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The Veterans Choice Program (VCP): Program Implementation

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Summary

Authorized under Section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), the Veterans Choice Program (VCP) is a new, temporary program (the VCP is set to expire in August 2017 or whenever funds in the Veterans Choice Fund are exhausted) that enables eligible veterans to receive medical care in the community. It supplements several existing statutory authorities that allow the Veterans Health Administration (VHA) to provide health care services to veterans outside of the Department of Veterans Affairs (VA) facilities. Generally, all medical care and services (including inpatient, outpatient, pharmacy, and ancillary services) are provided through the VCP—institutional long-term care and emergency care in non-VA facilities are excluded from the VCP and are provided under different authorities. The VCP is not a health insurance plan for veterans, nor does it guarantee health care coverage to all veterans.

Eligibility and Choice of Care

Veterans must be enrolled in the VA health care system to request health services under the VCP. A veteran may request a VA community care consult/referral, or his or her VA provider may submit a VA community care consult/referral to the VA Care Coordination staff within the VA.

Veterans may become eligible for the VCP in four ways. First, a veteran is informed by a local VA medical facility that an appointment cannot be scheduled within 30 days of the clinically determined date requested by his or her VA doctor *or* within 30 days of the date requested by the veteran (this category also includes care not offered at a veterans' primary VA facility and a referral cannot be made to another VA medical facility or other federal facility). Second, the veteran lives 40 miles or more from a VA medical facility that has a full-time primary care physician. Third, the veteran lives 40 miles or less (not residing in Guam, America Samoa, or the Republic of the Philippines) *and* either travels by air, boat, or ferry to seek care from his or her local facility *or* incurs a traveling burden of a medical condition, geographic challenge, or an environmental factor. Fourth, the veteran resides 20 miles or more from a VA medical facility located in Alaska, Hawaii, New Hampshire (excluding those who live 20 miles from the White River Junction VAMC), or a U.S. territory, with the exception of Puerto Rico.

Once found eligible for care through the VCP, veterans may choose to receive care from a VA provider *or* from an eligible VA community care provider (VCP provider). VCP providers are federally-qualified health centers, Department of Defense (DOD) facilities, or Indian Health Service facilities, and hospitals, physicians, and non-physician practitioners or entities participating in the Medicare or Medicaid program, among others. A veteran has the choice to switch between a VA provider and VCP provider at any time.

Program Administration and Provider Participation

The VCP is administered by two third-party administrators (TPAs): Health Net and TriWest. Generally, Health Net and TriWest manage veterans' appointments, counseling services, card distributions, and a call center. The TPAs contract directly with the VA. Then, Health Net or TriWest will contract with eligible non-VA community care providers interested on participating in the VCP.

Payments

Generally, a veteran's out-of-pocket costs under the VCP are equal to VHA out-of-pocket costs. Veterans do not pay any copayments at the time of their medical appointments. Copayment rates are determined by the VA after services are furnished. Usually, the VHA becomes the secondary payer when certain veterans with other health insurance (OHI) receive care for nonservice-

connected conditions under VCP. Participating community providers are reimbursed by their respective TPA, and VA pays the TPAs.

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Introduction

In response to concerns about access to medical care at many Department of Veterans Affairs (VA) hospitals and clinics across the country in spring 2014,¹ Congress passed the Veterans Access, Choice, and Accountability Act of 2014 (VACAA, P.L. 113-146, as amended). On August 7, 2014, President Obama signed the bill into law.² Since the VCAA was enacted, Congress has amended the act several times: P.L. 113-175, P.L. 113-235, P.L. 114-9, and P.L. 114-41. In addition, the VA has issued implementation regulations and guidance on several occasions in response to the changes to VACAA and challenges encountered during implantation of the law. **Table 1** provides major highlights pertaining to the Veterans Choice Program (VCP)—a new, temporary program that allows eligible veterans to receive medical care in the community authorized by section 101 of the VACAA.

Table 1. Veterans Choice Program (VCP) Timeline

Date	Action
August 7, 2014	The Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146) signed into law. The Secretary is required to publish regulations in the Federal Register for the implementation of Veterans Choice Program (VCP) no later than November 5, 2014.
September 26, 2014	The Department of Veterans Affairs Expiring Authorities Act of 2014 (P.L. 113-175) was signed into law. The Act makes several technical amendments to the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146).
November 5, 2014	The Department of Veterans Affairs issues interim final rules implementing the Veterans Choice Program (VCP). VA begins mailing out a Choice Card to every enrolled veteran and every separating servicemember.
December 16, 2014	The Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235) is signed into law. The Act made several technical amendments allowing the VA to reimburse providers in the State of Alaska, under the VA Alaska Fee Schedule, and in states with an "All-Payer Model" agreement, VA was allowed to calculate Medicare payments based on payment rates under such "All-Payer Model" agreements.
April 24, 2015	The Department of Veterans Affairs issues interim final rules modifying how VA measures the distance from a veteran's residence to the nearest VA medical facility. This modification considered the distance the veteran must drive to the nearest VA medical facility from the veterans' residence, rather than the straight-line or geodesic distance to VA facility.

¹ Department of Veterans Affairs, Office of Inspector General, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, 14-02603-267, August 26, 2014. For a summary of wait-time issues at a VA medical facility, by state, see Department of Veterans Affairs Office of Inspector General, *Administrative Summaries of Investigation Regarding Wait Times*, <http://www.va.gov/oig/publications/administrative-summaries-of-investigation.asp>. Accessed on December 27, 2016.

² P.L. 113-146 as amended by P.L. 113-175, P.L. 113-235, P.L. 114-9, and P.L. 114-41. For a detailed provision-by-provision explanation of the act, see CRS Report R43704, *Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230; P.L. 113-146)*, by Sidath Viranga Panangala et al.

