30) days after SHCD and updated monthly thereafter	VA PM, COR, CO
68	15.1	B	Monthly Electronic Prior Authorization Report (To Include Continued Need Justifications)	Thirty (30) days after SHCD and updated monthly thereafter	VA PM, COR, CO
69	15.2	A	Pharmacy Adequacy Plan	At the kickoff meeting	VA PM, COR, CO
70	15.2.1	A	Monthly Urgent/Emergent Prescription Performance Metrics Report	Thirty (30) days after SHCD and monthly thereafter	VA PM, COR, CO
71	15.4	A	Electronic Disaster Response Prescription Report	On a monthly basis during the period for which services are provided and for ninety (90) days following the end of the service	VA PM, COR, CO
72	18.2	A	Continuity of Operations Plan	Fifteen (15) days after kickoff meeting and updated thirty (30) days prior to the effective date of any material change	VA PM, COR, CO
73	18.2	B	Continuity of Operations Report	Quarterly after SHCD	VA PM, COR,
74	18.15.1	A	Network Provider File	At the kickoff meeting	VA PM, COR, CO

Item	PWS Task	ID	Deliverable Description	Due Date	Electronic submission to:
75	18.15.1	B	Network Provider Change File	Weekly after the initial, full Network Provider File up until HCD; Post HCD every two (2) – four (4) weeks as directed by the CO	VA PM, COR, CO
76	18.16.3	A	Final Section 508 Compliance Test Results	Six (6) months after Award	VA PM, COR, CO
77	19.2	A	Contractor Data Repository	Sixty (60) days prior to SHCD	VA PM, COR, CO
78	19.2	B	Data Definitions Dictionary	At the kickoff meeting	VA PM, COR, CO
79	19.4	A	Nightly ETL's of specified data	Daily after SHCD	VA PM, COR, CO
80	19.5	A	Monthly Data Integrity Report	One (1) week after SHCD and monthly thereafter	VA PM, COR, CO
81	A.2 CLIN 13	N/A	All Technical Data in accordance with Section B.4 and B.16	As indicated throughout B.16 and prior to contract closeout	VA PM, COR, CO
82	B.3,3. Informa -tion Security	A	Contractor Security Control Assessment (CSCA)	Thirty (30) days after award and yearly thereafter	VA PM, COR, CO
83	B.15,1.4. 9.	A	Annual PMPM Reconciliation Report	Ninety (90) days after option year / contract year	VA PM, COR, CO

Term	Definition
Active Veteran	A Veteran who has a Community Care claim paid by the Contractor during the billing month.

Term	Definition
Ancillary Provider	Providers who perform diagnostic or therapeutic services as an adjunct to basic medical or surgical services.
Approved Referral	Department of Veterans Affairs (VA)-Approved Referral constitutes an order under this contract. Approved Referrals from VA will support a specific plan of care as it relates to a specified number of visits and/or services related to a Standard Episode of Care as long as the services are provided by a Community Care Network (CCN) provider.
Average Speed of Answer	The average time it took for a call to be answered by an agent from when the caller first selected the option to speak to an agent. Does NOT include abandoned calls.
Blockage Rates	The percentage of callers that received a busy tone when they called.
Call Abandonment Rates	The percentage of contacts that spent time waiting to speak to an agent and then hung-up or otherwise exited the system before being offered to an agent. These calls are not resolved in the Interactive Voice Response (IVR).
Catchment Area	The geographical area served by a Department of Veterans Affairs (VA) Facility.
Claim	An invoice for healthcare, dental or pharmacy services submitted to the Contractor from in-network or out-of-network providers. This term also includes a request for payment of healthcare, dental or pharmacy services from the Contractor to VA. As used in the Performance Work Statement (PWS), this term does not include the meaning of the term "claim" as defined in FAR 2.101.
Clean Claim	A claim that contains all the required data elements necessary for adjudication without requesting supplemental information from the submitter.
Community Care Network (CCN)	Community Care Network (CCN) contracts to be awarded across specified regions to provide a network of licensed healthcare providers and practitioners for medical, surgical, complementary and integrative health services (CIHS), durable medical equipment (DME), pharmacy, and dental services. This acquisition is for one of those CCN regions. Once implemented contracts will be the preferred method of obtaining care from community providers
Complaint	Any expression of an actual or perceived issue.
Community Care Contact Center (VA)	The Community Care Contact Center, established by VHA Office of Community Care, to address customer service issues.
Critical Finding	Those findings or results that require immediate evaluation by a healthcare provider such that failure to take immediate appropriate action might result in death, significant morbidity, or serious adverse consequences to the Veteran.
Data Access Service	VA approved secure data transfer system

