Veterans Access, Choice, and Accountability Act of 2014

Summary of Interim Final Rule

On August 7, 2014, President Obama signed into law the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146) ("Veterans Choice Program"). Technical revisions to VETERANS CHOICE PROGRAM were made on September 26, 2014, when the President signed into law the Department of Veterans Affairs Expiring Authorities Act of 2014 (Public Law 113-175). These laws authorize the Veterans Administration (VA) to furnish hospital care and medical services to eligible veterans through agreements with eligible entities or providers. On November 5, 2014, an Interim Final Rule (IFR) was published in the Federal Register to implement Title I of VETERANS CHOICE PROGRAM, e.g., the "Veterans Choice Program" or "Program." The IFR, in conjunction with a Fact Sheet posted on the VA website, defines the parameters of the Veterans Choice Program and clarifies how veterans and physicians and other providers may access the program. Comments may be submitted on the IFR on or before March 5, 2015. A summary of key provisions of the IFR is set forth below.

Scope and start date of the Program: By law, the Program is authorized to run until August 7, 2017, or until the Veterans Choice Fund established by the Act is exhausted. The VA is phasing in implementation of the Program, beginning on November 5, 2014, to ensure it has the necessary resources in place to furnish hospital care and medical services to eligible veterans.

Eligibility criteria for veterans to participate in the Program: In general, veterans must have been enrolled in the VA health care system on or before August 1, 2014, or must be within 5 years of post-combat separation. A Veteran must also meet at least one of the following criteria:

- The Veteran is unable to schedule an appointment within the wait-time goals of the Veterans Health Administration—defined as within 30 days from his/her preferred date or the date medically determined by his/her physician.
- A Veteran is eligible if he/she resides more than 40 miles from the closest "VA medical facility." VA will calculate the distance between a Veteran's residence and the nearest VA medical facility using a straight-line distance, rather than the driving distance. "VA medical facility" is defined as "a VA hospital, a VA community-based outpatient clinic, or a VA health care center." The VA is interpreting this standard as meaning distance from "any" medical facility, even if that facility cannot provide the care that the Veteran requires. In response to whether the 40 mile rule refers to whether the specialty need, for example, orthopedic surgery, is available within 40 miles, or 40 miles from any VA facility, whether or not that specialty is available there, the Fact Sheet states "The law is clear that eligibility must be based on the distance from the Veteran's residence to *any* VA medical facility, even if that facility does not offer the specific medical service the Veteran requires for that particular visit."
- The Veteran resides in a location other than Guam, American Samoa, or the Republic of the Philippines that 40 miles or less from a VA medical facility, and needs to travel by plane or boat to the VA medical facility closest to his/her home.
- The Veteran faces a geographic challenge, such as extensive distances around water or other geologic formations, such as mountains, that presents a significant travel hardship.

Eligibility criteria for non-VA health care entities and providers to participate in the Program:

- As VETERANS CHOICE PROGRAM provides, in order to be eligible for the Program an entity or provider must be participating in the Medicare program, be a Federally-qualified health center, or be a part of the Department of Defense or the Indian Health Service.
- Non-VA entities and providers must enter into an agreement with the VA to provide non-VA hospital care or medical services through contracts, intergovernmental agreements, or provider agreements; the preamble to the IFR states that since VETERANS CHOICE PROGRAM authorizes the VA to use agreements reached before the enactment date, "As an operational matter, VA will, to the maximum extent practicable and consistent with the requirements of section 101, use existing sharing agreements, existing contracts, and other processes available at VA medical facilities prior to using provider agreements under this section."
- Non-VA entities or providers must be accessible to the veteran, meaning they must be able to provide timely care, must have the necessary qualifications to furnish the care, and must be within a reasonable distance of the veteran's residence.
- Eligible non-VA entities and providers must maintain at least the same or similar credentials and licenses as VA providers, and must submit information verifying compliance with this requirement annually.

Process for authorizing non-VA care under the Program: Eligible Veterans may elect to schedule an appointment with a VA health care provider, be placed on an electronic waiting list for VA care, or have VA authorize the Veteran to receive an "episode of care" for hospital care or medical services from an eligible entity or provider. If they elect to receive non-VA care, they may select the provider who will furnish their care, if that provider is eligible, or the VA will refer the Veteran to a specific entity or provider. According to the Fact Sheet, Veterans will receive a "Choice Card," which will be issued in three phases. Once a Veteran receives a Choice Card, they will be eligible to use the Program if they meet the specific eligibility criteria and call to receive approval for use. Veterans who are eligible based on their place of residence may elect non-VA care for any service that is clinically necessary. However, Veterans eligible based on "wait-time" may select non-VA care only for an appointment for the service that cannot be scheduled within the 30 day wait-time goal. "Episode of care" is defined to mean "a necessary course of treatment, including follow-up appointments and ancillary and specialty services, that lasts no longer than 60 days from the date of the first appointment with a non-VA health care provider." This period can be extended for another 60 days if the Veteran still qualifies for out-of-network care and wants to continue receiving care from the non-VA health care provider.

Payment rates and methodologies: Payment rates will be negotiated and set forth in an agreement between the Secretary and an eligible entity or provider. Except for in highly rural areas, the VA may not pay an eligible entity or provider more than the applicable Medicare rate under Title XVIII of the Social Security Act for hospital care or medical services furnished under the Program. When there are no Medicare rates available, the VA will follow its usual methodology for calculating payments to the extent such methodology is consistent with the Act. VA is a secondary payer for care furnished for a nonservice-connected disability if the veteran has another health-care plan. VA will only pay for authorized care where an actual encounter with a health care provider occurs. Veterans must seek authorization from VA before receiving care.

Co-payments: VA's existing copayment regulations are modified to clarify that no copayment is owed at the time of service for eligible veterans receiving care or services through the Program. VA will determine the copayment amount after the provider bills VA for the cost of furnished care, and veterans may be liable for some or all of the copayment amount at that time. Copayment rates will not exceed those currently established in regulation. If an eligible Veteran has another health insurance plan, the VA

will be secondarily responsible for costs associated with non-service connected care and services and primarily responsible for service connected care.

Claims Processing: The IFR establishes a claims processing system to receive requests for payment and to provide accurate and timely payments for claims received under the Program. This system will be managed by the Veterans Health Administration's Chief Business Office.

Effect of the Program on other benefits and services available to Veterans: In general, the Program does not affect a Veteran's eligibility for hospital care or medical services under the medical benefits package. The VA will pay for and fill prescriptions written by non-VA providers under the Program to the extent such prescriptions are covered by the VA medical benefits package. VA will reimburse veterans' copayments or cost-shares required by their other health-care plan to the extent authorized by law, and VA will calculate veterans' VA copayments as described above. VA will also reimburse veterans for travel to receive care under the Program if the veteran is otherwise eligible to participate in VA's beneficiary travel program.