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Implementation of the Veterans Choice Program (VCP)

In response to concerns about access to medical care at many Department of Veterans Affairs (VA) hospitals and clinics across the country, Congress passed the Veterans Access, Choice and Accountability Act of 2014 (VACAA). On August 7, 2014, President Obama signed the bill into law (P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235). 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)*.

Section 101 of VACAA authorized the Veterans Choice Program (VCP) —a new, temporary program that provides veterans the ability to receive medical care in the community. The temporary program will end when the $10 billion in *mandatory funding* are used, or no later than August 7, 2017. This new program is in addition to several already existing statutory authorities that allow the VA to provide care outside of its own health care system (38 U.S.C.§§ 1703, 1703note, 1725, 1728, 8111, and 8153). Generally, these statutory authorities fall into three broad categories: 1) contracts to purchase care, 2) non-contracted medical care purchased on a fee for service basis from providers in the community, and 3) emergency care when delays may be hazardous to a veteran's life or health. Furthermore, in September 2013, the VA had awarded contracts to two private companies (Health Net Federal Services, LLC, and TriWest Healthcare Alliance Corporation) to implement the Patient Centered Community Care (PC3) program—a care coordination and referral program to provide eligible veterans access to care when VA cannot provide health services either at a VA medical facility or through other federal agencies or sharing agreements. In FY2014, the VA spent approximately $7 billion (excluding VCP) to purchase care from the community, and authorized almost 14 million outpatient visits, among other services and procedures (excluding VCP).

VCP Eligibility

Section 101 of VACAA established specific eligibility criteria for the new VCP. Generally, to participate in the VCP a veteran must meet one of the following two broad sets of criteria:

- The veteran must be enrolled in the VA health care system as of August 1, 2014, including a veteran enrolled in the VA health care system who has not received hospital care or medical services from the VA and has contacted the VA seeking an initial appointment for the receipt of such care or services; ***or***
- Must be a combat-theater veteran discharged or released from active duty during a five-year period prior to enrollment.

Once a veteran meets one of the above requirements VACAA allows the VA to authorize care for veterans outside the VA health care system if any of the following requirements are met:

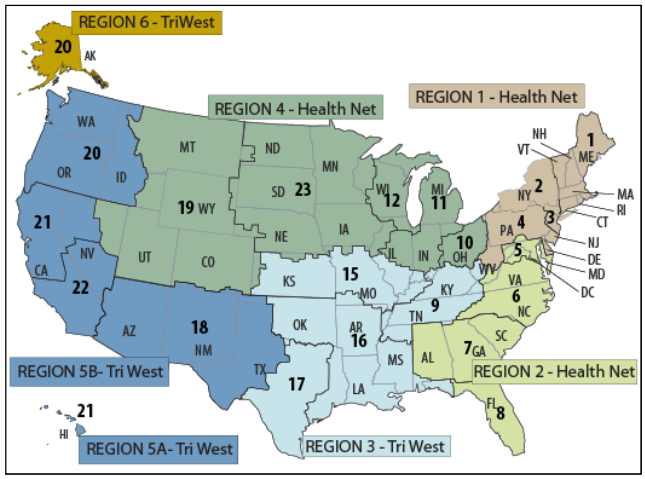
- The VA cannot schedule a medical appointment within 30 days of the veteran's preferred date, or the date determined medically necessary. This means that the VA is unable to identify a particular date, time, location, and entity or health care provider within 30 days of the date that the appointment was deemed clinically necessary by a VA health care provider, or, if no such clinical determination has been made, the date that a veteran prefers to be seen by a health care provider capable of furnishing the hospital care or medical services required by the veteran; ***or***
- The veteran resides more than 40 miles from his or her closest VA medical facility (On April 24, 2015, the VA announced that it will determine distance between a veteran's place of residence and the nearest VA medical facility using driving distance rather than straight-line distance or geodesic distance to such a facility.); ***or***
- The veteran resides 40 miles or less from a VA medical facility and faces an unusual or excessive burden in accessing such a facility due to geographical challenges; ***or***
- The veteran resides in a state without a full-service VA medical facility that provides hospital care, emergency services and surgical care and resides more than 20 miles from such a facility (this criterion only applies to veterans residing in three states: Alaska, Hawaii, and New Hampshire).

