2023 Mid America Summer Institute Aug. 7-9 • Minneapolis

Igniting the Spark

FOR HEALTHCARE TRANSFORMATION

HFMA Region 8

GREATER HEARTLAND • IOWA • MINNESOTA • NEBRASKA
NORTH DAKOTA • SOUTH DAKOTA • SUNFLOWER

Igniting the Spark FOR HEALTHCARE TRANSFORMATION

2023 Mid America Summer Institute Aug. 7-9 • Minneapolis

Working with the VA: Expectations, Updates, and Appeals

August 7, 2023

2023 Mid-America Summer Institute

WHO WE ARE

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COMPREHENSIVE SUITE OF REIMBURSEMENT SOLUTIONS

VETERANS ADMINISTRATION	WORKERS' COMPENSATION	MOTOR VEHICLE ACCIDENT/TPL	OUT-OF-STATE MEDICAID
A/R RESOLUTION SERVICES	DENIALS PREVENTION AND RESOLUTION	"SAFETY NET" DENIALS	ZERO BALANCE REVIEW

SOLUTIONS ACROSS REIMBURSEMENT LIFECYCLE

DAY ONE BILLING

Team of revenue specialists dedicated solely to your facility to ensure each claim is sent to the correct payer, the first time, for the maximum allowed reimbursement.

A/R RESOLUTION

Revenue specialists and litigators manage aged accounts once placed with us. Claims are analyzed, resubmitted, and if necessary, appealed on your behalf.

ZERO BALANCE

Claims designated as zero balance are reviewed for underpayment and appealed for correct payment.

NEGOTIATED SETTLEMENTS

Specifically focused on situations where organization is presented with a prompt pay request by a payer to assure proper payment.

FOLDS OF HONOR

- A nonprofit organization dedicated to providing educational scholarships to families of soldiers wounded or killed while on active duty in the US Military
- More than 29,000 scholarships have been awarded totaling over $145 million since 2007

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LEARNING OBJECTIVES

1. How the VA modernized itself to work with Community Care Providers
2. How Legislative Changes Past, Present, and Future drive care to Community Care Providers
3. What Appeal Strategies work when attempting to overturn denials

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Agenda

1. The 21st Century: A New Culture Shift
2. The MISSION Act
3. The COMPACT Act
4. The PACT Act
5. The Modernization of the VA
6. VA Pain Points: Authorizations, Denials, Reimbursement, and Appeals
7. Wolfe Cases (#18-6091 and #2020-1958)
8. IA, KA (Sunflower) MN, MO, NE, ND, and SD Market Analysis
9. Questions

Current Veterans Affairs Department

Department of Veterans Affairs, Founded March 15, 1989

- Secretary of Veterans Affairs – Denis McDonough
  - The Department has three central responsibilities
    - **Veterans Benefits Administration**
      - Veteran registration, eligibility determination, and the five business lines: Home Loan, Insurance, Vocational Rehab, GI Bill, and Pension.
    - **National Cemetery Administration**
      - Responsible for memorial benefits and Veteran cemeteries.
    - **Veterans Health Administration (the VA)**
      - Providing health care in all forms, biomedical research, and healthcare network maintenance.

The 21st Century – Previous Processing

Original Claim Processing

- Authorization / Non-Authorized
- Claim sent to VA Fee Basis
- Manually, the VA Fee Basis would go through the following three steps:
  1) Is the Patient a Veteran?
     - Stolen Valor / Registered Veteran / Expired Veteran
  2) Is the Patient's Injury related to Service?
     - Service Related (Full Medicare) or Non-Service Related (Millennium Bill [75th Percentile of Medicare])
  3) Is the Patient's claim authorized correctly?
     - Claim procedures, stay, correct individual.
- If the claim met a certain dollar threshold, the claim then went to Washington D.C. for confirmation scoring.
- Once the VA decided, they would either approve or deny the claim.
  - This entire process was manual with minimal technological impact as there was only one A/R system in existence (VistA). VistA is a 1970's system that has been franken-upgraded for the past five decades.
- VA payment came from the Department of Treasury.
- VA denial comes from the local with limited Appeal rights.

