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CLIENT ALERT

Veterans Choice Program Expanded in Interim Final Rule by the Department of Veterans Affairs

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On November 5, 2014, the Department of Veterans Affairs (the "VA") released its interim final rule ("Interim Final Rule") regarding the Veterans Choice Program (the "Program"), allowing eligible veterans to elect to receive hospital care and medical services from eligible non-VA health care entities and providers.[1] In order to address the VA health care access crisis, the Program was authorized by the Veterans Access, Choice, and Accountability Act of 2014 ("the Statute"), which was signed into law by President Obama on August 7, 2014.[2] The Program is funded through the Veterans Choice Fund, in which $10 billion has been appropriated, and the Program is authorized to continue until the earlier of the Veterans Choice Fund being exhausted or August 7, 2017.

The Interim Final Rule became effective upon publication, even though the VA is soliciting comments until March 5, 2015. We strongly encourage members of the health industry to take advantage of this comment period and offer the VA suggestions on ways in which the Interim Final Rule, and the issues contained therein, should be clarified and/or expanded to address the growing health access crisis for veterans. For example, providers should submit comments regarding the eligibility criteria for non-VA health care entities and providers to participate in the Program. In addition, providers should assess the likelihood and impact of an influx of veterans into their patient population; examine the eligibility, payment, and claims processing requirements; and consider submitting comments to flag issues and ambiguities.

[1] Expanded Access to Non-VA Care Through the Veterans Choice Program, 79 Fed. Reg. 65571 (codified at 38 C.F.R. 17).
[2] Technical revisions to the Choice Act 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).

Eligibility Criteria for Veterans to Participate

The Interim Final Rule outlines how eligible veterans may elect to receive, at the VA's expense, care from a non-VA provider of their choice that is eligible and accessible to them under the Program. Consistent with the Statute, a veteran is eligible to receive non-VA care if the veteran enrolled in the VA health care system prior to August 1, 2014, or within five (5) years of post-combat separation, and either:

1) the veteran is unable to schedule an appointment with a VA medical facility within the VA's established 30-day wait-time goal; or

2) the veteran either (a) resides more than 40 miles from any VA medical facility closest to the veteran's residence; (b) resides in a state without a full-service VA medical facility and the veteran lives more than 20 miles from such facility; or (c) resides within 40 miles or less of any VA medical facility in which the veteran (i) must travel by boat, air, or ferry to reach such facility or (ii) faces an unusual or excessive burden in accessing an VA medical facility due to geographical challenges.

The Interim Final Rule interprets the Statute's distance requirements for eligibility purposes. Under the Interim Final Rule, the distance is calculated based on the proximity of any VA facility, whether or not the particular VA facility has the specialty or practice needed by the veteran. Additionally, the Interim Final Rule allows the VA to calculate the distance from the veteran's residence to the nearest VA medical facility using a straight line distance rather than driving distance. The VA acknowledges that for some veterans the driving distance may be farther than 40 miles, while still within a 40-mile straight line distance, due to the layout of roads. Although the VA believes that the calculation of proximity based on a straight line distance serves to provide an equitable means for determining eligibility, unfortunately a straight line distance calculation will likely exclude veterans who live in rural areas in which the driving distance is beyond 40 miles but the straight line distance is less than 40 miles. While veterans in this category may still be eligible for non-VA care under the provision for geographic challenges, more clarity is necessary to determine whether the VA will frequently interpret unusual or excessive burdens in accessing a VA medical facility to include rural areas where the driving distance exceeds 40 miles. Otherwise, concerns may exist regarding the VA's interpretation of the distance requirements under the Interim Final Rule and whether it is equitable for veterans in rural areas.

To ensure adequate resources are available, the VA has varied start dates for eligibility under the Program as described in the Interim Final Rule. Veterans eligible due to the lack of proximity to a VA medical facility are able to start receiving non-VA hospital immediately (i.e., upon publication of the Interim Final Rule on November 5, 2014). All other eligible veterans are able to start receiving non-VA hospital care under the Program beginning December 5, 2014. It is important for providers to note that the Interim Final Rule does not affect a veteran's eligibility for hospital care or medical services under any other health care plan, nor does it limit any of the VA's authority under prior law to administer non-VA care. Eligibility under the Program will supplement, rather than supplant, any health benefits and care made available to veterans.

Eligibility Criteria for Non-VA Health Care Entities and Providers

The Interim Final Rule outlines how health care entities and providers who wish to participate in, and be reimbursed by, the Program must meet two requirements, consistent with the Statute. First, entities and providers must either (1) participate in the Medicare program or (2) be a federally-qualified health center, a part of the Department of Defense, or a part of the Indian Health Service. Second, entities and providers must be accessible to veterans. In determining if an entity or provider is "accessible" as required under the Statute, the Interim Final Rule sets out that the VA will consider the following:

1) the length of time a veteran would have to wait to receive hospital care or medical services from the entity or provider;

2) the qualifications of the entity or provider to furnish the hospital care or medical services; and

3) the distance between the eligible veteran's residence and the entity or provider.

