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Health Care Options

THROUGH VA

Effective June 6th, 2019



Choose **VA**

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Your VA Health Care Options

At VA, Veterans are the center of everything we do. We are constantly working to make sure you know about the health care and benefits you have earned through your service to our country. The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (MISSION Act) of 2018 strengthens VA's ability to provide you with state-of-the-art care and services. The law makes several improvements to VA care that begin on June 6, 2019. To help you understand your health care options through VA, we are sharing this educational material.

IMPROVING VETERAN HEALTH CARE

VA is devoted to providing an excellent experience for you and the important people in your life. We are strengthening our ability to deliver timely, high-quality health care through a network of providers and cutting-edge technology.

Under the VA MISSION Act of 2018, VA will:

- ▶ Continue to provide you with an excellent health care experience
- ▶ Deliver the right care, at the right time, at the right place
- ▶ Continue to offer care through telehealth in your home, in a VA facility, or in the community; and
- ▶ Provide more options for health care, including community care and urgent/walk-in care

For more information on the VA MISSION Act of 2018, please visit www.missionact.VA.gov.

Am I Eligible for VA Health Care Benefits?

You may be able to receive VA health care if you served in the active military service, have a qualifying discharge, and satisfy or are exempt from the minimum service requirement. To learn more, please review the eligibility information below.

Generally, to be eligible for VA health care you must have been discharged under “other than dishonorable” conditions, e.g., honorable, under honorable, or general. However, if you received a bad conduct discharge or other than honorable discharge, you may still qualify based on a determination made by VA.

Unless an exception applies, if you enlisted after September 7, 1980, or entered active duty after October 16, 1981, to be eligible for VA health care, you must have served the shorter of 24 months continuous active duty, or, for Reservists or National Guard members who were Federally activated, the full period you were called or ordered to active duty.

This requirement does not apply:

- ▶ If you were discharged for a disability that was caused—or made worse—by your active duty service, or
- ▶ If you were discharged for a hardship or “early out,” or
- ▶ If you have a disability for which disability compensation may be paid by VA.

It also does not apply to the provision of care in connection with a service-connected disability.

There are other exceptions that may apply to you. We encourage you to **apply for enrollment today**, so that we can determine your enrollment eligibility.

- ▶ Even if you are not enrolled or eligible for enrollment, you may be eligible for certain VA health care benefits under VA's special health care authorities:
 - ▶ Service-Connected Conditions –
 - ▶ Even if you are not otherwise eligible to enroll or choose not to enroll, you may receive VA care for service-connected conditions, unless the condition was incurred or aggravated during a period of service that ended in a bad conduct discharge or a discharge that is subject to a statutory bar to benefits.

- ▶ Military Sexual Trauma (MST) –
 - ▶ You may be eligible to receive MST-related health care if you are a Veteran of the active duty military, Reserves, or National Guard who experienced sexual trauma during:
 - ▶ A period of active duty
 - ▶ Active duty for training
 - ▶ The minimum service requirement does not apply to this benefit.
 - ▶ Presumptive Eligibility for Psychosis and Other Mental Illness –
 - ▶ If you developed a psychosis or mental illness within two years of discharge, you may be eligible for care for that condition even if you are not eligible to enroll in VA health care.
 - ▶ The minimum service requirement does not apply to this benefit.
 - ▶ Mental and Behavioral Health Care for Certain Former Servicemembers –
 - ▶ If you are a former member of the Armed Services, including the reserve components, and you
 - ▶ Served in the active military and have a qualifying discharge (not honorable and not dishonorable or a discharge by court-martial),
 - ▶ Are not enrolled, and
 - ▶ Served for a period more than 100 cumulative days and were deployed in a theater of combat operations, or while serving suffered MST
-

You may be eligible for mental and behavioral health care. The minimum service requirement does not apply to this benefit.

- ▶ When you are enrolled in VA health care, you are assigned to a priority group or groups, depending on a variety of factors, such as:
 - ▶ Your military service history,
 - ▶ Your disability rating,
 - ▶ Your income level,
 - ▶ Whether or not you qualify for Medicaid, and
 - ▶ Other benefits you may be receiving (like pension benefits)

Generally, Veterans with service-connected disabilities and lower incomes are placed in higher priority groups than those with a higher income and who do not have any service-connected disabilities.

