

PWS Section	Item #	QUESTION/COMMENT/SUGGESTION RECEIVED FROM INDUSTRY:	FINAL CONSOLIDATED RESPONSE FOR POSTING
3.7	38	<p>"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(...)The report must always contain information detailing the reasons for and circumstances related to the loss or adverse impact. "</p> <p>Further clarification is needed in regards to the provider information that the contractor would be expected to pass to VHA. Sanctions data is, in keeping with industry standards, considered privileged information between the Contractor and the provider. The discussion and crafting of a report that can be shared with VHA and clients will need to involve internal legal counsel. This may also require an update to the provider contract indicating that information will be shared.</p>	Further clarification can be discussed during implementation.
G.3	56	Section G.3 IT Contract Security has a requirement for contract personnel to have an active security clearance. What level security clearance is required and what types of classified data might contract personnel be dealing with?	We are looking further into whether or not a security clearance or background investigation will be required for this solicitation. A final determination will be provided upon contract award.
Section L of the Solicitation Instructions to Offerors	77	<p>a. When will complete instructions to offerors be provided?</p> <p>b. Can the Contractor assume that the instructions will be largely modeled on the previous CCN Regions 1-4 Solicitation?</p> <p>c. This offeror would like to encourage VHA to cross-reference the instructions to the specific PWS sections and requirements, as it did in the Regions 1-4 procurement (E.2.8). The offeror would also like to suggest that if included in the Region 4 instructions, terms such as "clinical outcomes" and "health outcome improvements" should be defined and provided a context within the RFP.</p>	a) The Final Solicitation will contain instructions to offerors for proposal development. b) No, the contractor should not assume modeling and instead should adhere to the criteria stipulated in the final solicitation. c) The VA will consider these suggestions for inclusion.
2.3	49	PWS 2.3 states the Contractor must provide a listing of its transition team members and team lead who is responsible for coordinating with VHA and the incumbent Contractors to identify the documentation, access to personnel and system access necessary to begin the process of reaching operating capability. Please provide details on the types of activities that would require coordination with the incumbent contractor. Specifically, are there any requirements for the contractor to assume workloads or transition data from the incumbent contractor?	The Contractor will coordinate the VA and incumbent contractor accordingly to achieve smooth transition from existing community care contract/program to CCN in a manner that ensures continuity of care. There is no requirement for the contractor to assume any existing workloads or transition of data from the incumbent contractor. Any data required for CCN will be coordinated between VA and the contractor.
3.2	5	<p>Provider Networks: "VHA will provide additional Fiscal Year 2018 (FY18) utilization data after contract award."</p> <p>How many days after contract award will this data be provided to the Contractor?</p>	A date will be established at the kickoff meeting with the COR.
3.2	20	3.2 Please confirm that it is the intent of VHA to eliminate from Region 4 the requirement for feedback from Veterans about their satisfaction of CCN providers?	This is no longer a requirement for CCN, however "satisfaction of the Veterans with service and quality of care" is in the Mission Act in § 1703C Standards for Quality. VA will address this requirement through other means.
3.7	71	Will hospital based providers be included in the scope of practitioners requiring credentialing?	Yes, however VA's intent is that the Contractor will validate the credentialing requirements in Section 3.7 of the PWS to the extent necessary to satisfy the requirements and determine which hospital based providers will be included in the scope of practitioners. In accordance with FAR 52.212-4(q) "Other compliances," the Contractor shall comply with all applicable Federal, State and local laws, executive orders, rules and regulations applicable to its performance under this contract.
Attachment E - Summary Demand Data	80	To better understand how VHA categorizes specific healthcare services listed in the Referrals by VISN for FYXX worksheets, can VHA provide a list of sub-specialties it has included under the following labels: 1) Orthopedics; 2) Cardiology; and 3) Dental.	No. VA's categories of care specialties are listed in Attachment E. Data on additional sub-specialties is not available.
18.15	26	Master Provider File - Many of the enumeration lists do not align to available standards (FHIR, Argonaut work). Can we expect the enumeration lists to align to industry standard, where applicable?	See Attachment U, Tab 16 - Master Provider File in the solicitation.
3.6	31	Regarding "Network Adequacy Reporting" fields from attachment U, how will Contractor report on missed, cancelled, rescheduled appointments if Contractor is not scheduling appointments or carrying out comprehensive care coordination or care coordination follow-up? Will this information be shared by VHA? The contractor's primary means of identifying when an appointment was missed/cancelled would be the presence of an open referral without an associated claim. Please confirm that there is no other mechanism by which VHA expects the Contractor to be aware of missed, cancelled or rescheduled appointments.	The Contractor must meet the requirements stated in PWS Section 3.6. No, there is no other mechanism by which VHA expects the Contractor to be aware of missed, cancelled or rescheduled appointments.
16.2	8	<p>Routine Prescriptions for DME and Medical Devices: "All VHA forms and templates for DME and Medical Devices, along with instructions for use, will be provided to the Contractor during the implementation phase. "</p> <p>In order for the Contractor to have complete web linkages and references in their Provider Handbook and Provider Portal, how soon can these forms and templates be made available to the Contractor?</p>	Templates will be made available to the Contractor during implementation.

3.2	9	CCN Healthcare Services Network: "The Contractor must always make every reasonable attempt to enroll providers that have and do currently accept Veteran referrals from VHA. " When will VHA provide the Contractor with an electronic list of these providers, so they can quickly be recruited to the Contractor's network? Could VHA provide this list in advance of award?	After contract award, VA will provide this electronic list of providers.
3.2	10	When will VHA provide the Contractor with the Veteran eligibility/enrollment file, so that Veteran home addresses can be measured for geographic distance from CCN providers? This is a key element in determining network adequacy. Without it, the contractor is forced to estimate network adequacy for purposes of proposal.	After contract award, VA will provide the eligibility/enrollment file.
7.1	51	PWS Section 7.1 requires contractors to pend claims for urgent, emergent, or behavioral health claims without a referral or prior authorization and forward to the VA for review and consideration. What is the expected time period for VHA to perform the review and send a determination to the contractor?	VA expects to make a decision within 24 hours (into the next business day) once all necessary documentation is provided.
3.7	68	Will VHA accept a facility with only CMS certification?	VA has amended the draft PWS and expanded the language which will be posted in the final solicitation.
Attachment E - _Summary_D emand_Data	79	In itemizing healthcare services for referrals by VISN, VHA lists "Primary Care" as one of its most heavily used referral categories. Typically, we assume these are referrals to Family Medicine and Internal Medicine providers. Is this assumption correct or does it also include other kinds of providers such as geriatricians?	No, The "Primary Care" referral category is linked to the referral, not the provider specialty. Primary Care can consist of any provider deemed eligible to provide primary care services.
B.1 SCHEDULE OF SERVICES, Page 12	89	CLIN09 is for emergent or urgent care and indicates care authorized by VA under the authority of 38 U.S.C. 1725, will be annotated by VA as such and paid by the Contractor at the 70th percentile of CMS rates. The Contractor must always reimburse the Community Care Network provider the lesser of the amount the Veterans is personally liable for or 70% of the applicable CMS rate. Will U.S.C. 1725 be flowed down to the Contractor in order for the Contractor to have legal authority to use this reference and pay at 70%?	Yes. VA will provide the approved referral indicating it is approved under Mill Bill. From this, the appropriate fee schedule(s) can be applied when paying claims.
3.7	47	Section 3.7.1, Credentialing Requirements, paragraph 3, indicates that "In accordance with requirements outlined in the OIG's Compliance Program guidance for Hospitals, the Contractor must always confirm that all services, facilities, and providers, as applicable, have a compliance program in place that includes the 7 elements of an effective compliance program." We interpret this requirement to be limited to Hospitals, Hospital-based providers and Hospital-based services. Is this correct?	The requirement in Section 3.7.1 Credentialing Requirements of the PWS is for the Contractor to validate that the provider maintains a compliance program that meets the requirements. VA will not be providing oversight.