Term	Definition
Days	All days within the PWS are calendar days unless otherwise noted. When "business day" is noted, business day is defined as Monday through Friday, excluding standard Federal Holidays and any other day specifically declared to be a national holiday.
Durable Medical Equipment (DME)	Equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.
Electronic Messaging	Any one on one communications leveraging technology. Could include online/instant messaging, secure email, or similar capabilities.
Eligible Veteran	Any Veteran who is eligible to receive care in the community.
Emergent Care	Medical care required within twenty-four hours or less essential to evaluate and stabilize conditions of an emergent need that if not provided may result in unacceptable morbidity/pain if there is significant delay in the evaluation or treatment. Emergent and emergency can be used interchangeably and has the same meaning throughout the PWS.
Emergent Need	Conditions of one's health that may result in the loss of life, limb, vision, or result in unacceptable morbidity/pain when there is significant delay in evaluation or treatment.
Enrolled Veteran	Any Veteran who is enrolled in VA's patient enrollment system and is eligible to receive healthcare benefits.
Standardized Episode of Care	A set of clinically related healthcare services for a specific unique illness or medical condition (diagnosis and/or procedure) provided by an authorized provider during a defined authorized period of time not to exceed one year.
Expired Approved Referral	An Approved Referral that has passed the end date.
First Call Resolution	The percentage of calls where the agent resolves the caller's issue without escalating, transferring, or returning the call.
Full Healthcare Delivery (HCD)	Total healthcare delivery of all CCN services at all sites or locations within an awarded CCN Region.
Specialty Care	All other care and services offered under VA Health Benefit Package other than Primary Care and complementary and integrative health services (CIHS).
Grievance	A written Complaint on an actual or perceived issue
Highly Rural Care Area	Any Highly Rural Location, any Critical Access Hospital or any geographic location that necessitates a reimbursement greater than Medicare rates in order to maintain network adequacy.

Term	Definition
Highly Rural Location	Defined as a sparsely populated area located in a county that has fewer than seven individuals residing in that county per square mile.
Julian Date	The continuous count of days since the beginning of the calendar year; January 1st being "1" and December 31st being day "365".
Medical Device	An instrument, apparatus, implement, machine, contrivance, or other similar or related article, including a component part or accessory, which is intended for use in the cure, mitigation, or treatment of disease or compensates for a person's loss of mobility or other bodily functional abilities and function as a direct and active component of the person's treatment and rehabilitation.
Non-service Connected Care	Medical care and services provided for a Veteran for an illness or injury that was not incurred in or aggravated by military service as determined by VA.
Ordering Officer	A VA employee, delegated in writing by the Contracting Officer (CO), to order services under the contract via issuance of Approved Referrals (in Section B.14, and PWS sections 4.0 and 7.0). There are two types of Ordering Officers under this contract: 1. Designated Ordering Officers with Routine referral authority and 2. Designated Ordering Officers with Elevated referral authority. Designated Ordering Officers with Routine referral authority may purchase all care under this contract, except for services identified in Section 7.4 of the PWS. Designated Ordering Officers with Elevated referral authority may purchase all care under this contract, to include those services specified in Section 7.4 of the PWS.
Primary Care	Healthcare at a basic rather than a specialty level.
Prior Authorization	A required process through which VA reviews and approves certain medical services to ensure the medical necessity and appropriateness of care prior to services being rendered within a specified timeframe from a non-VA provider or additional resources in the community. This type of process requires Prior Authorization be obtained "prior to" the specified service.
Referral Request	A request and approval process that authorizes the Veteran to obtain specified care within a specified timeframe from additional resources in the community. Upon approval, a referral number is generated. The referral number must always be included on claims submitted by CCN providers for payment.
Response Accuracy	The percentage of calls where the response provided by the Call Center is accurate and complete according to the terms of the contract. One mechanism for tracking this is the use of an automated survey at the end of the communication with the customer service representative session.