PRIORITY GROUP	CRITERIA
Priority Group 1	▶ Your service-connected disabilities are rated by VA as 50% or more disabling. ▶ You were determined by VA to be unemployable due to service-connected conditions. ▶ You have been awarded the Medal of Honor (MOH).
Priority Group 2	▶ Your service-connected disabilities are rated by VA as 30% or 40% disabling.
Priority Group 3	▶ You are a former Prisoner of War (POW). ▶ You have been awarded a Purple Heart medal. ▶ You were discharged for a disability that was incurred or aggravated in the line of duty. ▶ Your service-connected disabilities are rated by VA as 10% or 20% disabling. ▶ You have been awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation."
Priority Group 4	▶ You receive aid and attendance or housebound benefits from VA. ▶ You have been determined by VA to be catastrophically disabled.
Priority Group 5	▶ You have a nonservice-connected or non-compensable service-connected disability and you are rated by VA as 0% disabled and you have an annual income below VA's geographically adjusted income limit (based on your resident ZIP code). ▶ You receive VA pension benefits. ▶ You are eligible for Medicaid programs.
Priority Group 6	▶ You have a compensable 0% service-connected disability. ▶ You were exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki. ▶ You are a Project 112/SHAD participant. ▶ You served in the Republic of Vietnam between January 9, 1962, and May 7, 1975. ▶ You served in Persian Gulf War between August 2, 1990, and November 11, 1998. ▶ You served on active duty at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987. ▶ You are a currently enrolled Veteran and new enrollee who served in a theater of combat operations after November 11, 1998, and you were discharged from active duty on or after January 28, 2003; these criteria make you eligible for enrollment in priority group 6 for treatment of conditions related to your combat service for a period of five years post discharge. NOTE: At the end of this enhanced enrollment priority group placement time period, you will be assigned to the highest priority group for which you qualify.

PRIORITY GROUP	CRITERIA
Priority Group 7	▶ Your gross household income is below the geographically adjusted VA income limit for your resident location and you agree to pay copayments.
Priority Group 8	▶ Your gross household income is above the VA income limits and the geographically adjusted income limits for your resident location, and you agree to pay copayments. ▶ VETERANS ELIGIBLE FOR ENROLLMENT: You are rated with a non-compensable 0% service-connected disability and are: ▶ SUBPRIORITY A: Enrolled as of January 16, 2003, and you have remained enrolled since that date and/or were placed in this subpriority due to changed eligibility status. ▶ SUBPRIORITY B: Enrolled on or after June 15, 2009, and your income exceeds the current VA income limits or the geographically adjusted VA income limits by 10% or less. ▶ VETERANS ELIGIBLE FOR ENROLLMENT: You are nonservice-connected and: ▶ SUBPRIORITY C: Enrolled as of January 16, 2003, and you have remained enrolled since that date and/or were placed in this subpriority due to changed eligibility status. ▶ SUBPRIORITY D: Enrolled on or after June 15, 2009, and your income exceeds the current VA income and geographic income limits by 10% or less. ▶ VETERANS NOT ELIGIBLE FOR ENROLLMENT: You do not meet the criteria above: ▶ SUBPRIORITY E: Non-compensable 0% service-connected (eligible for care of their service-connected condition only). ▶ SUBPRIORITY G: Nonservice-connected.

Apply for VA health care today at <https://www.VA.gov/health-care/eligibility> or by visiting your local medical center.



What Kind of Care Will I Receive From VA?

At VA, we partner with you to help you stay healthy throughout your lifetime. VA offers a full range of health care services, including primary care, mental health counseling, vision, prescription drug coverage, surgical services, and in some cases, dental care. Other services, such as maternity care, are also available through VA's use of community providers. See VA Health Care Benefits Overview for more information: <https://www.VA.gov/healthbenefits/resources/publications/hbco/index.asp>.



Am I Eligible for Community Care Outside VA?

You may be able to receive care from a provider in your local community if you meet specific criteria. Initially, you must be enrolled in VA for care or you must qualify for care without needing to enroll. In addition, one of six eligibility criteria must apply to you based upon your individual health care needs or circumstances. If you are eligible for community care and choose to receive that care, VA generally will need to authorize your care prior to receiving that care.