3.7	33	The RFP states that CCN Providers without national accreditation standards for their specialty must provide the listed documentation ..."#11. Operate within the scope of their license." What type of documentation does VHA consider satisfying documentation of the providers "operating within one's scope of their license?" Would verifying the license be sufficient, or would other documentation be required? This is a requirement that exceeds industry standards for credentialing activities.	The Contractor must ensure that the CCN provider meets this requirement. In accordance with PWS Section 3.7.1 "The Contractor must always be responsible for ensuring CCN providers who are not credentialed under an accredited credentialing process have the following documentation". Acceptable documentation would be through primary source verification of an active and unrestricted license through the state licensing board.
2.7	92	Paragraph 2 requires separate Accreditation documentation of the "Credentialing Process" be provided no later than date of award. Because an offeror's credentialing process is a core element of its Health Network Accreditation, please confirm that a Contractor's Health Network Accreditation documentation will meet the requirements for both the Health Network and Credentialing Process Accreditation documentation.	No, the contractor's health network accreditation will not meet both requirements for Health Network and the Credentialing process.
18.7	103	This section requires that "the Contractor must provide VA a list of administrative and clinical support staff associated with each Network Provider that will require access to VA Community Care Provider Portal." Front office staff in provider's offices have a high degree of turnover. Since VA is going to construct a VA Portal then we would suggest including a self-enrollment and verification process built-into the portal with a help desk function for things that touch your portal.	VA will consider the suggestion in developing the Community Care Portal.
Attachment E	106	Various data attachments show a notable decrease in Veteran volume between FY16 and FY17 (including uniques from Attachment AA and eligibles from Attachment E), while scheduled Veterans and authorizations (Attachment AH) as well as referrals (Attachment E) increased nominally (an exception is authorizations from Attachment Z, which dropped by over half for Region 4). We would expect most of these volumes to be somewhat correlated. Can VA clarify why some volumes show decreases while others show increases?	Data sources are different among the various attachments, therefore comparison and correlation may not be applicable. Uniques are based on Veteran activity (authorization/referrals, claim/date of service). Eligibles are eligible for VA community care but may or may not have Non VA Community Care activity.
10.1	81	In Section 10.1.2, the draft RFP states "The Contractor must provide training at least sixty (60) days prior to the SHCD." Is it correct to interpret this requirement as the Contractor must commence required training no later than 60 days before SHCD or is their another interpretation? Does this requirement apply to all constituencies (CCN providers; Contractor staff and VA staff) or is it requiring the Contractor to start training with at least one of these entities within the specified timeframe?	Training must be commenced at least 60 days prior to SHCD. Yes, this requirement applies to all constituencies.
3.4	78	The requirements regarding designation of high performing providers (Institutional, Individual and Group) consistently refer to providers within the "CCN Healthcare Services Network." We interpret this to mean that the High Performing Provider designation applies only to providers that are part of the Healthcare Services network and not the Dental, Pharmacy or CIHS network components/requirements. Please confirm that this is an accurate interpretation.	The designation of high performing providers includes Healthcare Services Network, Dental, Pharmacy, and CIHS network components/requirements.
4.4	117	Will the VA please provide a list of the Reproductive Endocrinologists that are contracted for the Choice program?	After contract award, VA will provide this electronic list of providers.
3.2.1	115	This section states that a list of Tribal Health Service, Academic Teaching Facilities and Federally Qualified Health Services will be provided 30 days following award. Given the lead time needed to contract with these entities to have them be part of the CCN Network and to ensure that they are included in the provider listing, will the Government provide the listing of these facilities at an earlier date?	Provider listings will be provided as stated in the PWS Section 3.2.1

7	118	Will the VA please provide the 278 companion guide?	VA expects to have a 278 companion guide available by Start of Healthcare Delivery, and will make it available to the Contractor at that time.
B.1, ¶ 6	133	With respect to all of the "pass-through" CLINs covered by RFP B.1 ("Schedule of Services"), ¶ 6, which includes CLIN 02 Reimbursement for Highly Rural Care Areas and Scarce Medical Specialist Services, CLIN 09A Brand Name Medications, and CLIN09B Generic Medications (among others), we believe the agency has created a CLIN type that does not exist under the FAR. On the one hand, we understand that the agency has structured these CLINs as Firm Fixed Price (FFP). On the other hand, we understand that the aforementioned RFP sections effectively creates Cost Reimbursement CLINs with a ceiling. An FFP CLIN, of course, shifts risk to the contractor, but permits the contractor to earn profit. A Cost Reimbursement CLIN, on the other hand, shifts risk to the government, but does not include profit. The "pass-through" CLINs covered by RFP B.1 ("Schedule of Services"), ¶ 6, create a new type of CLIN in which the contractor will bear risk (due to the ceilings), but cannot price such risk into the respective CLINs (because the most the government may be charged is the contractor's actual cost). If our understanding is correct, that would mean offerors' only place to price the risk is in the administrative CLIN(s). Please confirm our understanding is correct, and, if so, advise how can offerors both price the risk described above while avoiding the agency's evaluation that administrative unit prices are not fair and reasonable.	It is the responsibility of the contractor to price items to incorporate the risks as well.
18.7	155	Staffing of clinical and administrative support within a provider office is very fluid. The roles and responsibilities of clinical and administrative staff within a provider office setting can change on a daily basis given the needs of the patients, providers, and staffing demands. In provider practices that are owned or affiliated with a large health system or regional/national provider group, some staff rotates among multiple or all practice locations. The turnover rate among clinical and administrative staff within provider offices is known to be historically high (not uncommon in the industry). The requirement to provide VA a list of administrative and clinical support staff is both onerous and not done in any other health plan contract and would add substantial administrative cost to this contract. Requiring a provider office to provide that information to the Contractor and maintain the information will place a significant additional administrative burden on the provider's practice and could severely limit the number of providers willing to participate in the CCN. We recommend VA consider another mechanism to allow access to this system. For example, the unique referral number could serve as the "password" to provide access to that specific Veteran information on that specific referral.	VA will consider the recommendation in developing the Community Care Portal.
14.1	125	This section states "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." How often are the meetings? Are the meetings telephonic or in person?	Meeting frequency and format will be determined during implementation. Meetings can be virtual or in person depending on the locale.
	105	How is VA taking into consideration local market considerations, tort reform statutes, provider types (e.g. acupuncture), or limited risk pools where provider insurance limits are inconsistent with your requirements?	PWS Requirement 3.7.1 states the need to maintain professional liability insurance in an amount in accordance with the laws of the state in which the care is provided. The coverage amount deemed necessary to protect the Government's interest is \$1,000,000 per occurrence - \$3,000,000 aggregate identified in Section I.21.
4.4	45	When reviewing for providers of IVF/ART services, we found that RNs that perform an educational role are generally included under the specialty taxonomy for Reproductive Endocrinologists. This inclusion of RNs performing educational roles appears to be standard industry practice of the proper taxonomy for care delivery in IVF/ART. Does VHA intend for our provider counts (as submitted in our provider file) to include this provider type when listing the number of specialists who provide IVF/ART as outlined in Section 4.4?	No, your provider lists should identify licensed independent practitioners.
4.1.1	94	This section specifically excludes Dialysis. However, VA recently issued a pre-solicitation (#36C79118Q9209) to provide Dialysis care nationwide and stated specifically that such care would transition to the CCN contractor based upon the CCN contractor's transition schedule although it was noted that Dialysis may or may not be included in R4. Has VA changed its future position with respect to bundling dialysis in CCN?	#36C79118Q9209 is a Sources Sought for commercial items and is applicable to Regions 1-3 but not Region 4. The bundling requirement still stands, however Region 4 is excluded.
6.1	95	Please provide the anticipated monthly volume of calls for the Contractor's VA Support Call Center to assure parity between offeror's bids.	No VA cannot provide.
12.5	122	Is the requirement for EOBs limited to Medical?	Yes, an EOB will only report on the adjudication status of medical services submitted for payment
	104	Is the minimum limited to only the Administrative Fee CLINs?	Yes. The Government's obligation for the minimum guarantee amount applies only to the base period of the contract. If the contractor submits claim(s) for reimbursement for less than the minimum guaranteed amount, the Government will pay the difference between the claim(s) amount(s) submitted for reimbursement and the minimum guaranteed amount.