Date	Action
May 12, 2015	Department of Veterans Affairs issues memorandum to Veterans Integrated Service Network (VISN) Directors on VA Care in the Community (Non-VA Purchased Care) and use of the Veterans Choice Program. The memorandum outlines that effective June 8, 2015, a specific hierarchy of care must be used when the veteran's primary VA medical facility cannot readily provide needed care to a veteran, either because the care is unavailable at the facility or because the facility cannot meet VHA's wait time criteria.
May 22, 2015	The Construction Authorization and Choice Improvement Act was signed into law (P.L. 114-19) and amended the 40 miles eligibility criteria for the Veterans Choice Program (VCP) to clarify that the 40 miles is calculated based on distance traveled (driving distance) rather than the previous straight-line or geodesic distance standard, and authorized VA to determine if there is an unusual or excessive burden in traveling to a VA medical facility.
July 31, 2015	The Surface Transportation and Veterans Health Care Choice Improvement Act (P.L. 114-41) is signed into law. Among other things the Act allowed all enrolled veterans to be eligible for the Veterans Choice Program (amended the August 1, 2014 enrollment date restriction), defined the nearest VA medical facility as a Community Based Outpatient Clinic (CBOC) with no full time primary care physician, removed the 60-day limitation on an episode of care, included clinically indicated date as a wait time eligibility criteria, and expanded provider eligibility.
October 1, 2015	Department of Veterans Affairs issues memorandum to Veterans Integrated Service Network (VISN) Directors on VA Care in the Community (Non-VA Purchased Care) and use of the Veterans Choice Program that modifies the May 12, 2015 memorandum. The memorandum provides guidance on the hierarchy of care in the Veterans Choice Program (VCP). This allows VA medical facilities to refer the veteran to VCP for care not available at the veterans' primary VA medical facility and a referral pattern does not exist to another VA medical facility or other federal facility.
October 29, 2015	The Department of Veterans Affairs (VA) publishes final rules based on interim final rules published on November 5, 2014 and on April 24, 2015. These rules don't incorporate amendments to the Veterans Choice Program (VCP) made by the Surface Transportation and Veterans Health Care Choice Improvement Act (P.L. 114-41).
December 1, 2015	The Department of Veterans Affairs (VA) publishes interim final rules revising previous VA regulations implementing the Veterans Choice Program (VCP) based on amendments made by The Construction Authorization and Choice Improvement Act was signed into law (P.L. 114-19) and the Surface Transportation and Veterans Health Care Choice Improvement Act (P.L. 114-41).
August 7, 2017	The authority for the Veterans Choice Program (VCP) expires on, or when funds in the Veterans Choice Fund have been exhausted—whichever occurs first.

The VCP supplements several already existing statutory authorities³ that allow the VA to provide care outside of its own health care system. These existing statutory authorities are briefly described in **Table A-1**. The Veterans Choice Program will end when the \$10 billion in mandatory funding deposited in the Veterans Choice Fund (section 802 of P.L. 113-146, as amended) is

³ For a complete summary of the VA Care in the Community programs, see, CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala.

exhausted, or no later than August 7, 2017.⁴ “It is important to note that the VCP does not provide guaranteed health care coverage or an unlimited medical benefit.”⁵

This report provides details on how the VCP is being implemented. It is meant to provide insight into the execution of the current VCP program.

Scope and Limitations

Information contained in this report is drawn from regulations published in the *Federal Register*, conference calls and numerous meetings with VHA staff, and briefing materials and other information provided by the VA Office of Government Relations (which may not be publicly available). This report does not discuss the numerous issues that have arisen during the implementation of VCP or VA’s plan to Congress that was submitted on October 30, 2015 (as required by P.L. 114-41) to streamline and improve the current VCP.

Medical Services under VCP

Once an eligible veteran is authorized to receive necessary treatment, including follow-up appointments and ancillary and specialty medical services, under the VCP, a veteran may receive similar services that are offered through their personalized standard medical benefits package at a VA facility. VA’s standard medical benefits package includes (but is not limited to) inpatient and outpatient medical, surgical, and mental healthcare; pharmaceuticals; pregnancy and delivery services; dental care; and durable medical equipment, and prosthetic devices, among other things.⁶ However, institutional long-term care and emergency care in non-VA facilities are excluded from the VCP. These services are authorized and provided under separate statutory authorities outside the scope of VCP (see **Table A-1**).

Eligibility

Generally, all veterans have to be enrolled in the VA health care system⁷ to receive care under the VCP. Once this initial criterion is met, a qualified veteran may choose to receive care through VCP. Veterans may become eligible for care under the VCP through one of four different pathways:⁸

- **30-day wait list (Wait-Time Eligible):** A veteran is eligible for care through the VCP when he or she is informed, by a local VA medical facility, that an appointment cannot be scheduled
 - within 30 days of the clinically determined date of when the veteran’s provider determines that he or she needs to be seen (this category also

⁴ 38 U.S.C. §1701 note. For more information about the veterans choice fund see, CRS Report R44301, *Veterans’ Medical Care: FY2016 Appropriations*, by Sidath Viranga Panangala.

⁵ Letter from Veterans Health Administration, Chief Business Office Purchased Care to Veteran, Eligible Choice 30-Day Wait Recipient, September 25, 2015.

⁶ For a complete summary of the VA’s standard medical benefits package, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala; and 38 C.F.R. §17.38.

⁷ For general enrollment procedures, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala.

⁸ Department of Veterans Affairs, “Expanded Access to Non-VA Care through the Veterans Choice Program,” 80 *Federal Register* 74991-74996, December 1, 2015 (codified at 38 C.F.R. §17.1510).

includes care not offered at the veterans' primary VA medical facility and a referral cannot be made to another VA medical facility or federal facility),⁹ *or*

- within 30 days of the date of when the veteran wishes to be seen.
- **40 miles or more distance (Mileage Eligible):** A veteran is eligible for care through the VCP when he or she lives 40 miles or more from a VA medical facility that has a full-time primary care physician.
- **40 miles or less distance (Mileage Eligible):** A veteran is eligible for care through the VCP when he or she resides in a location, other than one in Guam, American Samoa, or the Republic of the Philippines, *and*
 - travels by air, boat, or ferry in order to seek care from his or her local VA facility; *or*
 - incurs a traveling burden¹⁰ based on environmental factors, geographic challenges, or a medical condition.¹¹
- **State or territory without a full-service VA medical facility:** A veteran is eligible for care through the VCP when his or her residence is more than 20 miles from a VA medical facility *and* located in either
 - Alaska,
 - Hawaii,
 - New Hampshire (excluding veterans who live 20 miles from the White River Junction VAMC), or
 - U.S. territory (excluding Puerto Rico).

A veteran who believes that he or she meets one of the eligibility criteria to receive care through the VCP is to have his or her eligibility status confirmed by local VA staff. A high level overview of the eligibility process to access care through the VCP is illustrated in **Figure 1**. Local VA facility staff members are to review clinical and administrative records of the veteran to determine the appropriate medical benefits package and clinical criterion. Confirmation of the veteran's eligibility status is generally determined within 10 business days from when the request for confirmation was submitted. Veterans who are found ineligible to participate in the VCP are to be given instructions, in their notification letters, on how to appeal the VA's decision.¹²