Term	Definition
Root Cause Analysis	A process or procedure that helps guide people to discover and understand the initiating causes of a problem, with the goal of determining missing or inadequately applied controls that will prevent recurrence.
Rural	Areas not designed as Urban or Highly Rural Location.
Scarce Medical Specialist Services	A scarce medical resource is defined as any health care examination or treatment that has significantly reduced access due to geographic location, lack of providers to support patient demand, lack of equipment or technology to provide necessary services, or any other factors negatively impacting access regardless of geographic designation, i.e., urban, rural, or highly rural.
Service Connected Care	Medical care and services provided for a Veteran for a Service-Connected (SC) condition is an illness or injury adjudicated by the Veterans Benefits Administration (VBA) as having been incurred or aggravated in line of duty in the active military, naval, or air service.
Solution	All components of the Contractor's response and planned execution of the High Performing Network, claims processing, medical administrative management, customer service, and technology components.
Start of Healthcare Delivery (SHCD)	The beginning of healthcare delivery at a site or location within an awarded CCN Region.
State	One of the fifty (50) states of the United States, District of Columbia, U.S. Virgin Islands, Puerto Rico, Northern Mariana Islands, Guam, and American Samoa.
Service Availability	Services and applications being available, whether it is during abnormal system operation or software upgrade regardless of hardware or software failure.
Service Unavailability	"Service Unavailability" consists of the number of hours that the systems were not available. Calculation of Service Unavailability must not include any time the service is unavailable due to scheduled maintenance.
Site	The entire Catchment Area of a specific VA Facility, as identified by VA.
Tribal Health Services	Tribal health programs are defined as services contracted by tribes, from the Indian Health Service, through the authority of Public Law 93-638 (the Indian Self Determination and Education Assistance Act).
Urban	Census tracts with at least thirty (30) percent of the population residing in an urbanized area as defined by the Census Bureau.
Urgent Care	Provision of immediate medical service offering outpatient care for the treatment of acute and chronic illness or injury.

Term	Definition
VHA Office of Community Care (OCC)	VHA office designated to support CCN Region under this contract.
VA Facility	A VA Facility is a VA Hospital or VA Medical Center.
VA Hospital	A VA hospital is any VA-owned, staffed, and operated facility providing acute inpatient and/or rehabilitation services.
VA Medical Center	A VA medical center is a VA point of service that provides at least two categories of care (inpatient, outpatient, residential, or institutional extended care).
Warm Transfer	When the agent who is currently speaking with the caller (and wishes to transfer them) speaks with the new agent before the call is transferred and introduces the caller to the new agent.
Work Breakdown Structure	A hierarchical decomposition that organizes work into manageable portions of the total scope of work to be carried out to accomplish the project objectives.