The 21st Century – PC3 & VCP

❖ PC3 Claim Processing – Veterans Choice Program / 2014

- Eligibility
  - Most near VA Medical Center (VAMC) or Community Based Outpatient Clinic (CBOC) with a full-time Primary Care Manager is greater than 40 miles from their home, or
  - They are, or will be, on a wait list of 30 days or more with a VAMC, or
  - Services are not available at VAMC, or
  - The closet VAMC is not easily accessible from their home or there are significant geographic barriers.

- Authorization (Two Paths)
  1. Veteran calls TriWest to confirm VCP eligibility (**40-mile exception**) OR VA sends a referral to TriWest (**PC3, Choice First, or 30-Day exceptions**),
  2. PSR locates VCP / PC3 Provider,
  3. PSR makes appointment on behalf of Veteran, and
  4. TriWest sends authorization to provider via Fax.

- Claim Submission
  - Claim (UB, Itemized Statement, and Medical Records) go to TriWest within 180 days of date of discharge. Medical records can trail a UB / Itemized Statement by 30 days (no less and the claim is denied).

- Claim Processed within 30 days remitting payment or denial.
- Appeal Right – 90 Days from date of denial, not date of receipt of denial.

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The MISSION Act

- On May 23, 2018, the Senate passed an act introduced by Senators McCain, Akaka, and Johnson. The Act was the **M**aintaining **I**nternal **S**ystems and **S**trengthening **I**ntegrated **O**utside **N**etworks Act, also known as the MISSION Act, in response to the VA scandals throughout the decade. The Act became active on June 6, 2019.
- What changed on June 6, 2019?
  - Established the Veterans Community Care Program, which has different eligibility criteria for Veterans so they have an "easier" time of going out of network.
    - This was meant to allow Veterans another remedy to receive treatment that the VA could not provide in a timely manner or they lack the resources to provide.
    - Eligibility criteria significantly changed.
  - Terminated the Veteran's Choice Program, which exhausted the VA's resources in adjudicating.

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The MISSION Act – Veteran Eligibility

- How veteran eligibility changed under the MISSION Act:
  - The Veteran, in order for the VA to furnish care, must meet at least one of more of the conditions listed below;
    A. The covered veteran required hospital care, medical services, or extended care services and:
       1. No VA facility offers the care, services, or extended services the veteran requires, OR
       2. The VA does not operate a medical facility in the State in which the veteran resides, OR
       3. The veteran was eligible to receive care under the VACA Act of 2014, OR
       4. The veteran has contacted an authorized VA official to request the care required, but the VA has determined that they cannot furnish it, OR
       5. **The veteran and their referring clinician determined it is in the best medical interest of the veteran, to access care or services from an eligible entity based on the following factors:**
          a. Distance, Nature, Frequency, Timeliness, Improved Continuity of Care, Quality of Care, or if the Veteran faces an unusual burden:
             i. Excessive driving distance, Whether care at the VA is reasonably accessible, Whether a medical condition of the veteran affects the ability to travel, Whether there is a compelling reason the veteran needs to receive care and services from a non-VA facility, The need for an attendant, and The VA facility would not furnish the type of care that meets the VA quality standards.

