

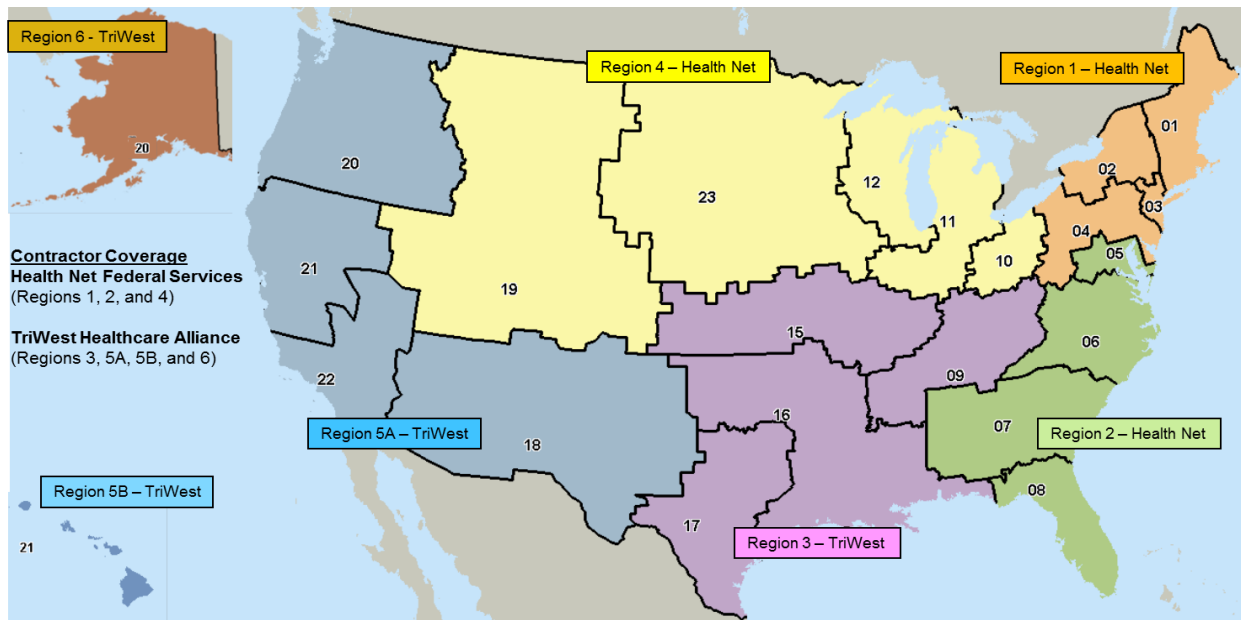
Non-VA Medical Care Program Provider Fact Sheet

Patient-Centered Community Care and Veterans Access, Choice, & Accountability Act

The Veteran’s Choice Program, or Choice Program, is a new, temporary program that provides Veterans the ability to receive medical care in the community if VA cannot schedule an appointment within 30 days of the Veteran’s preferred date, or the date determined medically necessary by their provider, or if the Veteran resides more than 40 miles from their closest VA medical facility. It was authorized under the *Veterans Access, Choice, and Accountability Act of 2014* and provides \$10B for non-VA medical care to eligible Veterans. The temporary program will end when the allocated funds of \$10B are used or no later than August 7, 2017. The Choice Program does not impact existing VA health care or any other Veteran benefits.

VA has expanded its Patient-Centered Community Care (PC3) contracts with Health Net Federal and TriWest Healthcare Alliance to include implementing the Choice Program. PC3 is a VA nationwide program to provide eligible Veterans access to certain medical care when the local VA medical facility cannot readily provide the care due to lack of available specialist, long wait times, geographic inaccessibility, or other factors. PC3 has been the VA method of purchasing care in the community. The Choice Program supplements PC3 and allows coverage for more services for eligible Veterans and provides Veterans more flexibility in their choice to receive care in the community or through VA.

PC3/Veterans Choice Contract Coverage Map



Region 5A: VISNs 18, 20 (excluding Alaska), 21 (excluding Hawaii & Pacific Islands), and 22
Region 5B: VISN 21 (Hawaii & Pacific Islands only)
VA Island locations not on map
 American Samoa (V21) Guam (V21) Northern Mariana Islands (V21) Puerto Rico (V8) U.S. Virgin Islands (V8), Philippines (V21) not covered by a PC3 contract.