VCP Implementation

The VACAA provided 90 days from the date of enactment to establish the temporary VCP. On September 17, 2014, the VA held an "Industry Day" to seek input from parties interested in providing Third Party Administrator (TPA) support to the VA. TPA functions included creating and distributing the Veteran's Choice Card, establishing a call center to provide education to veterans and providers on VCP details, responding to veteran and clinician inquiries, tracking, monitoring and reporting on veteran utilizations, and managing claims adjudication and payment to include receipt of clinical documentation. The TPA was also required to facilitate and manage patient referrals, and establish a utilization review department to make Non-Service Connected/Service Connected/Special Authority (NSC/SC/SA) determinations. Since there was feedback from the private industry about significant challenges of meeting VACAA's limited implementation timeline, VA awarded Health Net Federal Services, LLC, and TriWest Healthcare Alliance Corporation—the same contractors that

administer the PC3 program—TPA responsibilities by modifying the existing PC3 contract. **Figure 1** shows the VCP TPA regions.

Figure 1. Veterans Choice Contract Coverage Map
(Same as PC3 Regions)



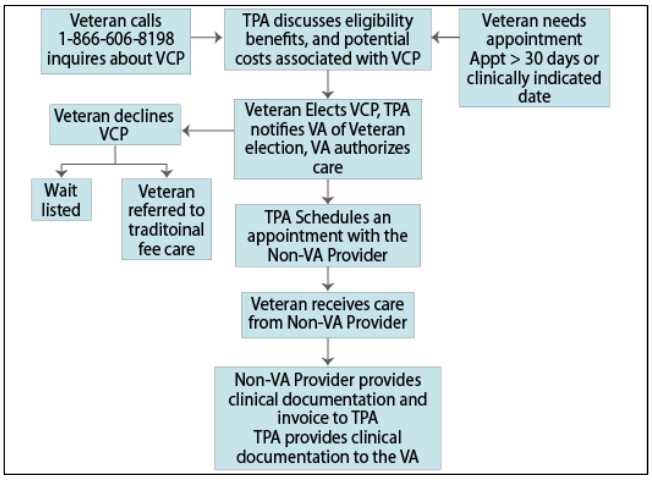
Source: Department of Veterans Affairs

How is the VCP Administered?

Those veterans who qualify under the 40-mile criteria will generally call the TPA for information or express interest in receiving care outside the VA health care system (see **Figure 2**). The TPA generally will have received a list of eligible participants from the VA. When an appointment is scheduled for a veteran who qualifies under the 40-mile criteria, TPA is required to notify the VA medical center (VAMC). Following the veteran's appointment with a non-VA provider, the TPA is required to gather clinical documentation, claim information and Explanation of Benefit (EOB) information from the provider, and submit it to the VA. The VAMC staff is supposed to retrieve documentation from the TPA's web portal and upload the information into the veteran's clinical record. The VA's Chief Business Office (CBO) Purchased Care (CBOPC) staff is required to then process claim payment to the TPA, and the TPA will make the payment to the non-VA provider.

For those veterans who qualify because they may have to wait more than 30 days for care, authorizations are made based on the Veterans Choice List or Electronic Wait List. The VAMC makes the veteran aware of eligibility to participate in the VCP. Generally, for those veterans who have to wait more than 30 days for care the VAMC submits clinical documentation to the TPA. The veteran will call the TPA for information or express interest in receiving care from a non-VA provider. If the veteran elects to receive care under the VCP, the TPA will then schedule an appointment, and notify the VAMC of the scheduled appointment. After the scheduled appointment with the non-VA provider, the TPA will follow the same process as described for those who qualify for the 40-mile criteria.

Figure 2. High Level Flow Chart for VCP



Source: Congressional Research Service based on VA information.
Notes: TPA= Third Party Administrator; VCP=Veterans Choice Program.

Some Potential Issues for Congress

- *Overlapping and sometimes contradictory eligibility requirements among the various non-VA care statutory authorities*. VA's statutory authorities (38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153) to obtain the services of non-VA providers in non-VA facilities were developed at various times in an incremental and uncoordinated manner to respond to specific requirements. Sometimes pilot programs have evolved into permanent programs. For example, Project HERO evolved into PC3 (see CRS Report R41065, *Veterans Health Care: Project HERO Implementation*). These overlapping and sometimes contradictory programs have led to confusion among veterans, and even VA's own employees who administer these programs.
- *Multiple reimbursement methodologies*. VA bases fee-for-service or contract care reimbursement rates to providers on the applicable Medicare or VA Fee Schedule rates. However, programs like PC3 reimburse the providers at rates that are generally lower than the Medicare rates VA typically pays for non-VA care. Nevertheless, VCP requires reimbursement at least at the Medicare rate.
- *Lack of Medicare rates for some services*. Currently, the VA obtains certain services in the community such as dental care, and VCP requires reimbursement at least at the Medicare rate. Medicare generally does not cover dental care.
- *Lack of provider agreement authority*. Currently, VA lacks provider agreement (a noncontractual mechanism) authority, which is simpler and less burdensome than VA contracting procedures. Such an authority may appeal to smaller or solo non-VA healthcare providers.

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