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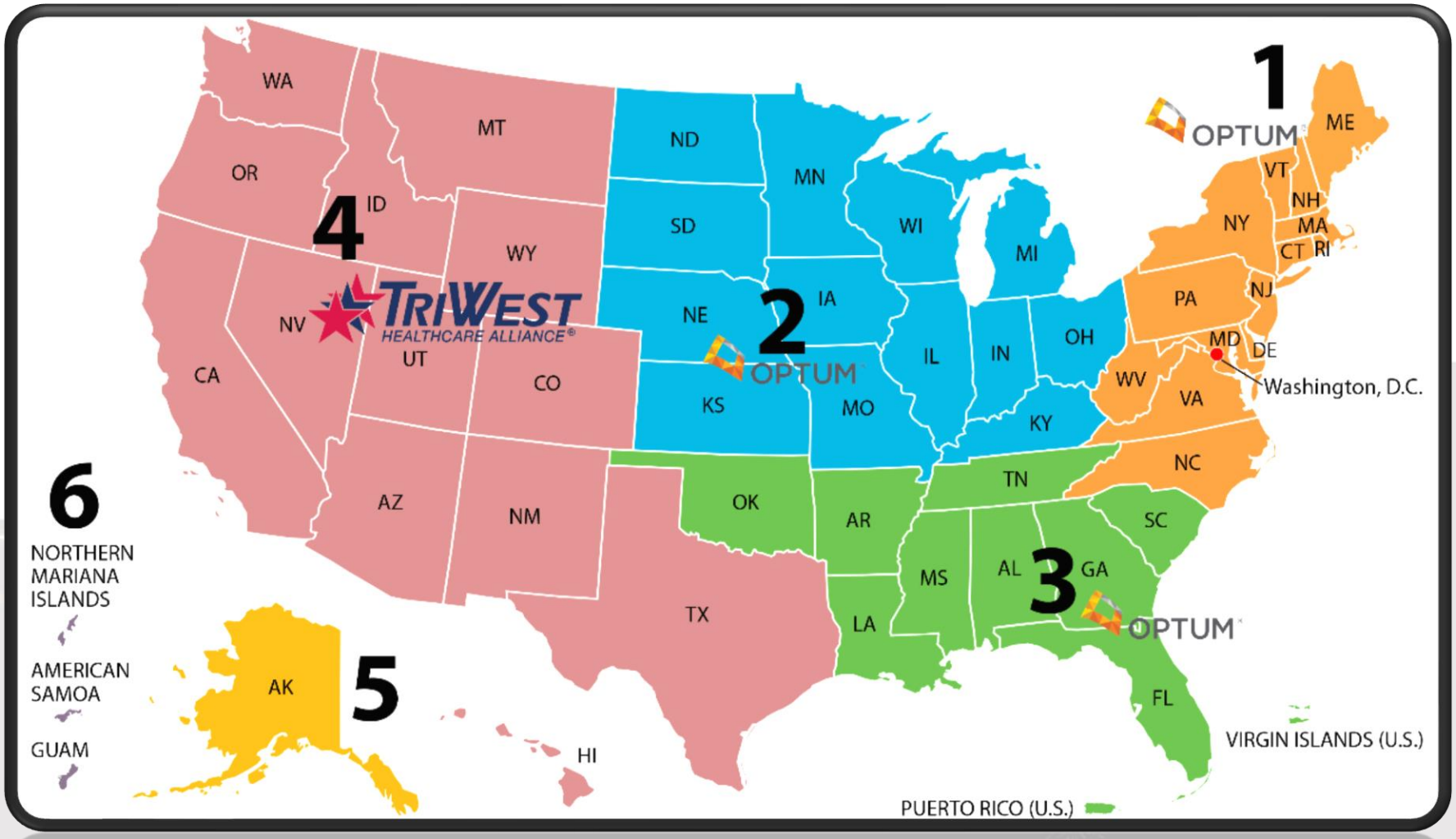
The MISSION Act – Claim Submission

- Under MISSION, the claim submission process changed.
  - How the MISSION changed Claim Submission
    - Claims are now divided by authorization.
    - AUTHORIZED
      - If the hospital received authorization from Optum, either a planned admission or an ER admission that was authorized within 72 hours, the Uniform Bill (UB) goes to CCN Carrier.
      - The VA receives the medical records (along with a copy of the claim to accelerate processing) to confirm that services rendered match the authorization.
        - If authorization matches, CCN Carrier will process and pay the claim.
        - If authorization does not match, TriWest will deny.
    - NOT AUTHORIZED
      - All non authorized claims should be submitted with the UB and Medical Records to the local VA that houses the Veteran.