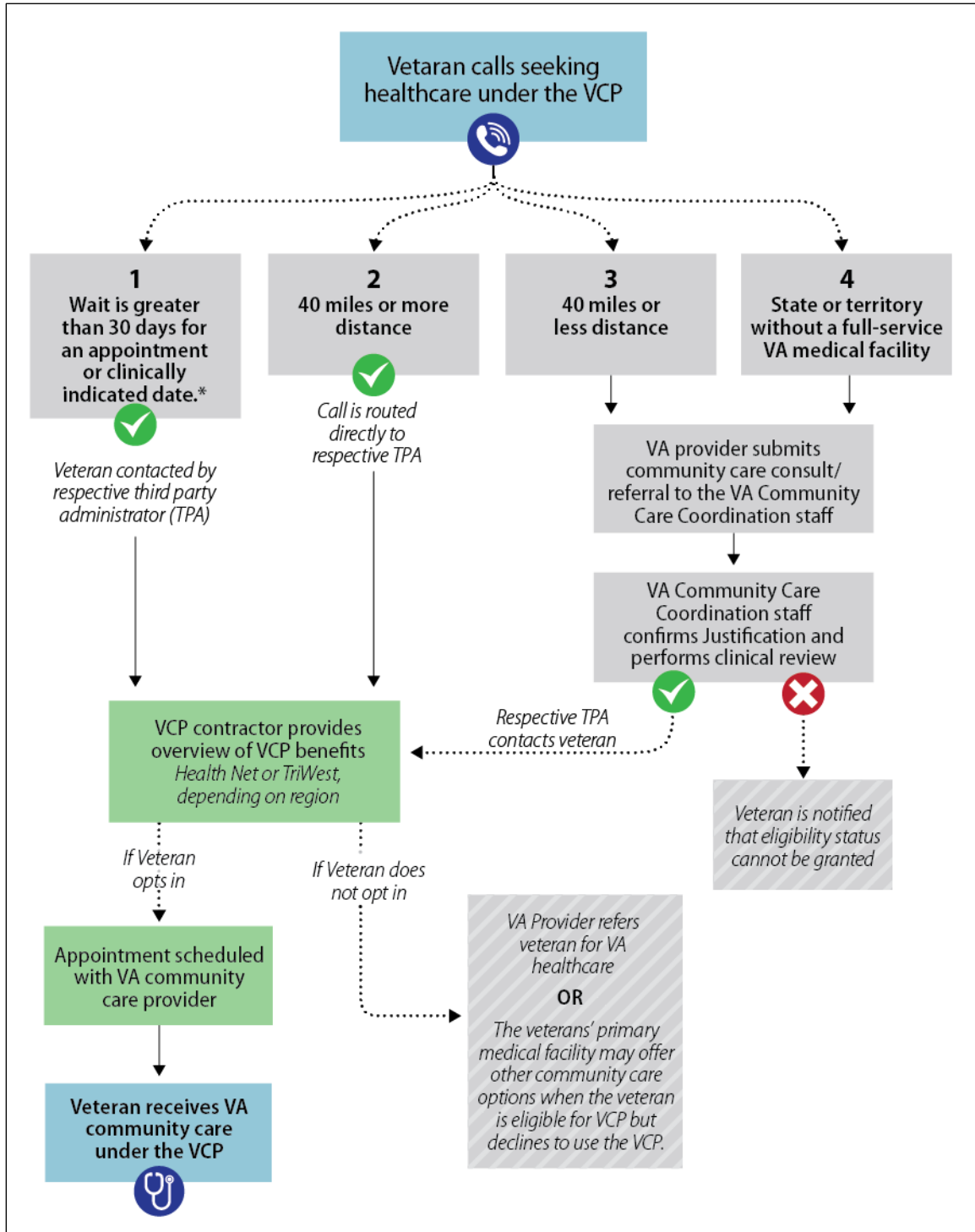
⁹ Department of Veterans Affairs, *VA Care in the Community (Non-VA Purchased Care) and use of the Veterans Choice Program*, Memorandum from Acting Principal Deputy Under Secretary for Health to Veterans Integrated Service Network (VISN) Directors, May 12, 2015, and amended on October 1, 2015.

¹⁰ Local VA staff decides whether or not the burden is unusual or excessive and likely to exist "at least 30 days or more from the date of the determination." Staff are to document the decision on VA Form 119, Report of Contact, which includes the date of determination, expected duration of travel burden, and reason(s) behind the decision. Notification is to be sent in a letter by mail to the veteran. Department of Veterans Affairs, Veterans Health Administration, *Veterans Choice Program - Unusual or Excessive Burden Determination*, September 11, 2015.

¹¹ A local VA provider or the facility's Primary Care Patient Aligned Care Team (PACT) determines whether or not a veteran is facing an unusual or excessive travel burden due to a medical condition. The duration of the burden is also assessed.

¹² Veterans may appeal the decision of their local facility to the Board of Veterans Appeals (BVA). First, veterans would send a notice of disagreement to their facility. Then the facility is to generate a statement of case (SOC). Lastly, the facility is to process the appeal and forward it to the BVA for processing. Department of Veterans Affairs, Veterans Health Administration, *Veterans Choice Program - Unusual or Excessive Burden Determination*, September 11, 2015, p. 3.

Figure 1. Eligibility Process to Access Care through the Veterans Choice Program (VCP)



Source: Figure prepared by CRS based on information from the Veterans Health Administration.

Notes: * this category includes care not offered at the veterans' primary VA medical facility and a referral cannot be made to another VA medical facility or federal facility.

Illustrated is a high level overview of the process to access care under the Veterans Choice Program (VCP). This figure does not specify (1) the criteria VA staff uses to determine veterans' eligibility statuses; (2) the interactions veterans will encounter throughout their processes to access care under the VCP; or (3) how local VA Medical Centers (VAMC) may enter into provider agreements with VA community care providers. This figure does not reflect the appeals process.

Choice of Care

Eligible veterans have two options for receiving health care services under the Veterans Choice Program (VCP). First, veterans may choose to receive their medical care from a VA provider. A veteran who chooses this option is to receive an appointment with a VA provider. The veteran may be offered a VA appointment that is more than 30 days out or at a facility that is more than 40 miles from the veteran's residence.¹³ If an offered appointment does not accommodate the veteran's clinical needs, the local VA staff may place the veteran on an electronic waiting list until an alternate appointment becomes available. *At any time*, the veteran (based on the availability of clinical appointments) may choose to receive his or her medical services from a VA community care provider.

The second option allows veterans to receive health care services from a VA community care provider (VCP provider) who accepts eligible VCP veterans. Veterans who choose this option are to have their names and medical authorization information sent to a VCP provider of their choice.¹⁴ *At any time*, veterans (based on the availability of clinical appointments) may choose to receive their medical services from a VA provider.

Two Options to Choosing Care under the Veterans Choice Program (VCP)

Based on the availability of appointments,

- A veteran may choose to receive medical care from a VA provider.
- A veteran may choose to receive medical care from a VA community care provider.

VCP Providers

Under the VCP several entities and providers are eligible to provide care and services. These include among others, federally-qualified health centers, Department of Defense (DOD) medical facilities, Indian Health Service outpatient health facilities or facilities operated by a tribe or tribal organization, hospitals, physicians, and non-physician practitioners or entities participating in the Medicare or Medicaid program, an Aging and Disability Resource Center, an area agency on aging, or a state agency or a center for independent living. VA employees are excluded from providing care or services under VCP, unless the provider is an employee of VA, and is not acting within the scope of such employment while providing hospital care or medical services through the VCP.¹⁵ Generally, VCP providers "must maintain at least the same or similar credentials and licenses as those required of VA's health care providers."¹⁶

¹³ Department of Veterans Affairs, "Expanded Access to Non-VA through the Veterans Choice Program," 79 *Federal Register* 65577, November 5, 2014 (codified at 38 C.F.R. §17.1515).

¹⁴ 38 C.F.R. §17.1515.

¹⁵ 38 C.F.R. §17.1530 .

¹⁶ 38 C.F.R. §17.1530.