13.2	11	Does VHA have standard language or templates it requires for the provider reconsideration letters, notifying providers/practitioners in writing, of any such denial, the reason for the denial, and the provider's right to request reconsideration?	The contractor must provide VA with its reconsideration plan in accordance with Section 13.2. VA will collaborate with the contractor with regard to communications and formats. VA will provide appeal information to the contractor(s).
14.2	12	"Attachment U - Tab 12 - Clinical Quality: For the PQIs, PSIs, ISIs, and IQIs reported in Column One, provide the number and percentage that fall into each of the following severity levels: high, medium, low." Does VHA have definitions for the severity levels: high, medium, low?	Definitions for Attachment U - Severities levels will be provided with the solicitation.

3.1	19	"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." - Does assurance of availability equate to a single point of access? Many Region 4 states are very rural and reliance may be on a single entity such as the academic medical center in the state?	VHA does not understand the question. The offeror needs to ensure availability of telehealth, transplant, non-urgent neurosurgery, and cardiothoracic surgery. Appointment availability and other factors are still required for these services.
3.5	21	3.5 The Region 4 solicitation has removed Alaska, Northern Marian Islands, Guam, American Samoa. Does VHA plan to reintroduce these states/territories to Region 4 during the 8 year period of performance of this contract?	No, VA doesn't plan on adding Alaska, Northern Mariana Islands, Guam, American Samoa to CCN Region 4
3.2	23	Will there be a minimum ratio requirement (i.e.: 1PCP:500 VA members) or a minimum choice requirement (i.e.: choice of 2 PCPs within the criteria)?	There is no minimum ratio or choice requirement explicitly stated in the PWS. The contractor must ensure accessibility, quality and standards of care as specified in the PWS.
3.2	28	Why are rheumatology and dermatology specifically called out in this section? "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...."	Rheumatology and dermatology are provided as examples and are included in this requirement.
3.7	37	"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." Additional guidance is needed to implement this requirement. The contractor has internally defined processes around a provider that is being credentialed with previous actions against them, but is now considered active and in good standing. Clarification is needed in order to understand what VHA would expect when that scenario arises.	As stated in PWS Section 3.7.1, "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."
3.7	41	Please provide additional clarification regarding the handling of providers that do not require accreditation - i.e. hospital based providers, RHC based providers, etc. We are looking for defined requirements around the credentialing, recredentialing, and ongoing monitoring needs of these provider types. NCOA does allow for "other" medical and behavioral providers to be included in an organization's credentialing program. Does VHA consider including these types within the Contractor's policies and procedures and credentialing program sufficient to being considered an accredited process?	VA's intent is that the Contractor validate the credentialing requirements in Section 3.7 of the PWS to the extent necessary to satisfy the requirements. In accordance with FAR 52.212-4(q) Other compliances, 'the Contractor shall comply with all applicable Federal, State and local laws, executive orders, rules and regulations applicable to its performance under this contract.'
3.4	42	High-Performing providers are currently not designated as part of our provider files. Please confirm that this designation will not be a required component of our provider file upon submission of the proposal, given that the metrics used to identify high performing providers are to be developed in collaboration with VHA.	Confirmed. The designation will not be required as a component of the provider file for the purposes of proposal submission. Contract awardee must work with VA to develop the metrics and this will be discussed during implementation.
4.4	44	What are VHA's expectations if there are no IVF/ART providers available within the drive time standard required by the RFP?	VHA expects the contractor to follow the process for deviations as referenced in PWS Sections 3.1 and 3.6.
G.3	48	Section G.3 Paragraph 5. INFORMATION SYSTEM HOSTING, OPERATION, MAINTENANCE, OR USE states a. For information systems that are hosted, operated, maintained, or used on behalf of VA at non-VA facilities, contractors/subcontractors are fully responsible and accountable for ensuring compliance with all HIPAA, Privacy Act, FISMA, NIST, FIPS, and VA security and privacy directives and handbooks. For VHA CCN Region 4, what systems security requirements (i.e. FISMA, NIST, or HIPAA Security) apply to contractor/subcontractor systems that support VA claims processing and customer service?	Section G3, Paragraph 5. INFORMATION SYSTEM HOSTING, OPERATION, MAINTENANCE and PWS Section 18, Technology list the security and privacy requirements to construct a proposal response. The contractor/subcontractor will both be held accountable to the security and privacy requirements as specified in the contracts.
5.1	50	PWS Section 5.0 previously addressed Eligibility Verification and Enrollment. Please confirm that the removal of this section indicates that the contractor will allow claim payment based on the presence of a referral or authorization approved by VHA without separate verification of eligibility or enrollment.	Correct. When VA makes a referral, eligibility is assumed to have been validated. The approved referral/prior authorization is the Contractor's order.
11.1	52	The Presolicitation Notice posted Mar 21, 2018 indicated that a notable change in the solicitation would be the removal of the Optional Tasks of Appointment Scheduling and Comprehensive Care coordination, Case Management and Disease Management; however, the requirements are still included in the draft PWS. Please advise if VHA will include these Optional tasks in the final RFP.	Optional Tasks are will be included in the final Solicitation
18.3	53	In Sections 18.3 and 18.8, mention of the Contractor Systems for Referral and Prior Authorizations Management and Eligibility and Enrollment have been omitted. These systems will still be needed to meet the requirements of the contract. Is this intentional?	Yes, the omission was intentional. The offerors can determine which systems are needed to meet requirements of the contract.
18.8	54	In Section 18.8, mention of the Veteran's Portal has been omitted. PWS Section 18.8 states that the Contractor must provide a website with functionalities for CCN providers and VHA Personnel. Is the omission intentional? If so, how will the Veteran's self-appoint, check the status of claims, view referral information, etc.? Please confirm that that the contractor does not have to offer web site functionality to Veterans on the Contractor Web Site.	The requirements in the Draft RFP Section 18.8 are correct. VA removed the requirement for the Veteran to access the contractor web site. The offeror can purpose solutions to facility Veteran self-appointment when the optional tasks are implemented. PWS Section 12.5 states "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."
19.2	55	Attachment W doesn't have a table for Eligibility, Referrals, Pharmacy Claim Details, Customer Service, is this intentional?	Yes. VA will provide eligibility and referral information prior to the Veteran receiving care through CCN.
G.3	57	Section 2. Access to VA Information and VA Information Systems. Question: Are providers, (doctors, dentists, pharmacy staff, etc.. required to have a valid security clearance?	Section G3, 2C does not state a need for an active security clearance. Should this requirement change an amendment to the solicitation will be issued.

G.3	58	Is VHA CCN contract for Region 4 considered a National Industrial Security Program?	VHA CCN Region 4 is not currently designated as NISP. Should this requirement change an amendment to the solicitation will be issued.
G.3	59	What, if any, classified data will need to be protected and thus require personnel to have security clearances?	Storage and use of VA data, to include VA Approved Referral data, requires compliance with all HIPAA, Privacy Act, FISMA, NIST, FIPS, and VA security and privacy directives and handbooks.
G.3	60	What is the highest classification of data that could be made available to VHA CCN staff, personnel, third-parties, etc.?	Storage and use of VA data, to include VA Approved Referral data, requires compliance with all HIPAA, Privacy Act, FISMA, NIST, FIPS, and VA security and privacy directives and handbooks.
	61	Will the gov't provide GFE to allow the contractor to test systems that are required to run on VA Federal Desktop Core Configuration to insure that all applications fully function and operate correctly?	There is no current PWS requirement to place systems on VA laptops
19.3	62	Is the Interactive Dashboard for QASP truly no longer a requirement for Region 4? If so, how does VHA anticipate receiving performance measurements/metrics?	The requirements of 2.5.1 , 2.5.2, and 18.8, 18.9, 19.0 remain in effect
3.7	63	Regarding the requirement for background disclosure (3.7.1) under the credentialing requirements; will disclosure questions on an application and a signed attestation from the provider suffice?	Yes.