The MISSION Act – Coverage Areas

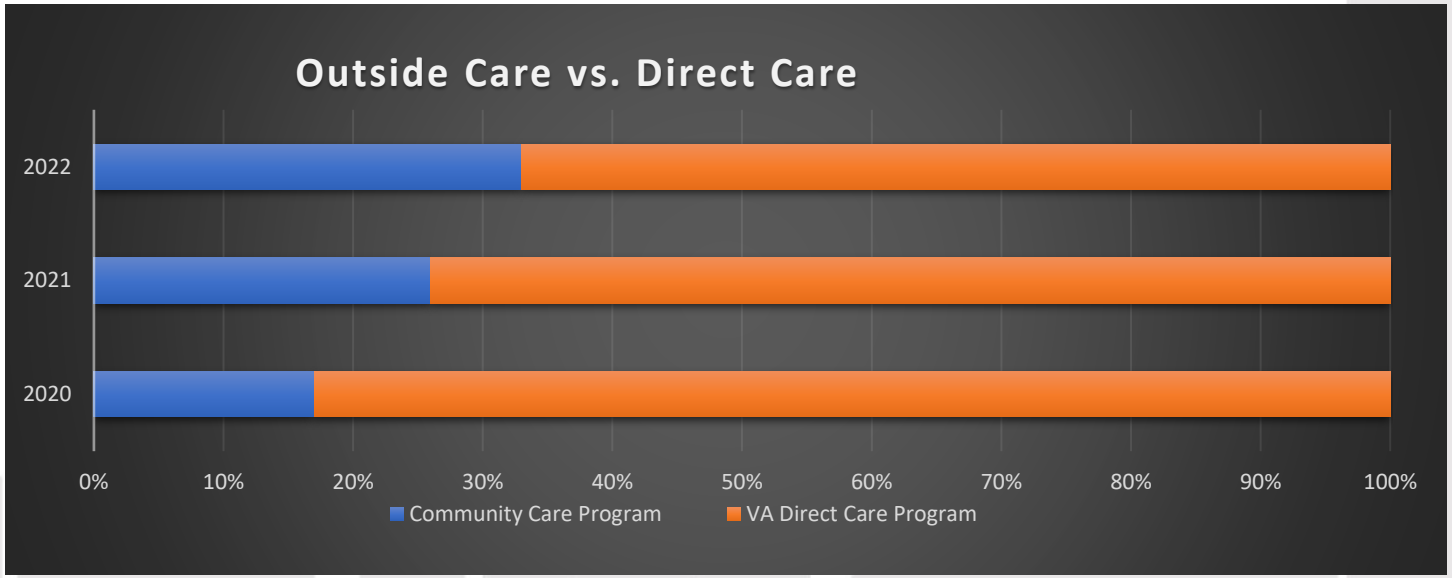


The MISSION Act – Coming Together

- Differences between VCP / PC3 and CCN
  - VCP / PC3 – Two programs that worked in "harmony"
    - VCP – 40-mile exception
    - PC3 – Wait list is longer than 30 days for services
    - PC3 – Services Not available in State
    - PC3 – Closet is not easily accessible
  - CCN – Rolled both programs and added fifth option
    - Services not available in State
    - VA does not operate in that State
    - Veteran eligible to receive benefits under VACA Act of 2014
      - Grandfather – AK, ND, SD, MT, or WY
    - VA cannot furnish those services in a timely manner
    - Best Medical Interest of the Veteran

The MISSION Act – Effects

- Community Provider Utilization
  - MISSION passed in 2019 and was fully implemented in 2020.



  - Utilization of CCN resources continues to increase at an accelerated pace.
  - Anticipated Usage for 2023 is at 40% (Pre-PACT Act)

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The COMPACT Act – Mental Health

Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (COMPACT)

- Signed into law on December 5, 2020
- As of 2020, 17 Veterans commit suicide every day
  - 16.8 Veterans for every 100,000 Veterans
- Due to an enormous outcry concerning Veterans committing suicide, Congress wanted more attention and resources available for suicide prevention.
- Upon passage, the VA created multiple programs and initiatives
  - Improve transitional phase resources and support networks.
  - Launched a pilot program to educate Veteran families for better advocacy regarding Veteran lives and mental health issue identification.
  - Tasked the VA with developing and enacting protocols and programs to assist those Veterans in imminent danger.

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The COMPACT Act – Changes

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The COMPACT Act – Mental Health

On January 17, 2023, the VA implemented the last program change which directly affects Hospitals

- If a Veteran presents to a hospital in an “acute suicidal crisis”, the Veteran can receive care at any Provider (time to find an “approved” community emergency department could endanger the Veteran)

- The government defines an “acute suicidal crisis” under 38 U.S.C. § 1720J(h)(1) as an individual that was determined to be at imminent risk of self-harm by a trained crisis responder or health care provider.

- If an enrolled Veteran presents in this condition, the Veteran is entitled to 30 days of inpatient care and 90 days of outpatient therapy / treatment at no cost to the Veteran.

- The process for COMPACT notification follows the same procedure as Emergency Notification.