Program Administration

The Veterans Choice Program (VCP) is not a health insurance plan for veterans. Under the VCP, veterans are given the option of receiving care in their local communities instead of waiting for a VA appointment and/or enduring traveling burdens to reach a VA facility.¹⁷

All veterans who are enrolled in the VA health care system are to be mailed a VCP card. The card lists relevant information about the VCP. Many veterans have attempted to use the VCP card as an insurance card. The VCP card may not be used to pay for medical services performed outside of or within the VA. Specifically, the VCP card does not

- replace veterans' identification cards,
- guarantee eligibility under the VCP,¹⁸ *or*
- provide health insurance-like benefits (i.e., the VCP, like all VA health care, is not health insurance).

Third-Party Administrators (TPAs)

In September 2013, the VA awarded contracts to Health Net¹⁹ and TriWest²⁰ to expand veterans' access to non-VA health care in the community, under the Patient-Centered Community Care (PC3) initiative.²¹ Later, in November 2014, the VA modified those contracts to include support services under the Veterans Access, Choice, and Accountability Act of 2014 (VACAA, or the Choice Act). Under the Veterans Choice Program (VCP), Health Net and TriWest manage the appointments, counseling services, card distributions, and a call center.²² They also oversee VCP providers, medical services reporting and billing processes, and the coordination of care with private health insurers. As illustrated in **Figure 2**, Health Net covers Regions 1, 2, and 4, and TriWest covers Regions 3, 5A, 5B, and 6.

¹⁷ Secretary Robert A. McDonald, *An Open Letter to America's Veterans*, Department of Veterans Affairs, Veterans Health Administration, 2014, <http://www.va.gov/opa/choiceact/documents/Open-Letter-to-Veterans.pdf>. Accessed on December 29, 2016.

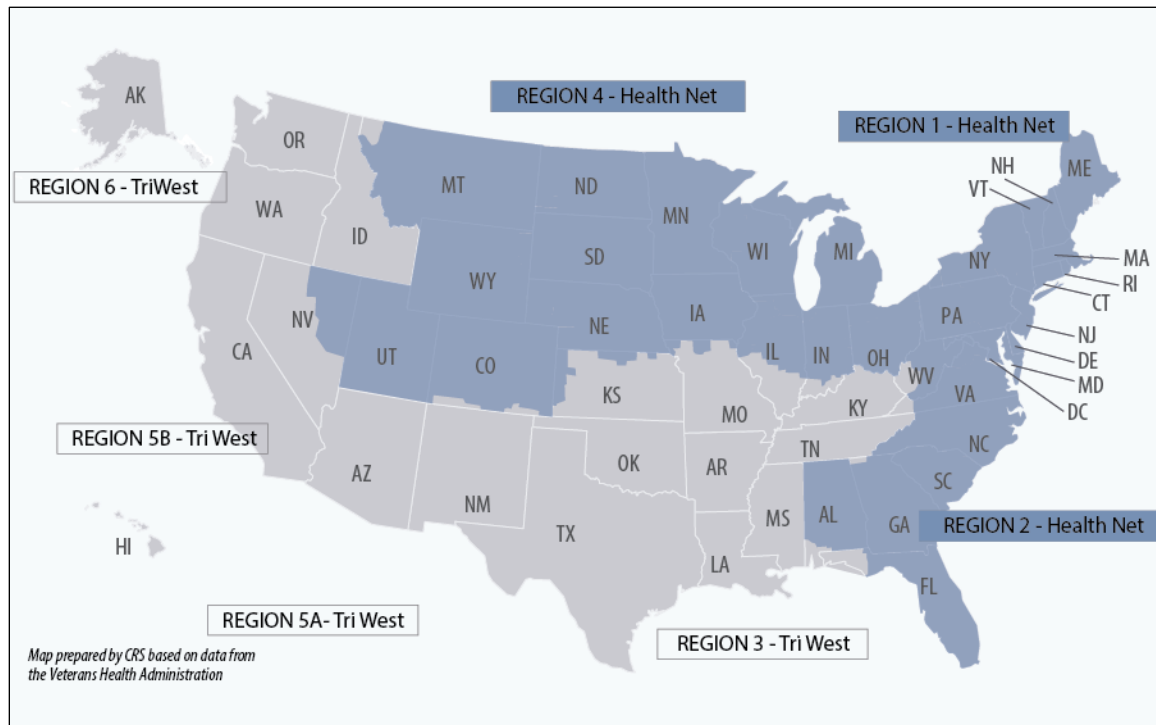
¹⁸ Department of Veterans Affairs, *Veterans Choice Program, Leadership Toolkit for VA Facilities*, p. 16.

¹⁹ Health Net Federal Services, *Company Information*, <https://www.hnfs.com/content/hnfs/home/company/company-information.html>. Accessed on December 29, 2016.

²⁰ TriWest Healthcare Alliance, *About TriWest*, <http://www.triwest.com/en/about-triwest/>. Accessed on December 29, 2016.

²¹ The Patient-Centered Community Care (PC3) initiative evolved from the Project on Healthcare Effectiveness through Resource Optimization (Project HERO) pilot program. Under the PC3 program, VA provides contracted inpatient and outpatient specialty care and mental health care to eligible veterans when VA medical facilities cannot provide services such as when there is a lack of medical specialists, or long wait times, or there is an extraordinary long distance from the veteran's residence.

²² Veterans Health Administration, *Choice Champion Call*, November 10, 2015, p. 31.

Figure 2. VCP Regions Covered by Third-Party Administrators

Source: Map prepared by CRS based on data from the Veterans Health Administration.

Community Care Provider Participation²³

Eligible non-VA community care providers may become VCP providers. Providers who are interested in participating in the VCP may do so either through the Patient Centered Community Care (PC3) network or the Choice network. Community providers who are under the Choice network may only render authorized services to VCP-eligible veterans. Under the PC3 network, all veterans who are eligible for VA community care may be seen.²⁴ The reason is that there are two different statutory authorities for care delivered through VCP and PC3. Interested providers are required to contact Health Net and/or TriWest to determine whether they qualify as a VA community care provider.²⁵ To qualify, providers must meet the following criteria:

- Have a full, current, and unrestricted state license and the same/similar VA credentials.

²³ Major portions of this section are adapted from, Department of Veterans Affairs, Veterans Health Administration, How to become a Veterans Choice Program and/or Patient-Centered Community Care Provider, VA Community Care Fact Sheet for Interested Providers, March 14, 2016, p. 2, http://www.va.gov/PURCHASEDCARE/docs/pubfiles/factsheets/VHA-FS_How-to-become-a-Provider.pdf. Accessed on December 29, 2016.

²⁴ Under the PC3 program, VA provides contracted inpatient and outpatient specialty care and mental health care to eligible veterans when VA medical facilities cannot provide services such as when there is a lack of medical specialists, or long wait times, or there is an extraordinary long distance from the veteran's residence.

²⁵ Health Net may be contacted by phone (1-866-606-8198; press Option 2) or email (HNFSPROVIDERRELATIONS@Healthnet.com). For additional information about Health Net, see, <https://www.hnfs.com/content/hnfs/home/va/provider.html>. Accessed on December 29, 2016. TriWest may be contacted by phone (1-866-284-3743) or email (TriWestDirectContracting@triwest.com). For additional information about TriWest, see <https://www.triwest.com/provider>. Accessed on December 29, 2016.