3.7	64	Regarding the requirement for professional references (3.7.1), what is the scope of the requirement? Is the expectation that the contractor will collect professional references for providers?	Yes the expectation is for the contractor to collect professional references.
3.7	65	Regarding the requirement for proof of identity by obtaining a government issued photo id and I-9 documentation (3.7.1); We contract with providers, and will not be employing providers for network participation. It is our expectation that the Contractor will not be responsible for collecting I-9 documentation for contracted providers. Please confirm.	Yes the expectation is for the contractor to collect I-9 documentation.
3.2	66	Please clarify whether inclusion of "Tribal Health Services" in the network refers to Tribal Health Service facilities, Indian health service (IHS) facilities, or both types of facilities.	Inclusion of the Tribal Health services includes both Tribal Health and Indian Health services.
3.7	67	For facility/organizational providers (3.7.1), NCQA does not prohibit the inclusion of specific provider types to an organization's credentialing program. If the facility is credentialed, would credentialing also be required for the practitioners within the facility for any facility provider types considered to be outside of an accredited process?	The Contractor must ensure that the CCN provider meets this requirement. In accordance with PWS Section 3.7.1 "The Contractor must always be responsible for ensuring CCN providers who are not credentialed under an accredited credentialing process have the following documentation".
3.7	69	Will the following accreditations be accepted by VHA as acceptable forms of accreditation for facility providers? AAAH- (Ambulatory Surgical Centers) ACHC- (Home Health Agencies, Hospices) AAAASF- (Ambulatory Surgical Centers, Outpatient Therapy, Rural Health Centers) HFAP- (Ambulatory Surgical Centers, Critical Access Hospitals, Hospitals) CIHQ- (Hospitals) CHAP- (Home Health Agencies, Hospices) DNV GL- (Critical Access Hospitals, Hospitals) IMQ- (Ambulatory Surgical Centers) TCT- (Rural Health Centers) JC- (Ambulatory Surgical Centers, Critical Access Hospitals, Hospitals, Home Health Agencies, Hospices, Psychiatric Hospitals)	The Contractor must meet the requirements for accreditation as specified in PWS Section 2.7.
3.7	70	Regarding the requirement for rehabilitation facilities to maintain accreditation with CARF or Joint Commission (3.7.1); is this applicable to inpatient rehabilitation facilities only?	This requirement applies to both inpatient and outpatient rehabilitation facilities in accordance with PWS Section 3.7.1.
Attachment A	74	The data provided in Attachment A - VA Medical Center Catchment Area - lists each station by Station number and name. These names do not always appear to be in active public use when compared with the VAMC information that is located online. For example, the Jerry L Pettis Memorial Veterans' Hospital appears to now be the primary hospital for the Loma Linda Health Care System, although unnamed as such on the website (https://www.lomalinda.va.gov/locations/directions.asp). For purposes of understanding the VAMCs and their catchment areas in Region 4, it would be helpful to have a crosswalk of names as well as a column that identifies what larger "system" the VAMC belongs to.	Attachment A - VA Medical Center Catchment Area will be revised to include a crosswalk. The crosswalk will include Station Number, Official Station Name, Location Descriptive Name (Common Name), and VA Healthcare System. The revised Attachment A with crosswalk will be included in the final solicitation.
Section M of the Solicitation Evaluation Criteria	76	When will evaluation criteria be provided to industry? Not having complete, specific evaluation information, such as Past Performance criteria, makes understanding how bids will be evaluated - and therefore our own structure and relevancy - challenging to accomplish. We assume that it is VHA's intent to provide a relatively short response period for this procurement. Not having evaluation criteria creates significant limitations for Offerors preparing and structuring their organization for response. Can the contractor assume that the past performance and other evaluation criteria will be largely modeled on the previous CCN Regions 1-4 Solicitation? If VHA anticipates significant differences in the criteria, can they provide some insight into what direction that may take?	The Final Solicitation will contain all evaluation criteria for proposal development. No, the contractor should not assume modeling and instead should adhere to the criteria stipulated in the final solicitation. All insight will be provided in the final solicitation.
10.2	82	In section 10.2, the draft RFP states "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." Does this requirement refer to any and all Training Materials developed for this procurement or specifically to materials used to train VA staff? If the former, does VHA intend to review and approve Training Materials used for all stakeholders or simply inventory those materials for reference if needed?	Yes, this requirement refers to all training materials. Refer to PWS Section 10.1 for review and approval details.

14.1	83	"4. A description of the process to work with VHA Office of Community Care (OCC) to align clinical quality monitoring activities with VHA OCC Quality and Patient Safety Improvement Program Description" Please provide information about, or a link to materials that describe, VHA OCC Quality and Patient Safety Improvement Program.	The contractor must develop the CQPSIP as stated in PWS Section 14.1. The intent is for the contractor to include the stated common elements listed in PWS section 14.1.2 in the contractor's CQPSIP process as a component of the CQMP deliverable.
14.1	84	"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." Please provide more detail regarding the CQPSIP. Is there a specific number of activities or programmatic approaches that the Contractor must carry out in order to meet this requirement? Can the contractor base its activities on prioritized needs as determined by a needs assessment? Can the approach taken include pilot programs that are limited in scope for purposes of testing success? Or is this intended to be a standardized approach that covers the entire region? Please confirm that the improvement types as numbered considered distinct strategies that the Contractor is required to utilize within the CQPSIP. Can the Contractor propose other strategies?	The contractor must develop the CQPSIP as stated in PWS Section 14.1 and include elements as stated in section 14.1.2 in the contractor's CQPSIP process, which is as a component of the CQMP deliverable.
3.7	85	"All documentation must be verified through primary sources and credentialing must be performed at a minimum of once every three years." Is it VHA's intent to require that all documentation listed in 3.7 be obtained through primary sources? The industry standard is that primary source verification only applies to some credentialing requirements and other sources are appropriate and accepted by accrediting bodies such as NCQA. Please confirm or clarify this new language for Region 4.	Contractors are required to primary source verify only elements required by their National Network Accreditation body (e.g. URAC, NCQA), and be specified in their credentialing plan. If Contractors use a third party for credentialing, or purchased/rented Networks, they should clearly articulate their oversight in the credentialing plan submitted to VA
14.2	86	"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." Please clarify as to what it means to "process to completion" a PQI/PSI/IQI/ISI. Does this mean to have completed the analysis, have begun implementation of the corrective action or to have completed the corrective action? Industry's response is that completion of the corrective action within the time frame given may not be feasible depending on the identified issue.	"Ninety-five (95) percent of all PQI, PSI, IQI, and ISI must be completed within ninety (90) days from date of identification. The contractor may extend the remaining five (5) percent of PQI, PSI, IQI, and ISI to be completed within one hundred eighty (180) days of identification to address issues that require a longer timeframe."
14.1	87	"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." Are the initiatives described here connected to the requirements of the CQPSIP? Are the three types of initiatives expected to be consistent with the three approaches outlined in the description of the CQPSIP - i.e. "(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." It is unclear how these two requirements relate, if at all. If they are not related, they are similar enough to require further clarification as to how they differ.	Yes, the CQPSIP is a component of the CQMP. The 3 outlined Clinical Quality and Patient Safety Improvement Program should adhere to PWS section 14.1.2.
3.1	88	Section 3.1; Tables 1 and 2 (pages 11/12) - Can you verify that telehealth services are included in the Table 2 appointment time requirements and metrics, but only if a request to provide telehealth services is received and approved by VHA?	Yes, telehealth services are included in the Table 2 appointment time. The offeror has to request to use telehealth through the COR.
B.1 SCHEDULE OF SERVICES, CLIN 11A p 13	90	In defining Active Veteran, can the same Veteran be active for multiple months under the same Authorization if the claims for that authorization span several months? Please confirm that the active veteran will be based upon submission of a claim for a veteran by any provider of care during the month.	The term "Active Veteran" will be defined in the final solicitation.