The PACT Act – New Coverage

- Promise to Address Comprehensive Toxics Act
  - Signed into law on August 10, 2022
  - Added more than 20 new Medical Conditions that result in **PRESUMPTIVE** eligibility for service-connected conditions.
    - Expanded and extended VA health care for Veterans with Toxic exposure from Vietnam, Gulf War, and post 9/11.
  - The VA is required to provide Toxic exposure screening to every Veteran enrolled in VA health care.
    - Due to conditions created by Burn Pits and other Toxic exposures (Agent Orange)

The PACT Act – What's Added

- Coverage extended by conditions created from Burn Pits and other Toxic exposures
  - Several Forms of Cancer are now considered covered and paid by the VA under 38 U.S.C. § 1728
    - Service-Connected Conditions are paid by the VA at 100% of the Medicare Allowable (paid by VA regardless of other medical coverage)
  - New Cancer include
    - Brain, Gastrointestinal, Gliobastoma, Head, Kidney, Lymphatic, Lymphoma, Melanoma, Pancreatic, Reproductive, and Respiratory.
  - New Illnesses include
    - Asthma (after service), Bronchitis, COPD, Rhinitis, Sinusitis, Emphysema, Granuolmatous, Interstital Lung Disease, Pleuritis, Pulmonary Fibrosis, and Sarcoidosis.
  - Coupled with MISSION Act CCN coverage, CCN providers should expect an increase of usage of their facilities for Veterans with the above noted conditions.

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Legislative Changes - Past & Present

- Past 5 years have seen the VA modernize and open itself up in ways that were unimaginable a decade ago.
  - MISSION Act 2018
  - COMPACT Act 2020
  - PACT Act 2022
- In July, Senate Committee reviewed several bills with potential impact to Community Providers
  - RELIEVE Act – ER Coverage for Veterans going through enrollment
  - Veterans Health Care Freedom Act – Reimagine VA Insurance
  - Making Community Care Work for Veterans Act of 2023 – Wait Times

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Modernization of the VA - Notice

- Notification
  - Prior to June 8th, 2020,
    - Emergency claims, hospitals would have to locate the local VAMC , contact their case management department, and begin the process of notification and authorization.
    - This process was time consuming, highly unreliable, and generally mismanaged.
  - As of June 8th, 2020
    - The VA moved to centralized Notification Center. 1 Center, Phone Number, and Email Address.
    - Phone 1-(844) 724-7842 / Email VHAEmergencyNotification@va.gov
    - Providers are expected to utilize VA Form 10-10143g for case specific information.
  - December 21st, 2020
    - After several issues developed at the time of go live for the email, the VA relaunched this process as a Portal. (PHI in email and inability to send Secure Emails)
    - Portal address → https://emergencycarereporting.communitycare.va.gov/#/request
    - Users can also call with Urgent Requests at (844) 724-7842

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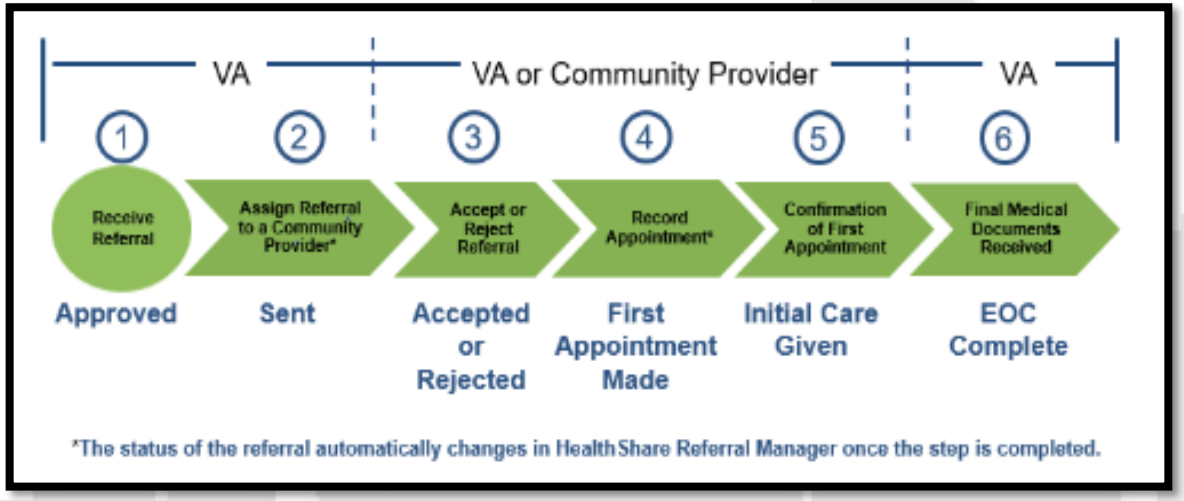
Modernization of the VA – Referrals / HSRM

- HealthShare Referral Management (HSRM)
  - During 2019, the VA rolled the HSRM program.
  - VA meant for this program to alleviate and accelerate Referrals and Approvals
    - The lifecycle example;



- In order to utilize this program, a hospital must opt in with the VA, undergo two-hour training (every Tuesday at noon EST), and submit an End User form to the HSRM.
- Once approved, your hospital can schedule referrals online, upload medical records for review, and access approved / denied authorization documentation.