- Not be named on the Centers for Medicare and Medicaid Services (CMS) exclusionary list.²⁶
- Meet all Medicare Conditions of Participation (CoPs) and Conditions for Coverage (CfCs).²⁷
- Accept Medicare or Medicaid rates.
- Provide resources (services, facilities, and providers) that are in compliance with applicable federal and state regulatory requirements.
- Submit all medical records of rendered services to veterans to the TPA for inclusion in veterans' VA electronic medical records.

After determining that a provider is eligible for participation, he or she may enroll (with Health Net and/or TriWest) as a VCP provider. At this time, the VA community care provider and respective third-party administrator (TPA) are to establish an agreed-upon reimbursement amount for rendered services to veterans. When Health Net or TriWest is unable to coordinate the delivery of health care services to veterans, local VA Medical Centers (VAMCs) may enter into VCP Provider Agreements with eligible VA community providers through the VAMCs Community Care Departments.²⁸

Consults/Referral Processes²⁹

Consults and referrals, known as the VA community care consults/referrals, are initiated in two different manners.³⁰ First, a VA physician may submit a VA community care consult/referral (through the Computerized Patient Record System [CPRS])³¹ on behalf of a veteran when there is a clinical need for the veteran to receive timely medical services. Second, a veteran may request a VA community care consult/referral (from his or her VA provider or local VA staff) in order to receive a medical service that is also timely. Regardless of how the consult/referral is initiated, all VA community care consults/referrals are to be processed by the VA Community Care Coordination staff within the VA. VA community care consults/referrals are processed based on whether the veteran requires emergent or urgent care. For urgent VA community care

²⁶ The Centers for Medicare and Medicaid Services manages the Medicare Exclusion Database (MED) which contains a list of excluded providers and their sanctions and reinstatement files. For additional information about the MED, see <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html>. Accessed on December 29, 2016.

²⁷ To determine if a provider or entity is required to meet the Conditions of Participations (CoPs) and Conditions for Coverage (CfCs), see <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/index.html>. Accessed on December 29, 2016.

²⁸ Veterans Choice Program (VCP) Provider Agreements may be authorized between local VA Medical Centers (VAMCs) and out-of-network VA community care providers only after Health Net or TriWest is unable to process a veteran's authorization request and/or schedule an appointment, within a timely manner, for the veteran.

²⁹ Major portions of this section are adapted from, Department of Veterans Affairs, Veterans Health Administration, VHA Chief Business Office, *Veterans Choice Program, Unusual or Excessive Burden Determination (Other Factors) Process*, December 2015.

³⁰ Generally, a veteran who becomes eligible under the VCP through the "30-day wait list" or "40 miles or more distance" pathway, may not have to go through the entire VA community care consult/referral process.

³¹ The Computerized Patient Record System (CPRS) is the electronic system VA providers use to input consults/referrals for VA community care. Once entered, the VA community care consult/referral is to alert a clinical reviewer who is to examine the veteran's medical need and confirm that the requested services are not available at a local VA health care facility.

consults/referrals, VA providers are to coordinate the veteran's care directly with the VA Community Care Coordination staff.

When a veteran's request for a VA community care consult/referral cannot be approved, the veteran's local VA facility staff are to notify the veteran. On behalf of the veteran, his or her VA provider is to continue coordinating the veteran's medical services within the VA. The veteran's provider might also explore other existing community care options (see **Table A-1**) offered by the Veterans Health Administration (VHA).

After a veteran's request is approved or the VA community care consult/referral is submitted by the veteran's provider, the VA Community Care Coordination staff are to confirm the veteran's eligibility status. A veteran may decline enrollment into the VCP. When a veteran declines enrollment, his or her respective third-party administrator (TPA) is to document the veteran's reason for opting out of the program. Then, on behalf of the veteran, his or her VA provider is to continue coordinating the veteran's medical services within the VA. The veteran's provider might also explore other existing community care options offered by the VHA.

If a veteran is found eligible to access care through the VCP, the VA Community Care Coordination staff is to then electronically upload the veteran's VA community care consult/referral and pertinent medical documentation in the Contractor Portal, which is visible to Health Net and TriWest. Once Health Net or TriWest receives the documentation, the respective TPA is to contact the veteran. During this contact, the eligible veteran is to be provided with an overview of VCP benefits and asked to confirm his or her choice to receive medical services under the VCP.

If a veteran reiterates his or her choice to receive medical care under the VCP, the veteran may select his or her VA community care provider and coordinate with a TPA to schedule an appointment. In addition, the veteran is to be asked to provide other health insurance information, if applicable, and is made aware of possible copayments and deductibles. A veteran with a clinical need for a service-connected and/or special authority condition³² (SC/SA) is to have his or her screening information reviewed by Revenue Utilization Review (R-UR)³³ nurses. The veteran's appointment is then to be entered in the Contractor Portal so that it can be viewed by the VA Community Care Coordination staff. Daily, the VA Community Care Coordination staff is to check the Contractor Portal for appointment statuses and other updates. After the appointment is scheduled, the VA Community Care Coordination staff are to enter the appointment information into the Appointment Management system (within the VA) and update the veteran's status to "scheduled."

³² Special authority conditions include those that are eligible for service-connection under Priority Group 6 (combat veterans, ionization radiation, Agent Orange exposure, Southwest Asia service, veterans stationed at Camp Lejeune between August 1, 1953 to December 31, 1987, and Project 112/ SHAD), military sexual trauma, nasopharyngeal radium irradiation, etc.

³³ "R-UR, under the auspices of the CBO, is the systematic evaluation and analytical review of clinical information in order to maximize reimbursement from third-party payers. In 2003, guidance was established standardizing the clinical review functions with third-party reimbursement responsibilities at VA medical facilities. R-UR in this context operates to promote improvements in patient care and to maximize the potential for the recovery of funds due VA for the provision of health care services to Veterans, dependents, and others using the VA health care system." For more information, see Department of Veterans Affairs, Veterans Health Administration, *Utilization Management Program*, VHA Directive 1117, Washington, DC, July 9, 2014, p. 8, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3018. Accessed on December 29, 2016.

Unusual or Excessive Burden Determination³⁴

Along with the environmental factors, geographic challenges, and medical conditions, veterans are assessed by

- the nature or simplicity of the hospital care or medical services the veteran requires,
- how frequently the veteran needs hospital care or medical services, and
- the need for an attendant for a clinical service.³⁵

Authorization of Care and an Episode of Care

Prior to delivering medical services to veterans under the Veterans Choice Program (VCP), such services are to be authorized by the VA.³⁶ If a veteran requires services beyond those authorized, his or her VCP provider may request another authorization. The delivery and usage of unauthorized medical services could result in non-reimbursement. Under the VCP, over 2 million authorizations have been validated by the third-party administrators (TPAs) Health Net and TriWest. These authorizations of care, shown in **Table 2**, were validated from November 2014 to July 2016, unless otherwise noted. From November 2014 through June 2016, TPAs made over 2.3 million appointments for veterans to receive care through VCP.