2.6	91	Requirements identify contractor responsibility for a Communications Plan, but does not specify the goal or objective of these communications. What is the essential theme of this communications plan? Will the Government specify in more detail what the Communications Plan is ultimately intending to accomplish (e.g., clear communications regarding the timing of implementation and changes in benefits, explaining summary of benefits and eligibility, etc.)?	The communications plan is the contractor's plan for getting key messages regarding CCN across to various audiences/stakeholders to achieve desirable outcomes.

3.6	93	The requirement for network adequacy include: (i) average Drive Time, calculated per claim received; (ii) average Appointment Availability to evaluate wait times, calculated using the date the referral is sent to provider from VA a; (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, and (v) documentation of rescheduled, cancelled, or missed appointments. Please explain how VA and the Contractor will coordinate to mitigate the risk to the Contractor of responsibility for meeting drive time and appointment availability standards when they are not the responsible agent for the appointment process?	VA has accounted for elements that need to be mitigated when monitoring Contractor's Network performance and are stated in the Quality Performance Requirement Summary (QASP) which will be posted at the final solicitation.
	96	Section 7.0 states "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." However, Section 7.1 states "VA Staff will determine the eligibility criteria and determine the authority in which they will pay if the Veteran is eligible." Please verify that a Veteran may seek Behavioral Health care whenever they need it (including telehealth) and a retroactive referral will be provided without placing the provider or Contractor at risk for retroactive reimbursement denial.	It is important to note the surrounding language in conjunction with the language cited in the question. Section 7.0 also states that, "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."
7.4	97	7.4 allows that the Community Care Provider Portal (CCPP) is under development and "slated" for readiness upon contract award. Because VA's CCPP is a critical operational component of the CCN program and contract, we would suggest that VA consider publicly posting their CCPP specifications and implementation schedule for interested offerors so that we may calibrate our implementation strategies and deployment plans accordingly.	Recommendation is noted. As stated in the PWS, the CCPP capability is under development but slated for readiness upon contract award
9.7	98	It appears that a notable change from the prior RFP to this draft is to remove the hands on responsibility for the contractor to direct medical documentation to VA. The contractor clearly has an obligation to train its providers to submit medical documentation back to VA but that alone does not lend itself to a process that could be audited. We recognize that VA has a need and right to audit for other functions but are unclear about the intention of audits within the medical documentation function given that the contractor is no longer responsible for submitting medical documentation to VA.	Contractor shall supply VA with access to information acquired or maintained by the contractor in performing services under agreement. VA will clarify the PWS to include the contractor responsibility to educate, train and coordinate their network providers in response to medical documentation audit requests.
10.1.3 #2	99	Section 10.1.3 references systems training for 50 VA data analytics users. Section 18.3 provides for 750 staff members having access to Contractor systems. Please resolve this apparent inconsistency.	The requirement will be updated to clarify that the contractor must train a VA trainer who will in turn train the VA data analytics users.
11	100	Section 11.0 references Section B.14.1.0, however, this reference can not be identified in the draft RFP. Please clarify.	The Final RFP will contain all referenced sections inclusive of instruction on the ordering of optional CLINS.
11.1.3a	101	Why would the contractor have responsibility for making sure a transfer out of a VA facility is compliant with EMTALA? We believe this is VA's responsibility.	This is a requirement for the Contractor in accordance with PWS Section 11.1.3a.
Attachment E	102	The Optional Tasks appear to have separate timelines based on when the task is exercised. Does this mean the systems required for these Optional Tasks will be tested in a different VA Testing session rather than the one listed in the base requirements?	Optional tasks can be executed anytime during the period of performance. Systems specifically required for optional tasks will be determined upon execution. Appointment Scheduling and Comprehensive Care Coordination Plan and Appointment Scheduling and Comprehensive Care Coordination Implementation Plan should provide the Contractor's approach/plan for meeting the optional tasks timelines.
	107	Attachment E "Dental Line Items by Category" shows almost five-times the Region 4 volume of dental referrals (by category of care) from the referral tabs of the same attachment (these referral volumes are within range of dental veterans from Attachment X). Can VA clarify why the "Dental Line Items by Category" volume is higher, and which is the most accurate depiction of dental referral volume?	Both Attachments are representative of the data they are reporting. For Attachment 'E' procedures are listed for each category of care in which a Veteran received treatment. For example, if a Veteran was seen in AZ for diagnostic and preventive procedures, it would be recorded in both categories. This spreadsheet was developed to provide data on the volume of dental procedures in each dental category for Veterans receiving care in the community. For Attachment 'X', the numbers represent each unique Veteran only once for each dental classification at the facility which approved and paid for their dental care in the community. Hence, if a Veteran was seen for three different categories of care, they would be represented three times in Attachment 'E' but only once in Attachment 'X.' An exception would be if the Veteran moved and received care in the community at another site in the same fiscal year, in which case they would be considered a unique patient at two different sites of care.
Attachment E	108	Will VA clarify what the "Pharmacy" category of care referral volumes in Attachment E signify? The referral volumes are significantly lower than the prescription volumes in the same attachment.	Yes, because Pharmacy volumes were split between VA Pharmacy filling the prescriptions and Veterans paying out of pocket at retail pharmacies, which VA Pharmacy did not have visibility over.

Attachment E	109	Something seems incorrect with the Region 4 FY17 Eligible Veteran data. The significant decrease of 73% from 2016 to 2017 is inconsistent with the actual Veteran data and other Region data.	An Attachment E with updated data will be included in the final solicitation.
3.1	113	This section states that transplant services are excluded from Drive Time Standards. Does this mean that CCN providers will receive referrals for transplant services and if so, which specific transplant categories?	Yes, transplant services are excluded from drive time standards. The CCN provider may receive referrals for transplant services. Transplant services are part of the benefits package and categories will be provided in a new attachment to the solicitation.
3.2	114	This section states "The Contractor must always identify Primary Care providers by specialty and subspecialty type within the CCN provider listing..." How does VA define Primary Care sub specialty?	PWS Section 3.2 references "The Contractor must always identify providers by specialty and subspecialty type within the CCN provider listing " not Primary Care specialty and subspecialty.
11.1	120	Can the VA please elaborate on how we will receive the Approved Referral with exercising any optional CLIN?	Please refer to Tables 14 and 15 under PWS Section 7.3.
12.1.1	121	Will the Veteran be required to pay out of pocket for BH\Emergency Rx?	Yes, In circumstances where urgent or emergent or behavioral health care is not pre-approved, Veterans may follow current processes to be reimbursed for prescriptions.
14.1	124	This section states "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." 1. Is this referring to the VHA National Patient Safety Improvement Handbook (VHA Handbook 1050.01 distributed 3/4/2011)? 2. If yes, is this the most current version? (The VHA Handbook is scheduled for recertification on or before March 2016). 3. If no, please direct us to or provide a copy of the VHA OCC Quality and Patient Safety Improvement Program Description.	Yes, this is the most update version- VHA Handbook 1050.01 distributed 3/4/2011 is the most current version
14.1	126	This section states "9. A description of the process to comply with the performance reporting schedule described in the CCN Quality and Patient Safety Measure Specifications Manual." Where is the Manual located? Will the VA provide a copy of the manual?	The VA will provide the manual to the Contractor during evaluation of the QPSIP deliverable. VA seeks to reconcile Contractor capacity along with Department needs for particular data specifications.
14.1.2	127	This section states "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. " 1. Is this referring to the VHA National Patient Safety Improvement Handbook (VHA Handbook 1050.01 distributed 3/4/2011)? 2. If yes, is this the most current version? (The VHA Handbook is scheduled for recertification on or before March 2016). 3. If no, please direct us to or provide a copy of the VHA OCC Patient Safety Guidebook.	Yes, this is the most update version- VHA Handbook 1050.01 distributed 3/4/2011 is the most current version
B.1, ¶ 8, CLIN02	134	Will VA please provide historical or projected utilization volumes by state, county, specialty, and provider type for care delivered and reimbursed through CLIN 02 Highly Rural Care Areas and Scarce Medical Specialist Services?	See Attachment AA - Uniques by Rurality by Station for utilization volumes based on rurality.