Modernization of the VA – Claim Submission

- Centralization of Submission
  - Prior to May 1st, 2020,
    - Hospitals had to submit claims to the local VAMC. The hospital may not know who the VAMC is if the hospital straddled region lines.
    - This would lead to significant delays in getting claims submitted, processed, and paid.
  - After May 1st, 2020,
    - At this time, the VA would like to move away from physical submission as they continue to push the Change Healthcare clearinghouse (as they are partnered with them).
    - For any physical submission, the information would need to go to;
      - **VHA Office of Community Care**
      - **P.O. Box 30780**
      - **Tampa, FL 33630-3780**

VA Pain Points – Medicare

- When Is Medicare Primary?
  - 38 U.S.C. § 1725 Reimbursement for Emergency Treatment [Medicare > VA]
    - The VA is primary if in cases where;
      - The veteran is enrolled and received care within the past 24 months AND
      - The veteran is enrolled with VA coverage (per § 1705 of this chapter)
    - Medicare is primary is the patient possesses Medicare at the time services were rendered.
      - VA will pay as a secondary payer in these instances now (see ***Wolfe vs. Wilkie*** & ***Wolfe vs. McDonough***)
  - 38 U.S.C. § 1728 Reimbursement of Certain Medical Expenses [VA ≥ Medicare]
    - The VA is primary if the patient presents with the following;
      - An adjudicated service-connected disability,
      - A nonservice connected disability associated with and held to be aggravating a service-connected disability,
      - Any disability of a veteran if the veteran has a total disability permanent in nature from a service-connected disability,
      - Any illness, injury, or dental condition of a veteran who
        - A participant in a vocational rehabilitee program; and
        - Medically determined to have been in need of care or treatment to make possible the veteran's entrance into a course of training or prevent interruption of course of training.
    - Even if the patient possesses Medicare, the VA is primary.
      - VA will process and pay this claim at 100% of the Medicare allowable
      - Per the MSP, if VA approves the claim, they are responsible for that claim.

VA Pain Points – Ambulance Claims

❖ Authorized Ambulance Transport – Conditions

- ❖ Veterans must meet the following administrative requirements for authorized transport:
  - ❖ Have a service-connected disability or combined rating of 30% or more, OR
  - ❖ Be in receipt of a VA pension, OR
  - ❖ Previous calendar year income does not exceed maximum VA pension rate, OR
  - ❖ Projected income in travel year does not exceed maximum VA pension rate, OR
  - ❖ Travel is in connection with care for a service-connected disability, OR
  - ❖ Travel is for a Compensation and Pension exam, OR
  - ❖ Travel is to obtain a service dog, OR
  - ❖ Travel relates to VA transplant care, AND
  - ❖ ***A VA clinician determines and documents that special mode transportation is medically required***.

- ❖ Per Policy 32 CFR 199.4(d)(3) there are a few requirements:
  - ❖ HCPCS Level II Codes → A0225 – A0384, A0390 – A0398, A0420 – A0436, and A0999
  - ❖ §§ III. POLICY → In all service areas where suppliers routinely bill a mileage charge for ambulance services in addition to a base rate, an allowable amount will be calculated based upon the POP (Point of Pickup) zip code of the beneficiary at the time he or she is placed on board the ambulance to the final destination.
  - ❖ The above policy is silent to the POP requiring additional Value Codes.