Table 2. Authorizations of Care for the Veterans Choice Program
Mileage Eligibles and Wait-Time Eligibles from November 2014 to July 2016

	Health Net	TriWest	Totals
Unique Authorizations: Mileage Eligible ^a	118,775	156,555	275,330
Authorizations: Wait-Time Eligible	304,386	396,377	700,763
Authorizations: care is unavailable at the veterans' primary VA medical facility and cannot be referred to another VA facility (June 2015- July 2016) ^b	508,413	571,639	1,080,052
<i>Sub-Total Unique Authorizations: Wait-Time Eligible^c</i>	<i>812,799</i>	<i>968,016</i>	<i>1,780,815</i>
Total Authorizations	931,574	1,124,570	2,056,144
Appointments Scheduled (November, 2014-June 2016) ^d	1,327,000	1,018,912	2,345,912

Source: Department of Veterans Affairs, Veterans Health Administration.

³⁴ Major portions of this section are adopted from Department of Veterans Affairs, Veterans Health Administration, VHA Chief Business Office, *Veterans Choice Program, Unusual or Excessive Burden Determination (Other Factors) Process*, December 2015.

³⁵ An attendant for clinical services is a person who provides essential aid and/or physical assistance to the veteran so that the veteran can travel to a VA medical facility to have hospital care or medical services rendered. 38 C.F.R. §17.1510(b)(4)(ii)(A)-(C).

³⁶ VA community care providers may call the Operation Center for Choice at (866) 606-8198 to request prior authorization from either Health Net or TriWest prior to delivering medical services to veterans. Failure to obtain preauthorization prior to rendering health services may result in uncompensated services.

- a. Each authorization for an episode of care under this category is counted only once. One veteran patient could have more than one authorization.
- b. Based on the Department of Veterans Affairs, *VA Care in the Community (Non-VA Purchased Care) and use of the Veterans Choice Program*, Memorandum from Acting Principal Deputy Under Secretary for Health to Veterans Integrated Service Network (VISN) Directors, May 12, 2015, and amended on October 1, 2015, VA categorizes care that is unavailable at the veterans' primary medical facility and that cannot be referred to another VA facility or federal facility as care that would qualify for VCP under the wait-time eligible category.
- c. Each authorization for an episode of care under this category is counted only once. One veteran patient could have more than one authorization.
- d. One authorization may result in multiple appointments; therefore, the scheduled appointments may be higher than the number of authorizations.

The VA defines an episode of care (EOC) as “a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which last no longer than one calendar year from the date of the first appointment with a non-VA health care provider.”³⁷ This one-year Choice EOC period of validity begins when the first appointment is scheduled. VA community care providers may request an authorization extension for a veteran’s current EOC through the veteran’s respective TPA.

Appointment Scheduling

Veterans and VCP providers verify eligibility status before scheduling medical appointments for clinical needs. Appointments are to be scheduled on the basis of clinical appropriateness.³⁸ VCP-eligible veterans are to receive a call from their respective third-party administrator (TPA), Health Net or TriWest. The TPAs are to provide veterans with information about the organization and schedule their appointments. Once appointments are scheduled, the contractor is to inform the VA. Emergent or urgent care authorizations are to be done expeditiously (see text box below).

Emergent and Urgent Care Determination

VA community care consults/referrals are to be prioritized by urgency levels. Urgency levels to deliver care are different under the VCP. Generally, emergent care under the VCP **does not** mean an emergency medical condition that needs immediate medical attention (emergency treatment furnished by non-VA providers are authorized under separate statutory authorities and not the VCP). Emergent consults/referrals are to be scheduled within five days from the veteran’s consultation date with his or her third-party administrator (TPA). Urgent consults/referrals have a timeframe that is within 48 hours. Furthermore, VA providers may bypass the Choice Program process and contact the VA Community Care Coordination staff directly to schedule an urgent appointment with a VCP provider for their veterans.

After receiving the notification, a veteran’s local VA facility staff are to cancel his or her appointment at the VA. Veterans may also choose to schedule their own appointments after receiving an authorization of care under the VCP.³⁹ If veterans choose to do so, they are asked to provide their appointment information to Health Net or TriWest.

Appointment information that is provided to the TPAs is to get uploaded into the Contractor’s Portal, so that it can be viewed by the VA Community Care Coordination staff. Daily, the VA Community Care Coordination staff are to check the Contractor Portal for veterans’ appointment

³⁷ 38 C.F.R. §17.1505.

³⁸ Ibid.

³⁹ Department of Veterans Affairs, “Expanded Access to Non-VA Care Through the Veterans Choice Program,” 80 *Federal Register* 66424, October 29, 2015.

statuses and other updates. After receiving the notification, the veteran's local VA facility staff are to cancel his/her appointment at the VA.

Medication Process

Veterans may have their prescriptions filled at their local VA pharmacies, non-VA pharmacies, and through the Consolidated Mail Outpatient Pharmacy (CMOP). If the VA is unable to fill a medication request within a prescribed timeframe or one that is not within the VA formulary, a non-VA pharmacy may fill the initial 14-day supply (without refills).⁴⁰ For veterans who require prescriptions for more than 14 days, the VCP prescribing clinician is to have the remaining supply of medication filled at a VA pharmacy. Similar to the provisions of health care services under the VCP, medications filled at non-VA pharmacies will also require prior authorizations from the VA.

The VA is to reimburse veterans for out-of-pocket expenses related to the purchase of medications that treat service-connected conditions. For nonservice-connected conditions, veterans may also be reimbursed for their out-of-pocket expenses, including those with other health insurance plans.⁴¹ To be reimbursed, veterans submit a copy of their prescriptions, authorizations, and original receipts to their local VA Community Care Office. The VA also allows non-VA pharmacies to process medication claims on a veteran's behalf.

Processing Medical Claims

Medical claims under the Veterans Choice Program (VCP) are processed through the veteran's respective third-party administrators. Health Net and TriWest upload and manage veterans' medical claims through the Contractors Portal. Through this web portal, the VA Community Care Coordination staff are to retrieve a veteran's documentation of clinical need and upload it in the veteran's medical records.

The VA community care provider is to submit medical claims to a veteran's respective third-party administrator. After Health Net or TriWest receives the claim, the TPA is to submit it through its web portal. Subsequently, the VA is to retrieve the documentation from the TPA's web portal and upload it in the veteran's medical records.

Per Federal authority, VA is the primary and exclusive payer for medical care it authorizes. As such, non-VA medical care providers may not bill the Veteran or any other party for any portion of the care authorized by VA. Federal law also prohibits payment by more than one Federal agency for the same episode of care; subsequently any payments made by the Veteran, Medicare, or any other Federal agency must be refunded to the payer [from the VCP provider] upon acceptance of VA payment.⁴²

⁴⁰ Veterans Health Administration, *Ten Things to Know About the Choice Program*, 2015, <http://www.va.gov/HEALTH/newsfeatures/2015/July/10-Things-to-Know-About-Choice-Program.asp>. Accessed on December 29, 2016.