B.1, PWS 2.9.2	136	Will VA add a CLIN for offerors' price associated with the contract Transition Out activities required under PWS Requirement 2.9.2? If not, under what CLIN should offerors include their price for these activities?	Transition In and Transition Out are both appropriate and should be expected/covered by the Government per contracting. We will consider including a CLIN for this item.
B.1, ¶ 8, CLIN 17B	137	Given the potential volume of encounters requiring Care Coordination Follow Up, will VA consider increasing the volume of cases per task order "lot" from 50 cases to 250 cases in order to simplify the administration of CLIN 17B?	No, the volume of cases per task order "lot" will remain at 50 cases.
2.6	138	Will WMC need to obtain the network accreditation in section 2.6 for the dental network?	The dental network does not require network accreditation.
4.1.1	139	The list of CCN Healthcare Service Exceptions shows the following for line 5: "5. Home deliveries Ambulance services (ambulance services must always be referred directly to VA for payment consideration)" Should item #5 be two separate items: #5 as Home deliveries and #6 as Ambulance services?	The CCN Healthcare Service Exceptions list will be amended to sperate Home deliveries and Ambulance Services.
6.1	140	Could VA define "electronic messaging?"	The government defines "electronic messaging" as any one on one communications leveraging technology. This could include online/instant messaging, secure email, or similar capabilities
6.2	141	Many times a provider will call Customer Service to inquire about a member's eligibility. This does not appear on the list of items the Contractor's Provider Call Center must be ready to answer. How will CCN providers obtain Veteran eligibility information?	CCN providers will obtain Veteran eligibility information through VA-issued Approved Referrals.
6.2	142	Will CCN providers use the "Referral" prompt required on the Contractor's provider call center number for both requesting referrals and requesting referral status? In other words, the VA Community Care Contact Center will handle those calls?	As stated Section 7 of the PWS, "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."

7	143	How long will a referral to a PCP for a distance-eligible Veteran be good for?	As stated in Section 7.0, 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.
9	144	Section 9.0 mentions submitting a Medical Documentation Submission Plan; the deliverable is not listed in the Schedule of Deliverables. What will the submission timeframe be for the Plan?	This item will be addressed in the final RFP.
10.1.3	146	Given the experience of WMC Affiliates, we have found that providing education/training for our business partners is most beneficial, leading to strong partnerships and higher member/customer and provider satisfaction. Would VA consider allowing WMC to provide VA CCN Field Operations Training for CCN Regional Staff, VA Program Offices, VISNs, and critical VA Facility Staff?	Although it is not required, the Contractor may propose providing training to VA staff in their training plan.
12.14.6	147	<p>Please clarify the requirements of PWS Section 12.14.6 related to IPERA and the Agreed Upon Procedures Audit overpayment recoveries. Sec 12.14.6 states "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."</p> <p>Sec 12.14.6 also states "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."</p> <p>These two requirements are potentially in conflict with one another. By definition an extrapolation will yield an estimate of overpayments, whereas a review of all invoices that meet a specific error criteria should result in an exact overpayment quantification. We understand that 12.14.6 requires contractors to adjust claims that resulted in an overpayment, which will ensure VA is credited for overpaid amounts via the CCN contractor's routine healthcare invoicing process with the VA. However, 12.14.6 also states that "In addition to the Contractor reimbursing VA for the projection of improper overpayments resulting in a loss to the Government . . . " [emphasis added], which implies the contractor will reimburse VA for the extrapolated estimate of overpayments.</p> <p>If the contractor is required to reimburse VA based on the error extrapolation, how will VA make the contractor whole in the event that the extrapolated estimate of overpayments is greater than the actual overpayment amount derived from the invoice-by-invoice review?</p> <p>We recommend that the extrapolated overpayment estimate be used for IPERA audit reporting purposes back to OMB, but that reimbursement to VA be based on the invoice-by-invoice</p>	<p>Any adjustments to previous payments, either an increase or a decrease, must follow the process for corrected invoices. An original invoice for \$10.00 that was paid but later to be found inflated by \$2.00 will have a corrected invoice (invoice number-01) forwarded to VA that will override the original \$10.00 payment and create a traceable offset in the amount of \$2.00 which is applied to another invoice and reported on the reimbursement reconciliation report. Additionally, we will take your recommendation related to the application of the extrapolation and explore this as an option.</p>
3.4.3	149	PWS 3.4.3 second paragraph refers to making AMA guidelines available to the high performing CCN providers and states, "Veteran care providers will have access to accredited training developed by VA, including in their provider file." Please describe specifically what "their provider file" is referring to.	The requirement will be amended to remove the phrase "including in their provider file".
3.6	150	PWS Section 3.6 states, "The CCN must always be customized for each VA Facility catchment area per Attachment A..." Please confirm the customization this requirement is referring is the type of mix of providers required in the network.	The network should be customized based on VA and regional needs as indicated in Attachment A.
3.2.2	151	Section 3.2.2 CCN Complementary and Integrative Healthcare Services Network, references that any "deviations from these minimum standards, including rheumatology and dermatology services;..." is it VA's intention to move rheumatology and dermatology services out from the CCN and into the CCN CIHS network?	No, VA will amend this section to list rheumatology and dermatology services in PWS Section 3.1. The deviation requirement still exists.
11.1	152	PWS Section 11.1 describes the requirements for the Optional Task Appointment Scheduling and Comprehensive Care Coordination. Please confirm it is VA's intention that the Care Coordination envisioned under this section is not clinical in nature and can be performed by a care navigator or a person with similar training and experience.	That is correct, Care Coordination this is a non-clinical position.
7	153	Please describe the functionality available through the VA Community Care Provider Portal (CCPP). Is this functionality currently tested and deployed? If not, will this full functionality be ready prior to contract award?	As stated in the PWS, the CCPP capability is under development but slated for readiness upon contract award.
12.8	154	Please describe the process the contractor is required to follow upon receipt of a claim for another CCN Region?	Claims received by the contractor that do not belong to the contractor should be rejected informing the submitter to follow the instruction for billing received with the approved referral.
G.15	156	Can VA please describe the process, transaction details, and file structure associated with VA's acceptance or rejection of contractor's submission of invoices for payment under RFP section G.15?	VA has selected a number of basic business rules on which to base the acceptance or rejection of an invoice. When contractors follow the submission requirements in G.15, they have assurance what all required data elements will be present. Anytime an invoice is rejected, a reason for that rejection will be clearly stated on the Reimbursement Reconciliation Report.
Attachment AE	157	Can VA please include National Drug Code (NDC) identifier in the Attachment AE VA national formulary?	No additional mapping will be required as VA does not expect the contractor to purchase the same NDC products. Contractors are requested to provide equivalent best price products in their proposal.

Attachment S	158	Please explain the role of the Health Information Handlers (HIHs) as shown in draft RFP Attachment S. Is this a role for the CCN contractor? If not, are these VA staff members? Please share the scope and extent of their responsibilities.	If the CCN Provider utilizes a Health Information Handler, the documentation submission processes must be coordinated with VA per standard industry practices.
	14.2	128 This section states "The Contractor must always adhere to processes identified in VA Guidance (e.g., VHA OCC Patient Safety Guidebook, VHA Patient Safety Handbook 1050.01)". Will the VHA provide the current VA Guidance the Contractor is expected to adhere to?	VHA OCC Patient Safety Guidebook, VHA Patient Safety Handbook 1050.01 is attached with the solicitation.
	14.1	13 "9. A description of the process to comply with the performance reporting schedule described in the <u>CCN Quality and Patient Safety Measure Specifications Manual</u> ." Where is the CCN Quality and Patient Safety Measure Specifications Manual? Can VHA provide this manual, or a draft manual, as an attachment?	VA has provided the CCN Quality and Patient Safety Measure Specifications Manual as an Attachment since it is required for the Contractor to submit a CQMP to include compliance of the CCN Quality and Patient Safety Measure Specs Manual.