Acronyms

Acronym	Definition
AAHHS	Accreditation Association for Hospitals/Health Systems
ACR	Adverse Credit Reporting
ADA	American Dental Association
AICPA	American Institute of Certified Public Accountants
ANSI	American National Standards Institute
API	Application Programming Interface
ART	Assisted Reproductive Technology
AT	Attestation Standards
AWP	Average Wholesale Price
CAP	Corrective Action Plan
CARF	Commission on Accreditation of Rehabilitation Facilities
CCD	Continuity of Care Document
CCDA	Consolidated Clinical Document Architecture template

Acronym	Definition
CCN	Community Care Network
CCPP	Community Care Provider Portal
CDT	Current Dental Terminology
CFR	Code of Federal Regulations
CFU	Criteria for Use
CHAMPUS	Civilian Health and Medical Program of Uniformed Service
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CIHS	Complementary and Integrative Health Services
CMS	Centers for Medicare and Medicaid Services
CLIN	Contract Line Item Number
CO	Contracting Officer
COB	Coordination of Benefits
CoE	Centers of Excellence
COO	Continuity of Operations
COOP	Continuity of Operations Plan
COR	Contracting Officer's Representative
CPT	Current Procedural Terminology
CQPSIP	Clinical Quality and Patient Safety Improvement Program
CQMP	Clinical Quality Monitoring Plan
DAF	Data Access Framework
DAS	VA's Data Access Service
DEA	Drug Enforcement Agency
DME	Durable Medical Equipment
eCRUD	Electronic, Create, Read, Update, Delete
ED	Emergency Department

Acronym	Definition
EDI	Electronic Data Interchange
EDIPI	Electronic Data Interchange Patient Identifier
EHR	Electronic Health Record
EIT	Electronic and Information Technology
EOB	Explanation of Benefits
EMG	Emergency
EMTALA	Emergency Medical Treatment and Labor Act
ETL	Extract, Transform, Load
FAR	Federal Acquisition Regulation
FDA	Food and Drug Administration
FHIR	Fast Healthcare Interoperability Resources
FQHC	Federally Qualified Health Centers
FWA	Fraud Waste and Abuse
FY	Fiscal Year
HCD	Full Healthcare Delivery
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HTTPS	Hypertext Transfer Protocol Secure
ICD	International Classification of Diseases
ICN	Internal Control Number
IDIQ	Indefinite Delivery/Indefinite Quantity
IMS	Integrated Master Schedule
IPERA	Improper Payments Elimination and Recovery Act
IQI	Identified Quality Issues

Acronym	Definition
ISA	Interconnection Security Agreement
ISI	Identified Safety Issues
IT	Information Technologies
IVF	In-Vitro Fertilization
IVR	Interactive Voice Response
MOU	Memorandum of Understanding
MPR	Monthly Progress Report
MVI	Master Veteran Index
NCPDP	National Council for Prescription Drug Programs
NPI	National Provider Identifier
OAT	Oral Appliance Therapy
OCC	Office of Community Care
OHI	Other Health Insurance
OIG	Office of Inspector General
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OO	Ordering Officer
OSA	Obstructive Sleep Apnea
PBM	Pharmacy Benefits Management
PC3	Patient Centered Community Care
PDF	Portable Document Format
PM	Program Manager
PMR	Program Management Review
POC	Point of Contact
PoP	Period of Performance

Acronym	Definition
PQI	Potential Quality Issues
PSI	Potential Safety Issue
PWS	Performance Work Statement
QASP	Quality Assurance Surveillance Plan
QAP	Quality Assurance Plan
QPR	Quarterly Progress Report
RA	Remittance Advice
RMP	Risk Management Plan
SC	Service-Connected
SCORM	Shareable Content Object Reference Model
SEOC	Standardized Episode of Care
SHCD	Start of Healthcare Delivery
SME	Subject Matter Expert
SOC	Service Organization Controls
SQL	Structured Query Language
SSAE 18	Statement on Standards for Attestation Engagements No. 18
SSN	Social Security Number
THS	Tribal Health Services
TIN	Tax Identifier Number
UCC	Urgent Care Center
U.S.C.	United States Code
WBS	Work Breakdown Structure
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Heath Administration

Acronym	Definition
VISN	Veterans Integrated Service Network