VA Pain Points – Authorization vs. Notification

- How do you review a patient encounter?
  - Registration
  - Notification (ER) or Prior Authorization (Planned)
  - Transfer (VA Facility) or Episode of Care Occurs
  - Discharge
  - Claim Submission
  - Follow Up
  - Review
  - Appeal

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VA Pain Points – Top 5 Denials

When working a Veteran claim, you can encounter some difficult denials to overturn

- Top 5 Denials from the VA are :
  1. Untimely filing
     - 90 Days for Mil Bill, 180 Days for CCN, 2 Years for Service
  2. Lacking an authorization
     - Did not meet criteria or process
  3. Patient not enrolled
     - Veteran did not enroll in 24 months
  4. The responsibility of another carrier
     - TriWest / Optum Serve (CCN claim)
  5. Coding
     - Standard Episode of Care Listing

VA Pain Points – Authorization Denials

- When working a Veteran claim
  - Authorizations
    - If the patient presents for ER services, they must be Notified (exception to EMTALA). The timeline is 72 hours from start of treatment and the call is whether a bed or bay is available.
    - You have two options with this denial.
      - **<u>OPTION #1 (Authorization on file)</u>**
        - Under TriWest → If there is an authorization on file, see if a Secondary Authorization Request ("SAR")or Request For Service ("RFS") is appropriate.
        - Under VA → If there is an authorization on file, did you attempt a Service Authorization Review for an extension?
      - **<u>OPTION #2 (Appeal)</u>**
        - Utilizing the Standard of Care as noted in the VA statute, if the patient feels their life is in danger and a **<u>reasonable person</u>** would conclude that services are needed, the VA will not deny the claim.

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VA Pain Points – Reimbursement Rates

- How does the VA process and pay your claims?
  - Based on the Veteran's Injury
  - Non-Service Related Injury versus Service-Related Injury
    - Non-Service Related Injuries
      - Under the Millennium Act of 2001, Non-Service-related Injuries are covered by the VA at a discounted rate
      - Discounted Rate equals 70% of Medicare (38 C.F.R. §17.1005)
    - Service Related Injuries
      - Service-Related Injuries are paid at 100% of the Medicare allowable. (38 C.F.R. §17.4035)
    - VA rules changed in 2022 regarding source of referral and payment logic.
      - In 2022, Urban hospitals receive urban rates, while rural hospitals receive rural rates.

Reimbursement continues to be a point of contention as demand from Veterans continues to grow.

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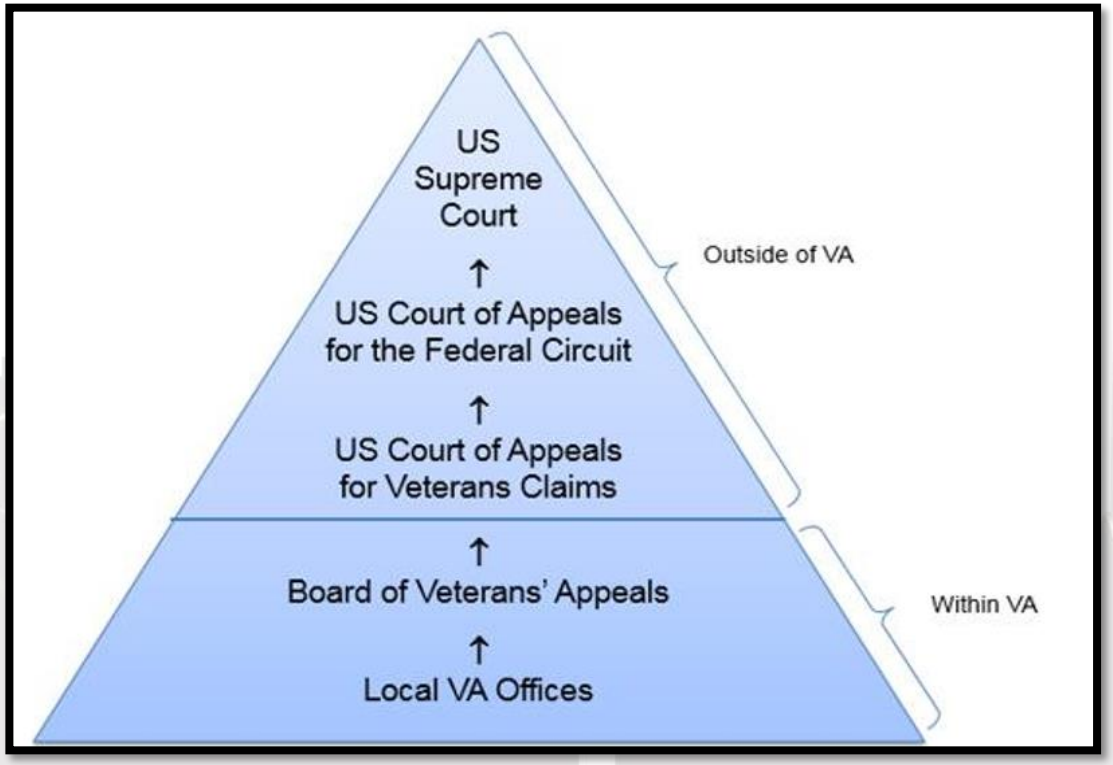
VA Pain Points – Appeal Road Map