2.5	7	QAP: "The QASP will be finalized upon award and a copy provided to the Contractor after award." How many days after award will the Contractor be provided the finalized copy of the QASP?	The QASP will be provided 30 days after award
12.7	123	The RFP requires the 837 COB file to be used for VA invoicing. Will the VA allow offerors to use commercial best practice and provide a daily summary report instead?	No, our automated systems are entirely dependent upon receiving the invoices and formats as specified in the contract.
9	145	To streamline the process of ensuring providers submit medical documentation to VA's standards, it will be important for the Contractor to receive updates when documentation is not submitted timely or is submitted below standards. How and on what timeframe will VA notify the Contractor of a provider's non-compliance with medical documentation?	Non-compliance of medical documentation communication will come from the COR, and timing will be established at Contract Award.
Attachment U - Data Specifications	132	Will the VA please provide a more concise master provider data file format (attachment U)?	See Section 18.15.2, VA Provider Data.
	2.6	111 This section states that a comprehensive list of Community Care Stakeholders will be provided for reference at the kick-off meeting. However, Section F, Deliverables or Performance requires the CCN Communication Plan to be submitted at the kick-off meeting. Will the Government provide the comprehensive list of Community Care Stakeholders with the release of the final solicitation so that it can be used to develop the required CCN Communication Plan?	VA will provide Community Care Stakeholder roles in the final solicitation, see Attachment CCN Stakeholders List v2 in the solicitation.
7	1	REFERRALS AND PRIOR AUTHORIZATION - The DRFP states that VHA will provide SEOC tables to the Contractor during contract implementation. Has VHA already created the SEOC tables? If so, how many SEOC tables are there? Can the government please identify that episodes of care that are defined?	Yes, the tables have been created. Currently there are nearly 200 SEOC tables.
3.2	6	Provider Networks: "For VHA Providers ordering pharmacy services under this contract, the Contractor will need to have an Approved Referral." Please explain how this process will work.	Please see PWS Section 7.0 regarding the approval process. In addition, refer to PWS Section 6.2 (Call Center) for additional guidance on approvals.
15	14	15.0 Pharmacy: "The Contractor must always require all routine/maintenance prescriptions to be forwarded to VA pharmacy for processing and fulfillment." What is VHA's detailed process for how this will work? Will contact information be provided for each VAMC & will the eligible member's assigned VAMC be included among the data on the approved referral?	Yes. Refer to Section 15.3, Routine/Maintenance Prescriptions, for detailed process.
Attachment E - Summary Demand Data	17	Breakdowns of referrals in the CCN RFP for Regions 1,2 and 3 previously issued by VHA had a specific reference to "Inpatient" referrals to community providers. The data for FY15, FY16 and FY17 by state and by VISN in Attachment E does not have an inpatient category. Should we assume that inpatient referrals are in fact distributed across other categories of care referenced or that it was omitted from the list? Will VHA make available a breakdown of inpatient referrals by station?	The data provided in Attachment E includes inpatient referrals in the categories of care. Additional data will not be provided.
Attachment AG - Urgent vs Emergent Care	16	While the column headings "Referrals" and "Unique Veterans" are clear, what does the heading of "Volume" refer to?	VA defines Volume as the measure which counts the number of occurrences of an event. It represents the CPT volume (on outpt and inpt ancillary) and for inpatient the volume is number of days. The payment record is laid out so that there is one record per occurrence (i.e. CPT code) but if a particular CPT is performed more than once in a single visit the volume indicator will display this occurrence to know that it happened more than once. See to the updated Attachment AG, Urgent vs Emergent Care.
18.8	148	For the Contractor Self Service Website, will there be additional requirements for reporting or specific functionalities identified for either the VA Staff SSW or Provider SSW? It is unclear in Section 18.8 Contractor Self Service Website if referrals and prior authorizations or eligibility status, for example, is necessary. Would VA consider clarifying this in the RFP section regarding the Contractor Self Service Website?	No additional requirements at this time. No additional clarification is provided to the section regarding the Contractor Self Service Website.
7	2	REFERRALS AND PRIOR AUTHORIZATION - "VHA will also provide the Contractor with optional read-only access to referral and authorization information through VHA Community Care Provider Portal." Using technical specifications, please describe how the CCPP information-sharing process will work.	Please refer to Section 7.2, Referrals from VA to CCN Provider, 7.3, Referrals Requested from a CCN Provider for VA Provided Care or Another CCN Provider, 7.4, Prior Authorizations /Attachment I. Additional information on the CCPP will be shared during kick-off meeting.

18.8	129	This section states that "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." Is the expectation that this functionality will not be required for Veterans?	The requirements in the Draft RFP Section 18.8 are correct. VA removed the requirement for the Veteran to access the contractor web site. The offeror can purpose solutions to facility Veteran self-appointment when the optional tasks are implemented. PWS Section 12.5 states " 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."
Attachment E - Summary Demand Data	130	In attachment E (Summary Demand Data) the FY 17 - Eligible Veterans tab shows the Region 4 total as 245,534 (column C, row 14). This is a significant drop from the FY15 and FY16 Eligible Veterans tabs. Is there an error with that number? If not, can VA explain the drastic decrease?	An Attachment E, Summary Demand Data, with updated data will be included in the final solicitation.
Attachment E - Summary Demand Data	131	Can the VA confirm the data in attachment E for Regions 1-4 is most recent, as it is significantly different than what has been previously released?	See updated Attachment E, Summary Demand Data, in solicitation.
14.1	30	Attachment PQR - [CPSADD] - ADD025 – Data Routing Service LINK NOT WORKING for this	See updated Attachment PQR, DAS Interface Control Document (ICD) in the solicitation, which includes an active link.
14.1	29	Attachment PQR - [DCGADD] - ADD010 - DAS Client Gateway - LINK NOT WORKING for this	See updated Attachment PQR, DAS Interface Control Document (ICD) in the solicitation, which includes an active link.
11.1	32	Attachment W - Data Repository Schema no longer contains fields for Scheduling Care Coordination needed to generate the Daily Appointment Scheduling and Comprehensive Care Coordination Report. Please confirm that this was intentional.	See updated Attachment W, Data Repository Schema, in the solicitation, which includes fields required for Scheduling Care Coordination needed to generate the Daily Appointment Scheduling and the Comprehensive Care Coordination Report.
Attachment A	75	The data provided in Attachment A - VA Medical Center Catchment Area - identifies each county that has enrollees from a particular VAMC. In many cases, a single county may have enrollees at multiple VAMCs. For purposes of better understanding VA's catchment areas, could the VA please describe how it assigns a particular VAMC to an enrollee? Do enrollees have a choice of VAMCs if multiple VAMCs are located within a specific drive time? Is the assignment to a VAMC based on the enrollee's zip code, rather than county? This latter approach would account for multiple VAMCs having the same county as part of their catchment area. Ultimately, we are looking to understand whether VHA has dedicated, non-overlapping health service area boundaries that it defines for each VAMC, or if shared counties (or possibly zip codes) is truly VA's model for defining catchment areas. Without zip code level data, we cannot be sure.	The data in Attachment A is based on the driving distance between enrollees geocoded residential address and the nearest secondary healthcare site. When a single county has multiple VAMCs, it is because some of the enrollees residing in that county live closer to one VAMC than the other(s). The decision about where an enrollee will receive care is based on the type of specialty care needed, where that type of care is available, if there is a shuttle bus or other transportation available, and other patient/local factors.
3.1	112	Will the VA please provide the VA security standards for Telehealth that are applicable to this contract?	The Government is not providing Government Furnished Equipment (GFE) under this contract. GFE is required to connect to the VA Healthcare system
Attachment Z - Station Category of Care Provider Zip Uniques	18	What exactly does the zip code column in Attachment Z refer to? Is it the provider zip (as suggested in the name of the file) or the "vendor" zip (e.g., VHA Choice vendor) as indicated in the comments at the top? If it is the latter, can VHA supply the zips for the providers to which Veterans were referred by category of care?	See updated Attachment Z, Station Category of Care Provider Zip Uniques, in solicitation, which includes revised headings and titles.
