



Department of Veterans Affairs

Care in the Community Integrated Project Team Charter

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Care in the Community Integrated Product Team (IPT) Charter

I. Purpose

The Care in the Community Integrated Project Team (IPT) has been established under the authority of the Acting Principal Deputy Under Secretary for Health to provide recommendations for establishing a managed care model as part of the continuum of VA health care services. The IPT has been charged with developing a comprehensive business case analysis for the recommended managed care models. The IPT will compile relevant industry data and analyze industry standards, provider networks, local and national contracts, make buy opportunities, health plan options, and associated costs.

The goals of the IPT are to learn and understand the various opportunities afforded to the Veterans Health Administration (VHA), along with the challenges inherent in such a major effort; provide subject matter expertise, senior leadership, direction, and decision making based on the data; research and workgroup recommendations that are developed over the life of the effort; and guide/confirm decisions regarding options for purchasing care in the community as part of a managed care program.

The IPT will be established once approved and will end once all scope, milestones, and deliverables have completed.

II. Vision

The IPT vision is to ensure efficient, effective access to care for Veterans by developing a comprehensive approach to managed care. This vision is intentionally broad and should closely follow strategic direction of the National Leadership Council with respect to the future of VA healthcare.

III. Mission

The IPT mission is to establish a managed care program within VHA that integrates multiple Care in the Community programs and authorities, establishes access and quality standards for Care in the Community, and allows for the seamless continuity of care between VA and non-VA providers. The IPT will make recommendations for that model, considering needs of Veterans, contracting options (national, regional, and local), make/buy determinations (including what care should be provided in-house and what should be provided in the community, as well as whether VA should “make” or “buy” community provider networks), and cost factors. The ultimate goal of the IPT is to ensure Veterans have access to needed healthcare, whether through a VA facility or through an efficient referral to a community provider.

IV. Structure

The structure chartered herein is to provide the necessary levels of research, subject matter expertise, decision boards, and oversight to accomplish the work. As needed, the IPT will consult with additional stakeholders, such as Veterans Service Organizations, labor unions, and industry leaders.

Below is a description and graphic depicting the structure:

- **Oversight Board:** Provide VHA's strategic direction and guidance to the IPT in establishing a future-state managed care model.
- **IPT:** Recommend approach for managing Veteran care in the community based on analysis of alternatives, make/buy analysis, and integration with current/future processes. Recommend clinical/administrative requirements for potential contracting activities and identify technology, staffing, and reporting requirements. Appendix A holds the membership names for the IPT.
- **Workgroups:** Teams of subject matter experts to provide input and analysis for IPT recommendations. Appendix B holds the scope for each of the proposed workgroups. Additional workgroups or sub workgroups will be further defined as needed and approved by IPT. The workgroups include:
 - Process Integration and Standardization
 - Market Products
 - Provider Network
 - Data and Compliance
 - Claim Processing and Billing
 - Medical Cost and Quality
 - Finance

V. Procedural Guidelines:

1. IPT Meetings: Led by the Chairs and at a minimum will meet monthly or as determined during the IPT kickoff meeting. The Chairs may call for additional meetings as required.
2. The IPT will make recommendations to the oversight board for decision or issue resolution.
3. The IPT will operate on a consensus basis with a determination of consensus being made by the Chairs after obtaining input from the members. In cases where a decision lacks clear consensus, the issue will be handled by majority vote.
4. Workgroup sessions will be conducted through in person meetings and teleconference/web conferences. Work groups may be used to accomplish short term goals that meet the overall objectives, and should be compiled with SMEs to tackle the major facets of requirements that should be included in a managed care model. Workgroups can meet on a more frequent basis and must be established and authorized by the IPT.
5. The IPT will establish sub-working groups as needed.

6. The IPT support team will provide administrative support for the oversight board, IPT, and workgroups.
7. Review of Charter: This charter will be updated annually from date of approval.

VI. Scope of Responsibilities of IPT

The scope of the IPT:

a. Refine IPT and Workgroup Objectives

Scope: IPT members will meet to clarify the overall purpose, timeline and approach for workgroups. This will provide a foundation by establishing the goals and objectives as well as the guidelines for the next steps. Once these are vetted and validated by IPT stakeholders, the IPT will vote and finalize goals and objectives.

b. Develop Strategy

Scope: The IPT will utilize lessons learned from prior contracted healthcare efforts, studies and analyses of VA capabilities, and industry best practices to stand up the workgroup framework required to review, research, develop approach and make actionable recommendations for approval.

c. Evaluate Workgroup Findings

Scope: Using information obtained from the previous steps, the IPT will assess workgroup findings and integrate workgroup recommendations into a single recommended approach for establishing a VA managed care model.

d. Conduct Analysis of Alternatives (AoA) and resulting Cost Benefit Analysis (CBA)

Scope: The Analysis of Alternatives (AoA) and resulting Cost Benefit Analysis (CBA) will be based on the 6 critical areas outlined at the National Leadership Council (NLC) in May. The CBA consists of three integrated phases, each contributing to a defensible cost benefit analysis. Each AoA will be evaluated on four alternatives:

- Alternative 1: Status Quo
- Alternative 2: Own Work In-House (Make Decision)
- Alternative 3: Outsource Work (Buy Decision)
- Alternative 4: Hybrid of 2 and 3

The final CBA will result from IPT decisions made during the AoA process

e. Develop RFP (if applicable)

Scope: Based on the results of the AoA, the IPT will develop requirements for any contracting activities and use those requirements to develop a Request for Proposals and begin contract solicitation. Market research and pre-solicitation outreach will be conducted based on the contracting direction recommended by the IPT. The IPT will establish an evaluation panel to review proposals.

f. Closeout

Scope: Capture lessons learned from IPT for handoff to Implementation Team.