⁴¹ Department of Veterans Affairs, Veterans Health Administration, *Prescription Reimbursement Associated with VACC Delivered under the Choice Program*, VA Care in the Community (VACC) Program Reference Sheet, October 27, 2015. Department of Veterans Affairs, "Expanded Access to Non-VA Care Through the Veterans Choice Program," *79 Federal Register* 65572, November 5, 2014.

⁴² Department of Veterans Affairs, Veterans Health Administration, *Working with the Veterans Health Administration: A Guide for Providers*, October 2014, p. 3, http://www.va.gov/PURCHASEDCARE/docs/pubfiles/programguides/NVC_Providers_Guide.pdf. Accessed on December 29, 2016.

Medical Services Not Previously Authorized

Under the VCP, medical claims for unauthorized non-VA health care services may be submitted to the VA for payment consideration. Veterans, VA community care providers, and persons who paid for services on behalf of a veteran are required to submit to the VA the following documentation:

- a standard billing form,⁴³ or an invoice (i.e., Explanation of Benefits [EOB]), and/or receipt of services paid and/or owed;
- an explanation of the circumstance that led to the veteran receiving unauthorized care outside of the VA;
- any statements and/or supporting documentation;⁴⁴ *and*
- VA Form-10-583, Claim for Payment of Cost of Unauthorized Medical Services.⁴⁵

Payments

Veterans' Out-of-Pocket Costs

Veterans who are enrolled in VA health care do not pay premiums,⁴⁶ deductibles,⁴⁷ or coinsurances⁴⁸ for their medical services. However, they may be required to pay a fixed copayment amount (for nonservice-connected disabilities or conditions) as shown below. When veterans receive care at a VA facility, they do not pay copayments at the time of their medical appointments; copayment rates are determined by the VA after services are furnished—based on if the care was for a service-connected or nonservice-connected condition. Therefore, veterans' out-of-pocket costs under the VCP are the same as if they were receiving care and services from a VA provider in a VA facility—if a veteran does not pay any copayments at VA health care facilities, the veteran will not have to pay any copayments under the VCP.⁴⁹ For example:

- A veteran could pay \$50 copayments for a specialty care visit and \$15 for a primary care visit for a nonservice-connected disability or condition.
- A veteran in Priority Groups 7 and 8 could pay a \$9 copayment per 30-day or less supply of medication.⁵⁰

⁴³ The standard billing forms for reimbursement include the UB-04 CMS-1450 or CMS-1500.

⁴⁴ 38 C.F.R. §17.124.

⁴⁵ VA Form 10-583, Claim for Payment of Cost of Unauthorized Medical Services, at http://www.va.gov/vaforms/form_detail.asp?FormNo=583. Accessed on June 2, 2016.

⁴⁶ An amount paid, by an enrollee or by an employer or a combination of both parties, to an insurer for a beneficiary to enroll in a health insurance plan.

⁴⁷ An amount a beneficiary must pay out of pocket before the health insurance plan begins paying for services.

⁴⁸ A specified percentage a beneficiary pays out of pocket to a provider after meeting any deductible requirements.

⁴⁹ Only veterans in Priority Group 1 (those who have been rated 50% or more service-connected) and veterans who are deemed catastrophically disabled by a VA provider are never charged a copayment, even for treatment of a nonservice-connected condition. For more information, see Department of Veterans Affairs, "Criteria for a Catastrophically Disabled Determination for Purposes of Enrollment," 78 *Federal Register* 72576-72579, December 3, 2013.

⁵⁰ The VA categorizes veterans into eight Priority Groups, based on factors such as service-connected disabilities and income (among others). For a detailed summary of eight Priority Groups, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala.

- All veterans are exempt from paying copayments for services and medications that are related to a service-connected disability or condition.⁵¹

Under the VCP, veterans with Medicare, Medicaid, or TRICARE who are authorized care in the community are not required to pay any deductibles, coinsurances, or copayments for nonservice-connected medical care—even if Medicare, Medicaid, or TRICARE requires certain level cost sharing under those plans.⁵²

VCP providers bill private health insurers for medical care, supplies, and prescriptions provided to veterans for their nonservice-connected conditions.⁵³ As stated in the final rule on the VCP:

[The] veteran may owe some copayment, cost share, or deductible amount from their other health insurance to the provider. VA is unable to completely eliminate any potential copayment liability because under the Program [VCP], VA is a secondary payer while under other non-VA care, we [VA] are the primary payer, and our payment to the non-VA health care provider is payment in full.⁵⁴

Responsibilities of payer and cost-sharing obligations for veterans are categorized by service-connected care and nonservice-connected care (see **Table 3**).

Table 3. Payer Responsibility and Cost Payments for Veterans

	(1) Veteran Receives Service-Connected Care	(2) Veteran Receives Nonservice-Connected Care
Primary Payer ^a	VA	Other Health Insurance (OHI)
Secondary Payer ^a	Not Applicable	VA
Out-of-pocket costs to Veteran	No Payments	Yes ^b

Source: Department of Veterans Affairs, *Veterans Access, Choice, and Accountability Act of 2014, Title 1: Veterans Choice Program and Health Care Collaboration*, Washington, DC, December 1, 2015, pp. 2, 5, <http://www.va.gov/opa/choiceact/documents/Factsheets/External-Choice-Program-Fact-Sheet.pdf>. Accessed on December 29, 2016.

- “Primary payer” is a health plan that pays its allocated benefits first on a medical claim. “Secondary payer” is a health plan that pays its allocated benefits after the primary payer. In rare cases, veterans obtain a tertiary payer (third health plan) to cover any remaining balances and/or out-of-pocket costs.
- Veterans have to pay for any cost-sharing payments (premiums, deductibles, coinsurances, and/or copayments) associated with an “other health insurance” plan and nonservice-connected condition.

Cost Shares for Veterans with Other Health Insurance (OHI)

The VA defines other health insurance (OHI) as commercial insurance. Commercial insurance, often referred to as *private insurance*, is not funded by federal and state taxes. This type of insurance is offered by companies such as Blue Cross and Blue Shield, Aetna, Cigna, and the Kaiser Foundation. Plans purchased through the state health exchanges are also considered as OHI. In addition, veterans who purchase commercial insurance plans agree to cost-sharing

⁵¹ 38 C.F.R. §§17.108, 17.110, 17.111.

⁵² Veterans Health Administration, *Non-VA Medical Care Program and Provider Fact Sheet*, p. 2, <http://www.manchester.va.gov/documents/123014-VACAA-ProviderFactSheet.pdf>. Accessed on June 2, 2016.

⁵³ CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala.

⁵⁴ Department of Veterans Affairs, “Expanded Access to Non-VA Care Through the Veterans Choice Program,” 80 *Federal Register*, 66426, October 29, 2015.

responsibilities. Such cost-sharing obligations include copayments, deductibles and coinsurance (e.g., 80/20 rule: 80% insurer responsibility/20% patient responsibility).