Attachment AA - Uniques by Rurality by Station	15	None of the data presented in each worksheet adds to the Grand Totals shown in Row 42. Can we assume the data for each HCS is correct and adjust our Grand Total accordingly for the purpose of analysis?	Yes, the detailed data is accurate and a revised Attachment AA, Uniques by Rurality by Station, with updated totals will be included in the solicitation. See revised Attachment AA, Uniques by Rurality by Station.
Attachment AA - Uniques by Rurality by Station	25	Should the "insular island" and "other" from the Uniques by Rurality by Station be factored for network adequacy? If so, what is the criteria? Is there a zip code level definition for insular island?	Yes, Veterans located in Insular Islands should not be factored for network adequacy. See updated Attachment AA, Uniques by Rurality by Station, in the solicitation, which excludes Insular Islands.
3.7	34	When "privileging" is mentioned throughout the RFP, is the Offeror referring to the process whereby a specific scope and content of patient care services (that is "clinical privileges") are authorized for a healthcare practitioner by an Institutional Provider that may be part of the CCN Healthcare Services Network? Unlike the Credentialing process, which the Contractor directly performs for providers in independent and group practices, health plans (and other third party administrators) do not directly privilege providers. The Contractor achieves the intent of privileging by requiring Institutional Providers in the CCN Healthcare Services Network to have Joint Commission Accreditation, (or other accreditation relevant to the Institutional provider type), which accounts for the privileging process. Documentation related to the credentialing process rests with the Contractor, but documentation related to privileging rests with the Institutional Providers themselves. Can VHA please specify what documentation it expects the Contractor to obtain related to privileging?	Yes, The VA is referring to the process whereby a specific scope and content of patient care services (that is "clinical privileges") are authorized for a healthcare practitioner by an Institutional Provider that may be part of the CCN Healthcare Services Network. For documentation, the Contractor needs to ensure how their providers will support credentialing and privileging requirements as referenced in PWS Sections 2.6 and 3.7.
2.7	35	"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." The timeframe for supplying requested documentation, particularly in regards to delegated agreements, is concerning. Industry standard practices would require time to allow for gathering documents and providing an internal review prior to due date.	Your concerns are received. At this time, the requirement stands.

6.5	40	<p>"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."</p> <p>As we receive the occasional patient concern as part of the sanctions process, we are concerned with the requested timeframe allowing the information to process through our workflow prior to gathering for submission.</p>	Your concerns are received. At this time, the requirement stands.
3.1	3	<p>"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."</p> <p>What was VHA's criteria for specifically adding these services to this list?</p>	Criteria based on historical data/experience of limited to no availability of identified specialties in rural areas within R4
3.2.2	116	The CIHS Network section states "Any deviations from these minimum standards, including rheumatology and dermatology services; or requests to use telehealth capabilities..." Was rheumatology and dermatology services added in error?	No. VA will amend this section to list rheumatology and dermatology services in PWS Section 3.1. The deviation requirement still exists.
4.4	43	Which specialties are approved by VHA to deliver IVF/ART services? Are there specialties outside of Reproductive Endocrinologists that VHA would consider as approved provider types for the delivery of ART/IVF services?	The specialties/services that are approved for IVF/ART will be provided in Attachment AM "ART-IVF Standard Episodes of Care v2". Specialties to provide IVF/ART services would be in accordance with privileging and credentialing of the contractor. (Section 3.7.1).
3.2	36	<p>"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."</p> <p>The contractor's current industry-standard practice does not currently note the provider's THS, AA, or FQHC status within the provider file. Please confirm that this notation by the contractor is not required upon submission of the Region 4 Proposal (which we assume will require our provider listing).</p>	Yes, the annotation will be required in the file. While this is not required upon submission of proposal, the proposal should address contractor's approach to including the required information in the provider file if it is not currently included.
3.7	72	Regarding site visits; Per NCQA, accredited facilities are not required to have site visits conducted. Will VHA accept Contractor's policy to exclude non-accredited facilities to the network?	Yes, however VHA will only accept what is stipulated in PWS 3.7. "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."
4.4	73	Has VHA developed a Standard Episode of Care (SEOC) that will encompass covered provider and service types for ART/IVF? Could VHA share that definition?	Yes, VHA has developed a SEOC. Please see Attachment AM ART-IVF Standard Episodes of Care v2 as referenced in PWS Section 4.4
4.2	39	Please provide additional information regarding what is acceptable in regards to CIHS certification/licensing, particularly for Relaxation Techniques.	See Section 3.7.1, Credentialing Requirements
3.2	22	Is there a % threshold for VHA eligibles within the drive time standard (i.e.: 90%), similar to the 70% appointment availability within 30 days?	The drive time standards do not include percentage thresholds and are stated in Table 3, Maximum Drive Times, outlined in Section 3.2.2, CCN Complementary and Integrative Healthcare Services Network.
17.1	24	Is there a % threshold for VHA eligibles within the drive time standard (i.e.: 90%)? Is there a % threshold for appointment availability for dental care, similar to the 70% reference under 3.2.2 for the CIHS Network?	The drive time standards do not include percentage thresholds and are stated in Table 3, Maximum Drive Times, outlined in Section 3.2.2, CCN Complementary and Integrative Healthcare Services Network.
3.7	27	Please note that the documentation of Accreditation/Annual Attestation attachment is missing in DRFP.	The documentation of accreditation/annual attestation is listed as contractor deliverable 25 in section F of the solicitation. This document is will not be added to the solicitation. Instead it must be generated by the contractor post award.
7	119	This section states "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." Will the spouse of the Veteran be required to be enrolled and eligible in the VA Healthcare System to seek treatment for ART & IVF?	Yes
3.1	4	<p>"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."</p> <p>Will VHA allow the Contractor to recommend additional services to be added to this list?</p>	Where the solicitation permits, an offeror may propose standards that exceed the Government's minimum standards or propose additional standards. The offeror shall commit to these in the proposal and shall state the proposed standard/requirement in contractual language that the Government would be able to incorporate into the contract as stated. (See L6.1.1.)

B.1	110	Due to the high cost, competitiveness, and scarcity of specialty services such as ART, IVF, and transplant services, contractors may be challenged to ensure network adequacy at 100% Medicare rates for those service types. May the contractor utilize CLIN 02 for these services?	No. CLIN 20 has been established to accommodate the unique aspects of specialty services, and additional information will be provided in the CLIN descriptions to assist with the estimation process.
	B.1 , ¶ 8, CLIN02 135	RFP B.1, ¶ 8, CLIN 02 states, "This CLIN only applies if the Contractor must execute a specific agreement in a Highly Rural Care Area at a rate that exceeds Medicare as required to maintain Network Adequacy. Adequate documentation must be provided to the Contracting Officer for review and disposition to support a request for higher than Medicare rates. The Contractor may, in Highly Rural Care Areas, exceed Medicare rate but shall not exceed the stated maximum percentage above the locality adjusted Medicare rate in this CLIN." If a situation arises during the contract period of performance where the contractor must exceed its offered CLIN 02 price in order to maintain network adequacy, please clarify whether this contract requirement stipulates that contractors may not execute that provider agreement or whether the contractor will be required to absorb the healthcare expense in excess of its offered CLIN 02 price.	The Contractor may, in Highly Rural Care Areas, exceed Medicare rate but shall not exceed the stated maximum percentage above the locality adjusted Medicare rate in this CLIN. If the contractor exceeds the maximum amount then they would be required to absorb that cost.
B.1	46	It is anticipated that Region 4 will have more highly rural areas than other regions. How does using CLIN02 affect the Contractor's evaluation by the government - both pre-award (during proposal evaluation) and during the period of performance?	Please refer to attachment Z to determine the various areas in Region 4. The government will provide instructions on how all proposals are evaluated in the evaluation criteria and instructions to offers. For questions on performance offers should refer back to 3.1, 3.2.2, 15.2; 17.1 in the PWS.