PC3 and/or Choice Program Network of Providers

- All PC3 providers are automatically eligible to participate in the Choice Program
- If a provider is interested in becoming a PC3 provider, they must establish a contract with one of the Third Party Administrators (TPAs), Health Net or TriWest
 - TPA and provider must have an agreed upon reimbursement amount
- If a provider is not interested in becoming a PC3 provider, but wants to become a Choice provider, they must establish a provider agreement with Health Net or TriWest
 - Providers must accept Medicare rates
 - Providers must meet all Medicare Conditions of Participation and Conditions for Coverage as required by the U.S. Department of Health and Human Services
 - See <http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/index.html> for further detail
 - Any provider on the Centers for Medicare and Medicaid Services (CMS) exclusionary list shall be prohibited from network participation.
 - See <http://oig.hhs.gov/exclusions/index.asp> for further detail
 - All services, facilities, and providers shall be in compliance with all applicable federal and state regulatory requirements.
 - All providers shall have a full, current, unrestricted license in the state where the service(s) are delivered and must have same or similar credentials as required by VA staff
 - Providers must submit a copy of the medical records to the TPA for the medical care and services provided to the Veteran for inclusion in the Veterans VA electronic record
- Contact information for Health Net:
 - Provider Customer Service Phone Number: 1-800-979-9620
 - E-mail: HNFSProviderRelations@Healthnet.com
 - Website: www.hnfs.com/content/hnfs/home/va/home/provider/join-our-network.html
- Contact information for TriWest:
 - Provider Services Contracting: 1-866-284-3742
 - Email: TriWestDirectContracting@triwest.com
 - Website: <https://joinournetwork.triwest.com/>

Billing/Payment

- Providers will be paid by the TPA; VA will pay the TPA
- For PC3:
 - Payment for medical care and services will be paid based on the an amount agreed upon between the TPA and the provider
 - VA is the primary payer for all PC3 services and the Veteran has no out-of-pocket costs
- For the Choice Program:
 - Payment for medical care and services will generally be made at the applicable Medicare rate; however, a TPA may negotiate a rate that is more than Medicare for highly rural areas

- Highly rural areas are defined as a county that has fewer than seven individuals residing in that county per square mile
- Federally Qualified Health Centers (FQHC) need to clarify in the TPA Provider Agreement that the reimbursement rate is 100% of their Medicare rate as determined by CMS, e.g. FQHC Medicare Prospective Payment System Rate, Critical Access Hospital Rate, or Fee for Service Rate
- The TPA will notify the provider if a Veteran is receiving service-connected or non-service-connected care
 - For all service-connected care, VA is the primary payer and the Veteran has no out-of-pocket costs
 - If the care is non-service-connected and the Veteran has other health insurance (excluding government health benefit plans, i.e. Medicaid, Medicare, TRICARE, etc.) the provider will bill the other health insurance
 - VA copayments will be determined by VA after the services are provided and Veterans should not pay a VA copayment at the time of their visit

Medical Care

- Authorizations are needed for every episode of medical care covered under PC3 or the Choice Program
- For the Choice Program, the authorization lasts no longer than 60 days from the date of the first appointment with the provider
 - If a Veteran requires additional services/treatments following the initial 60 day episode of care, the provider may submit a request for additional services to the TPA
 - The TPA will coordinate with the VA to either transition the Veteran to VA or authorize additional care

Emergency Care

- Emergency care is not covered under PC3 or the Choice Program
- Although not covered under PC3 or the Choice Program, VA can make payment or reimbursement for non-VA emergency care
 - For additional information on non-VA emergency care, including reimbursement criteria and Fact Sheets, please visit http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/Emergency_Care.asp

Clinical Information

- The TPA will provide clinical information to a provider when the appointment is requested
- After the visit is completed, the provider will submit clinical documentation to the TPA
- The TPA is responsible for providing the clinical documentation back to the VA

Prescriptions

- Prescriptions written under either PC3 or the Choice Program must adhere to the VA National Formulary (<http://www.pbm.va.gov/PBM/NationalFormulary.asp>)
- For non-urgent prescriptions, the provider can either mail or fax the prescription and the PC3/Choice Program episode of care authorization form to the local VA medical facility or provide the Veteran hard copies of both.
- Once the prescription and episode of care authorization form is received, VA will fill it and mail it to the patient at the patient's address on file with VA
 - Schedule II controlled substance prescriptions may not be faxed to VA for processing; they must be mailed or presented in person.
 - Prescriptions for Schedule III-V prescriptions must contain the provider's hand written signature.
- All non-urgent prescriptions must be filled by the VA.
- Urgent prescriptions may be filled at a local non-VA pharmacy for up to a 14 day supply and must adhere to the VA National Formulary
- Prescriptions sent to VA that do not adhere to the VA National Formulary will likely result in patient care delays.
- When a non-formulary medication is required due to a bona-fide, documented medical necessity, the non-VA provider must contact VA medical facility pharmacy staff to submit a non-formulary request before submitting the prescriptions to be filled.