Entities and providers are required to maintain the same or similar credentials and licenses as those required of VA health care providers, and must not be a part of, or an employee of, the VA. VA health care providers are allowed to participate in the Program, but they must do so during time outside of their VA commitments, using non-VA resources. All participating entities and providers must enter into an agreement with the VA to provide non-VA hospital care or medical services, which can be in the form of a contract, intergovernmental agreement, or provider agreement consistent with the Statute. The Interim Final Rule, however, also notes that VA is able to use prior agreements with non-VA care providers reached before the enactment of the Act, so long as such agreement is with an eligible entity or provider as defined in the Statute.[3] This is beneficial to non-VA providers who meet the eligibility criteria defined in the Interim Final Rule since they will be able rely on previous agreements with the VA to participate in the Program.

The Interim Final Rule also provides that the VA will cover prescriptions while furnishing hospital care or medical services under the Program. Although the Interim Final Rule's preamble recognizes the Statute's requirement to not alter the process for filling and paying for prescription medications, the Interim Final Rule does not explicitly adopt such language. Instead, the preamble explains how the VA will not alter these processes, only eliminate a VA requirement that is inconsistent with the Program. Under prior non-VA care authorities, the VA did not usually fill prescriptions written by non-VA providers without having the VA determine the medical necessity and appropriateness of the prescription (except for emergency prescriptions). The VA has determined that such a

[3] While the providers will be executing or already have executed an agreement with the VA to furnish care, the Statute was explicit that any entities providing care or services under the Statute would not be treated as a Federal contractor or subcontractor by the Department of Labor's Office of Federal Contract Compliance Programs ("OFCCP"). This exemption from OFCCP jurisdiction was not specifically reflected in the Interim Final Rule. *See* Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, § 101(d)(3)(A).

requirement in the Program would be problematic because the veteran's eligibility is based on being unable to be seen within a timely manner or because of difficulties they face in traveling to a VA medical facility, so the VA has removed the requirement under the Program in the Interim Final Rule. The VA will fill and continue to pay for prescriptions, including prescription drugs, over-the-counter drugs, and medical and surgical supplies prescribed by eligible entities and providers under the Program. Consistent with prior non-VA care authorities, the VA will only pay for those items that are on the VA National Formulary, and eligible veterans will be charged a VA copayment (if applicable). While the Interim Final Rule does not alter how prescriptions are filled or reimbursed, given the expansion under the Program, we anticipate that the number of prescriptions filled at the VA from non-VA providers may increase.

Payment Rates and Claims Processing Systems

The Interim Final Rule establishes that the reimbursement for services under the Program will supplement reimbursement for services under the eligible veteran's other health plans. To the extent that the eligible veteran has an additional health care plan, eligible non-VA health care entities and providers must first bill a veteran's other health care plan, then the remaining balance, if less than the established rates under the Program, will be covered by the VA, to include co-payments, cost shares, and deductibles. Implementing the Statute's payment requirements, the Interim Final Rule provides that health care entities and providers participating in the Program will be reimbursed at rates that do not exceed the rates paid by the federal government according to the Medicare Fee Schedule. For services that are authorized by the VA medical benefits package but not included in the Medicare Fee Schedule (such as dental and obstetrics/gynecological care), the VA will determine the appropriate rate using its existing payment methodology for authorized care furnished by non-VA providers. Entities and providers in highly rural areas (defined in the Statute as a county with fewer than seven residents per square mile) may receive rates higher than the Medicare Fee Schedule, to be determined by the VA. Copayments paid by veterans at the time they receive inpatient hospital care, outpatient medical care, medications, and extended care services furnished through the Program will be $0. The VA will determine the veteran's copayment amount at the end of the billing process, and will develop and operate a claims processing system to reimburse entities and providers that provide authorized services.

Consistent with the Statute, hospital care or medical services provided for non-service-connected disabilities will be primarily paid for by the eligible veteran's health plan, with the VA only being responsible for the costs of VA-authorized services not covered by the health plan. For hospital care or medical services provided for a service-connected disability, the VA is solely responsible for reimbursing the entity or provider for the care rendered. It is important for providers to note that the VA will only pay for services that have been authorized by the VA. If an entity or provider determines that additional services are necessary beyond what the VA has authorized, the entity or provider must obtain authorization from the VA prior to furnishing the additional services. There must be an actual encounter between the veteran and a health care provider who either has a Program agreement with the VA or is employed by an entity that has a Program

agreement. The encounter can be virtual (such as through telehealth) so long as the provider furnishes hospital care or medical services during the encounter.

Epstein Becker Green is available to assist with drafting and submitting comments concerning the VA's Interim Final Rule, which are due on or before March 5, 2015.

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