VII. Signatures

IPT Co-Chair

Date

IPT Co-Chair

Date

Appendix A: IPT Membership

NAME	OFFICE
JEFF MILLIGAN (CO-CHAIR)	VA North Texas HCS
GENE MIGLIACCIO (CO-CHAIR)	CBO
YEHIA BALEIGH	
DREW CORNACCHIO	OGC
STEVEN DEVINE	OGC
MARA WILD	OALC
GABE HARRIS	OALC
REGAN CRUMP	OPP
NORB DOYLE	VHA Procurement and Logistics
MARK YOW	VHA Finance
TODD LIVICK	VHA Communications
JOANNE SHEAR	Patient Care Services
GINA CAPRA	Office of Rural Health
LELIA JACKSON	Office of Community Engagement
LORI AMOS	CBO
ELLIOTT BLOXOM	Strategic Investment Management
LINDA M. WILLIAMS	Office of Small and Disadvantage Business Utilization (OSDBU)
SANDY STRUCK	DMA
SANDRA HALLMARK	Medical Sharing Office
KATE ANDREWS	OSI
MARVIN RYDGBERG	OSI
MARGARET DONAHUE	Physician, Canandaigua VA Medical Center
PATRICIA SUH	Prosthetics and Sensory Aids Service
PENNY NECHANICKY	Prosthetics and Sensory Aids Service
ANDY WELCH	Director, Albuquerque VAMC
STEVE YOUNG	Director, Salt Lake City VAMC
BRIAN HANCOCK	Chief Medical Officer, VISN 11
MARCIA INSLEY	Director, Health Information Governance
GAVIN WEST	ACAP
PETER BREGENZER	VISN 21 BIM
JOSEPH GIRIES	Risk Management
CRAIG ROBINSON	Office of Acquisition and Logistics (OAL)
ALAN BRIDGES	
CLARK GREGG	
JOE FRANCIS	
JENNIFER FORD	

Appendix B Workgroups

Several workgroups will be utilized to gather data and perform analysis for the IPT:

1. Process Integration and Standardization Workgroup

- Develop strategy for standardizing processes across continuum of Non-VA Care
- Should consider end-to-end process from the initial consult through completion of the episode of care

Market Products Workgroup

- Develop Market & Product Strategy
- Assess marketplace
- Define market opportunities
- Develop roll-out, and sunset products
- Engage consumers and drive enrollment
- Manage distribution channels
- Develop go-to-market strategy
- Manage talent and performance
- Administer compensation
- Enable and support sales

Health Plan Benefits, Eligibility/Enrollment, and Provider Network Workgroup

- **Set Up & Maintain Products/ Benefits**
 - Build and Maintain Products
 - Administer benefits
 - Build and maintain benefit infrastructure/ non-standard benefits
- **Manage Eligibility & Enrollment**
 - Set up and maintain new accounts and members
 - Enroll and maintain accounts and members
- **Develop & Maintain Provider Network**
 - Develop and manage provider network
 - Credential providers
 - Perform provider education
 - Manage provider contracts & reimbursements

Data and Compliance Workgroup

- **Manage Compliance & Regulatory Requirements**
 - Monitor and address compliance and standards issues
 - Monitor legislative shifts and implement changes/new programs to support new regulations
 - Perform required regulatory reporting
- **Manage Data & Reporting**
 - Integrate and store all types of data for analysis and reporting
 - Support data quality, accuracy, integrity, accessibility and security
 - Perform analytics and business intelligence

- Develop internal and external reports

Claim Processing and Billing Workgroup

- Process Claim
 - Process claims and encounters efficiently and accurately
 - Manage fraud, waste, and abuse
 - Perform secondary payer functions
- Manage Billing and Reconciliation
 - Generate and distribute bills
 - Manage member account reconciliation
 - Manage delinquency

Medical Cost and Quality Workgroup

- Develop and review medical policies
- Perform case, disease management and wellness programs
- Manage utilization and prior authorizations
- Manage clinical quality and health outcomes
- Member engagement
- Enable data sharing and decision support

Finance Workgroup

- Prepare and manage budgets, plans, and forecasts
- Manage payables, receivables, and delinquency
- Perform benchmarking and cost containment
- Manage capital investments
- Manage MLR considerations

NAME	OFFICE
ELAINE HUNOLT	PROCESS INTEGRATION AND STANDARDIZATION
JENNIFER ROSENBALM JENNIFER ADAMS	HEALTH PLAN BENEFITS, ENROLLMENT/ELIGIBILITY, AND PROVIDER NETWORKS
ROBBI WATNIK DAVID ISAACKS	DATA AND COMPLIANCE
WENDY KENT JOE ENDERLE	CLAIMS PROCESSING AND BILLING
WENDY HEPKER SHEILA GELMAN	MEDICAL COST AND QUALITY
MICHAEL KUCHYAK	FINANCE
TOMMY DRISKILL JILL SNYDER	MARKET PRODUCTS