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MEMORANDUM

November 10, 2014

TO: Tribal Health Clients

FROM: Hobbs, Straus, Dean and Walker LLP

Re: *VA Issues Interim Final Rule on Veterans' Access to non-VA Health Facilities, including Tribal and IHS facilities*

On Wednesday, November 5, the Department of Veterans Affairs (VA) released an Interim Final Rule implementing the Veterans Choice Program (Program), which allows eligible veterans to access hospital care and medical services (Services) at non-VA health care facilities, including those of tribes and the Indian Health Service (IHS), pursuant to the Veterans Access, Choice, and Accountability Act of 2014 (Act), Pub. L. 113-146, § 101 (2014). The Interim Final Rule is effective immediately, but the VA will consider and address comments received until March 5, 2015. Please let us know if you would like assistance in developing comments on the Interim Final Rule.

Scope, Funding, and Duration

The Veteran's Choice Program is a short-term solution designed to expand veterans' access to health care while the VA enhances its capacity to furnish care in a timely and accessible manner.

It allows veterans to receive services from non-VA providers if they can demonstrate they had too great a wait time at a VA facility, or if services at VA facilities are not accessible to them. The Program makes a $10 billion Veterans Choice Fund available for VA to purchase care from other providers through the Program, including IHS, tribal facilities, and urban Indian programs. It expires either when the VA has exhausted the Veterans Choice Fund or three years after the Act's August 7, 2014, enactment date—whichever comes first.

The Program is designed to supplement the VA's existing purchased/referred care system, and it does not replace that system. For example, it only covers services received through an appointment, and as a result it does not cover emergency services. Veterans may still receive care for emergency services from outside providers under the VA's existing program.

Eligible Veterans

To be eligible for the Program, a veteran must satisfy two criteria. First, the veteran must be enrolled in the VA's patient enrollment system as of August 1, 2014, or be eligible for services under 38 U.S.C. § 1710(e)(1)(D) and a veteran under 38 U.S.C. § 1710(e)(3). As explained in the Preamble to the Interim Final Rule, this requires a veteran to be within five years of post-combat separation.

Second, the veteran must experience hardship in accessing VA facilities due to one of the following reasons: (1) he or she has attempted but been unable to schedule an appointment within the wait-time goal of the VA, which is currently 30 days; (2) he or she resides more than 40 miles from a VA medical facility; (3) he or she resides more than 20 miles from and in a state without a VA medical facility that provides hospital care, emergency medical services, and surgical care; (4) he or she resides in a location that requires travel by air, boat, or ferry to reach a VA medical facility that provides hospital care, emergency medical services, and surgical care; or (5) he or she resides in a location that causes an unusual or excessive burden in accessing a VA medical facility that provides hospital care, emergency medical services, and surgical care.

The VA is phasing the Program in, and veterans eligible based on place of residence may receive services beginning November 5, 2014, while those eligible based on wait time may begin receiving services no later than December 5, 2014.

Eligible Providers

Providers must meet certain qualifications to be eligible for participation in the Program. First, a provider must qualify under one of the following categories: providers participating in the Medicare program; federally-qualified health centers as defined by Section 1905(1)(2)(B) of the Social Security Act; the Department of Defense; or the IHS. According to the Preamble, IHS facilities qualify because the Act specifically provides for them.

However, with regard to tribal facilities, the Preamble states that "[o]utpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination and Education Assistance Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act" qualify because those entities are included in the definition of "federally-qualified health centers" in Section 1905(l)(2)(B) of the Social Security Act. 79 Fed. Reg. 65571, 65579 (2014). This statement muddies the water regarding whether tribal inpatient facilities operated under 638 contracts or compacts qualify for the Program. IHS programs are specifically included in the list of entities eligible to serve as non-VA providers in the Act, and, if a tribe were to take over that IHS program under a 638 contract or compact, it should be able to stand in the shoes of the IHS for purposes of qualifying as an eligible provider under the Program. Tribal health programs with inpatient facilities may want to comment on this aspect of the Interim Final Rule.