When veterans receive health care services for nonservice-connected conditions/diseases and have OHI, they may have to share the cost of the rendered services with the OHI company. Furthermore, veterans who receive VA community care services and have an OHI plan may also incur cost-sharing responsibilities.^{55,56} However, veterans may have their copayment responsibilities paid by the VA.

After [the] VA has paid for the non-VA care under Choice, and *if there are funds available to reimburse the veteran*, VA will apply a dollar-for-dollar offset to the Veteran’s applicable VA copayment responsibility. In addition, VA can reimburse the Veteran for any payments made by the veteran to cover the cost of copayments, deductibles, or cost shares required by their OHI. Unless an exception applies, the VA payment is capped at the Medicare (or other allowable) rate. If the OHI payment does not completely satisfy the veteran’s VA copayment responsibility, VA will bill the veteran for the remainder of the VA copayment amount.⁵⁷

As stated previously Medicare, Medicaid, or TRICARE are not considered “other health insurance” plans under the VCP. Therefore, veterans with these plans will not incur any deductibles, coinsurances, or copayments costs.

Provider Payment Methodologies

Guidance on rates for the delivery of care is outlined in **Table 4**. First, the Veterans Choice Program providers are to receive their reimbursements from either Health Net or TriWest. Then the VA is to reimburse the third-party administrator.⁵⁸ Eligible VA community care providers who decide to participate under the PC3 network (rather than the Choice network) may incur reimbursement rates lower than those of Medicare.⁵⁹ If these providers move to the Choice network, they may negotiate for a similar rate as contracted under the PC3 Network.

Table 4. Payment Rates and Methodologies

	Episode of Care	
	Service-Connected Condition	Nonservice-Connected Condition
Payment Responsibilities	VA is solely responsible.	<ul style="list-style-type: none"> The primary payer is the veterans’ other health insurance. The secondary is the VA.
Payment Rates	Rates are not to exceed those in the “Medicare Fee Schedule;” with exceptions in highly rural areas, Alaska, All-Payer Model Agreements, and when there are no available rates.	
Highly Rural Areas ^a	<ul style="list-style-type: none"> Higher rates that exceed the “Medicare Fee Schedule” may be negotiated. 	

⁵⁵ Department of Veterans Affairs, Veterans Health Administration, *Veterans Choice Program Other Health Insurance and Copayment Responsibility*, August 12, 2015, p. 1.

⁵⁶ Veterans Health Administration, *Choice Champion Call*, January 12, 2016, p. 23.

⁵⁷ *Ibid.*, p. 2, and 38 C.F.R. §§17.1520(b), 17.1535(b).

⁵⁸ *Ibid.*, p. 33.

⁵⁹ Department of Veterans Affairs, “Expanded Access to Non-VA Care Through the Veterans Choice Program,” 80 *Federal Register* 66425, October 29, 2015.

	Episode of Care	
	Service-Connected Condition	Nonservice-Connected Condition
Alaska	<ul style="list-style-type: none"> Rates are computed under 38 C.F.R. §§17.55(j), 17.56(b). 	
All-Payer Model Agreements	<ul style="list-style-type: none"> Rates are calculated based on the rates within the agreement. 	
No Available Rates	<ul style="list-style-type: none"> In this, the Secretary will follow the methodology outlined in 38 C.F.R. §§17.55, 17.56. 	
Authorized Care	Health Net or TriWest, on behalf of the VA, will authorize services.	
	The VA requires that all rendered services delivered to veterans receive prior-authorizations.	
	Medical services are delivered by an eligible entity or provider after a veteran chooses to receive care under the Veterans Choice Program.	

Source: 38 C.F.R. §17.1535.

a. A “highly rural area” is defined as a county having fewer than seven individuals residing per square mile.

Veterans and VA community care providers may call the Community Care Call Center⁶⁰ to discuss billing issues. These issues range from the need to resolve a debt collection to inappropriately billed services.

⁶⁰ Veterans may call the Community Call Center at 1-877-881-7618 from 9 am to 5 pm EST.

Appendix. VA Care in the Community

Table A-1 summarizes the existing major statutory authorities that allow the VA to provide care to veterans in the community utilizing non-VA providers.

Table A-1. VA Care in the Community
Existing Statutory Authorities

Program Title	Description
Veterans' Choice Act (Veterans Choice Program) [38 U.S.C. §1701 note]	Temporary program, set to expire in August 2017 or whenever the Veterans Choice Funds are exhausted, to furnish hospital care and medical services to eligible veterans through eligible VA community care providers.
Traditional VA Care in the Community (formerly Non-VA Medical Care) [38 U.S.C. §1703]	Authority to contract for hospital care and medical services when VA facilities are not capable of furnishing care due to geographic inaccessibility or are not capable of furnishing care; can also furnish counseling and related mental health services under 38 U.S.C. Section 1712A(e)(1).
Project Access Received Closer to Home (ARCH) [38 U.S.C. §1703 note]	Pilot program in five Veterans Integrated Service Networks (VISNs) to provide by contract covered health care services to covered veterans. The pilot would expire in August 2016.
Enhanced Sharing Authority [38 U.S.C. §8153]	Authority to make arrangement by contract or other forms of agreement, for the mutual use, or exchange of use, of health care resources between VA facilities and any health care provider, or other entity or individual. Sharing agreements with academic medical affiliates are executed under this authority.
Indian Health Service (IHS)/Tribal Health Program ^a (THP) [25 U.S.C. §1645]	Authorizes the Secretary of Department of Health and Human Services (HHS) to enter into or expand sharing arrangements between IHS, tribes, and tribal organizations, and VA and Department of Defense (DOD). This authority is cited in VA's Direct Care Services reimbursement agreements with IHS and THP.
Sharing of VA and Department of Defense (DOD) Health Care Resources [38 U.S.C. §8111]	Authority to enter into sharing agreements and contracts with DOD for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed.
Emergency Care for Certain Veterans with Service-Connected Conditions ^b [38 U.S.C. §1728]	Authority to pay or reimburse charges of emergency treatment furnished in a non-VA facility where such treatment was needed for/related to a service-connected condition or in certain instances vocational rehab or provided to a veteran permanently and totally disabled.
Emergency Care for Nonservice-connected Conditions [38 U.S.C. §1725]	Authority to pay or reimburse charges of emergency treatment furnished in a non-VA facility under certain circumstances to certain eligible veterans.

Source: Table prepared by CRS based on U.S. Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, October 30, 2015, pp. 104-107, http://www.va.gov/opal/publications/VA_Community_Care_Report_11_03_2015.pdf. Accessed on December 29, 2016.

Notes: This table does not show community care programs authorized under 38 U.S.C. §§1720 and 1720C, which includes community nursing home care, community adult health day care, home health care services, respite care, and hospice care.

- a. The VA and Indian Health Service/Tribal Health Programs signed a Memorandum of Understanding (MOU) to coordinate and share resources for services provided to eligible American Indian/Alaska Native Veterans.
- b. Treatment may be for either a service-connected condition or a nonservice-connected condition that is aggravating a service-connected connection.

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