❖ Veteran Health Administration Appeal Map

- Appeal landscape is difficult
- Timeline;
  - 90 Days for VA appeal
  - 1 Year for Court Appeals
  - Must go through each step
  - If you skip a step, will be dismissed
  - Various Admin Law Standards

- Success
  - Not a great overturn rate
  - Board of VA Appeals
  - Goes to Veteran's Benefit File



- Roadblocks
  - Will not get a copy of the Veterans Benefit file. Hospital does not have standing to sue on this issue.
  - Significant language barrier → Standards continue to shift, no established standard such as "Arbitrary and Capricious". Mostly "De novo" or "clearly erroneous"

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VA Pain Points – Drafting an Appeal

- How to write an appeal?
  - Format – Issue, Rule, Analysis, and Conclusion
    - **Issue** – Clearly Identify the reason for the denial
      - Examples; Authorization, Timely Filing, Responsibility
    - **Rule** – Layout the rule per statute or policy
      - Authorization – 72 hours when treatment starts
    - **Analysis** – Show your actions
      - Give detailed notes that you took to follow the procedure
    - **Conclusion** – Demand that the VA review
      - Request the VA overturn their previous decision after a de novo review

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Wolfe Cases – Secondary Insurance

- VA as a Secondary Payer
  - Wolfe vs. Wilkie
    - VA Coordination of Care - Previously, the VA was known as a Payer of Last resort and would never work as a secondary payer.
    - The Court of Veteran Appeals approved and directed the VA to act as a secondary payer for Emergent Claims paying only Deductible and Co-Insurance at the Medicare rates.
  - Wolfe vs. McDonough
    - Court reviewed the prior ruling and reviewed the definitions of Co-Insurance and Deductible.
    - Court modified the ruling by allowing Co-Insurance to continue coverage but denying deductibles as clearly part of the ban.
- VAMC Fee Basis payments resumed as of 7/17/2022.
  - VA will only pay for co-insurance for Emergent Care claims.

Probably not the last time we've seen issue as Congress may take up this issue in the future

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Region 8 – AIR Market Analysis

VISNs – 15, 16, and 23 (Region 8 States)

- Population Changes

State	2019	2029	% Change
Iowa	95,805	86,335	-9.88%
Kansas	177,614	172,640	-2.80%
Minnesota	159,149	150,737	-5.29%
Missouri	149,470	138,409	-7.40%
Nebraska	70,255	68,358	-2.70%
North Dakota	39,770	36,866	-7.30%
South Dakota	54,943	49,559	-9.80%

Population shift, increase in demands for services, and more openings to seek care outside the VA will continue

- Result
  - ❖ Keeping VA facilities staffed, modernized, and agile to offer services is an tremendous undertaking.
  - ❖ The VA reviewed their current coverage and found possible ways to utilize Community Care Providers to offset the decrease in demand

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Region 8 – AIR Market Analysis

VISNs – Highlights of Recommendations and Cost

- Iowa - $1.6 Billion
  - Partner with a CCN Provider with CLC outside of Iowa City
- Kansas - $1.6 Billion
  - Converting Leavenworth and Topeka VAMCs and outsourcing some services
- Minnesota - $3.5 Billion
  - Modernize Minneapolis VAMC
- Missouri - $74 Million
  - Shift services to Community Partners surrounding STL – Barracks and Poplar Bluff
- Nebraska - $754 Million
  - Modernize the Omaha VAMC
- North Dakota - $614 Million
  - Est RRTP services at Fargo VAMC
- South Dakota - $406 Million
  - Closure of Ft. Meade and Hot Springs VAMC and shifting to Community Providers

Total Cost
$8.5 Billion

Total Budget
$5 Billion

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QUESTIONS?

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