Second, a provider must enter into an agreement with the VA for provision of services under the Program. Agreements include contracts, intergovernmental agreements, and provider agreements. In the Preamble, the VA states that it will use existing sharing agreements, contracts, and other processes that were available prior to the Program. 79 Fed. Reg. 65,571, 65,579 (2014). This is important, as many tribes and the IHS have already entered into agreements with the VA to provide services to IHS-eligible veterans that allow IHS and tribal facilities to bill the VA for the provision of such services. These existing agreements should be able to cover services reimbursed by the VA under the Program as well.

Third, a provider must maintain at least the same or similar credentials and licenses as those required of VA's health care providers, and it must submit verification to the VA at least once per year. The Preamble states that the requirements are available through the Veterans Health Administration Handbook 1100.19 and the Veterans Health Administration Directive 2012-030. The Preamble suggests that any agreement entered into between the VA and the provider should further clarify credential and license requirements.

Fourth, a provider must be accessible to the veteran, and this may change depending on each time services are rendered. The Act and Interim Final Rule both state that veterans are able to choose which non-VA provider accessible to them they will utilize. The Interim Final Rule, however, goes further by requiring the VA to determine on a case-by-case basis that the provider is accessible to the veteran. In making a determination regarding whether a provider is accessible, the VA examines whether the wait time before the earliest appointment is reasonable, the expertise and equipment of the provider related to the services the veteran requires, and the distance to the provider.

Eligible Services

The VA must authorize a veteran to receive services from a non-VA provider, and the Interim Final Rule requires a provider to contact the VA to obtain prior authorization before rendering services. For that reason, unscheduled services, such as emergency room services, are not covered by the Program. In order to receive an authorization, the Preamble states that the VA must deem the services necessary. 9 Fed. Reg. 65571, 65581(2014).

The VA's authorization for services covers an entire episode of care. This episode may encompass more than an initial visit but may not exceed 60 days. The authorization may include follow up care, and the Interim Final Rule further states that it may include special and ancillary services.

According to the Interim Final Rule, when a provider determines that additional services are necessary beyond those included in the VA's authorization, it must seek an additional authorization for those services.

Rates

The Act and the Interim Final Rule impose a Medicare-Like Rate for services, which requires the VA to negotiate a rate with providers that does not exceed what Medicare would pay for the same service. However, in order to ensure continued access to care, the Act and Interim Final Rule provide that rates may exceed the Medicare-Like Rate if the provider is located in a highly rural area, which is defined as a county that has fewer than seven individuals per square mile. The Interim Final Rule also provides an exception if there are no Medicare rates for the particular service sought.

Billing

The Program's billing procedures are different depending on whether a veteran is seeking services for a non-service-connected disability and whether the veteran has another health-care plan. The VA must disclose this information to a provider. The Act defines non-service-connected disability, and the Interim Final Rule further defines the term using the VA's longstanding definition.

When a veteran is seeking services for a non-service-connected disability and has another health-care plan, the health-care plan is primarily responsible for reimbursing the provider to the extent the services are covered by the plan. The provider should seek reimbursement from the health-care plan first. The Interim Final Rule provides that the VA is secondarily responsible, paying the amount the health-care plan does not cover but not more than the negotiated-for rate. The Interim Final Rule states that the VA will reimburse veterans' payments required by other health-care plans. The Preamble clarifies that the VA will cover any copayment, cost-shares, or dedications required of the veteran by the health-care plan.

The Program provides for veteran copays. The Act states that providers should collect Program copays from veterans at the time of service. However, the Interim Final Rule states that veterans will pay a $0 copay at the time of service and will instead give the provider the appropriate copay after billing is completed.

The Act calls on the VA to create a centralized system for processing and paying bills to providers. The Chief of Business Office of the VA is to oversee the implementation and maintenance of the system. The Interim Final Rule does not provide more guidance regarding what the VA's claim-processing system will look like.

Possible Issues for Comments

- Whether the Interim Final Rule too narrowly constricts which tribal health care facilities are eligible providers under the Program.

- What the requirements are for demonstrating to the VA that services are necessary in order to receive an authorization.

- Whether an existing agreement with the VA must be modified to incorporate the Program's rate limitations.

For further information on the Interim Final Rule, please contact Elliott Milhollin at (202) 822-8282 or emilhollin@hobbsstraus.com or Geoff Strommer at (503) 242-1745 or gstrommer@hobbsstraus.com.