Under the VA MISSION Act of 2018, there are six different eligibility criteria for community care. Meeting any one of these criteria either in general or for the specific care you need means you are eligible to elect to receive that care either through direct VA care or a community provider in VA's network:

- ▶ You need a service not available at any VA medical facility. Examples of these services include maternity care and other obstetric care.
- ▶ You live in a U.S. state or territory without a full-service VA medical facility. These states and territories are Alaska, Hawaii, New Hampshire, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands.
- ▶ You qualify under the "Grandfathering" provision related to distance eligibility for the Veterans Choice Program. Specifically, you must:
 - ▶ (1) Have been eligible for the Veterans Choice Program based on the "40 mile" eligibility criterion (you resided more than 40 miles from the nearest VA medical facility with a full-time primary care provider);
 - ▶ (2) Continue to reside in a location that would qualify you under that criterion; and
 - ▶ (3) Either (A) reside in Alaska, North Dakota, Montana, South Dakota, or Wyoming; or
 - ▶ (B)(i) Reside in another state,
 - ▶ (ii) Have received care from VA (directly or in the community) between June 6, 2017, and June 6, 2018; and
 - ▶ (iii) Be seeking care before June 6, 2020.
- ▶ VA cannot provide care within certain designated access standards (discussed in greater detail below), including:
 - ▶ Average drive time to a VA medical facility that can provide the care you need; and
 - ▶ Appointment wait time at that VA medical facility
- ▶ You and your referring clinician agree it is in your best medical interest to receive this care in the community, based on established criteria, including, but not limited to:
 - ▶ The distance between you and the facility that could provide your care;
 - ▶ The nature of the care you need;
 - ▶ The frequency of the care you need;
 - ▶ When you need the care;
 - ▶ The potential for improved continuity of care;
 - ▶ The quality of care that would be provided to you; and
 - ▶ Whether you face an unusual or excessive burden in accessing care from a VA facility.

- ▶ VA has determined the VA medical service line that would provide the care you need is not providing care that complies with VA's standards for quality.

In addition, please consider the following information about eligibility for community care:

- ▶ You must receive approval from VA prior to obtaining care from a community provider in almost all circumstances.
- ▶ You must either be enrolled in VA health care or be eligible for VA care without needing to enroll to be eligible for community care.
- ▶ Eligibility for community care continues to be dependent upon your individual health care needs or circumstances.
- ▶ You must notify VA within 60 days of changing your residence.
- ▶ You must provide to VA information on any other health care plan contract under which you are covered prior to obtaining authorization for care and services and notify VA within 60 days if it changes.
- ▶ VA staff members generally make all eligibility determinations.
- ▶ You may appeal eligibility decisions using the clinical appeal process.
- ▶ You will usually have the option to receive care at a VA medical facility regardless of your eligibility for community care.

What if I Need Urgent or Walk-in Care?

You have several options for the treatment of minor injuries and illnesses that are not emergencies, such as colds, sprains, pink eye, and other minor infections. You can visit a VA medical facility for same-day service, and you may be eligible to access VA's network of community providers for treatment. If you choose to access VA's network of community providers, you may be liable for a VA copayment, and you cannot receive preventive care or manage chronic conditions. If you choose to receive care in a VA facility, you will pay your usual VA copayment, and you can receive any necessary care and services within VA's medical benefits package.

You're eligible for urgent/walk-in care if you're enrolled in VA health care and received care through VA (from either a VA or community provider) within 24 months prior to receiving this care. If you are eligible, you can go to a provider in VA's network and receive covered care and services without prior authorization from VA. The services available at any specific provider may vary by location.

To find an eligible provider in VA's network, you will be able to use VA's provider locator, or you can contact your local VA medical facility. VA staff can inform you of available in-network locations and offer to find the closest locations using VA's provider locator on VA.gov at <https://www.VA.gov/find-locations/>.

IMPORTANT: You can only receive urgent/walk-in care if the provider is part of VA's community care network. If you go to an out-of-network provider, you may be responsible for the full cost of care. You may also be responsible if the care you receive is outside the scope of the covered benefit. Finally, you must tell the provider when you arrive that you are using your VA benefit.

You may be charged a VA copayment for urgent/walk-in care; this copayment amount is different from other VA copayments. Your copayment may depend on your assigned priority group and the number of times you have used this benefit in a calendar year. VA will determine your VA copayment after the visit; you will not owe a VA copayment at the time of your encounter.

Contact your VA medical facility for more information about urgent care. You may be able to receive similar care at your VA medical facility, and the copayment will likely be lower than in the community.



How Does Other Health Insurance Interact With VA Benefits?

HEALTH INSURANCE COVERAGE

Health insurance can be obtained by you or your spouse through an employer, in the private market, or a Federal agency other than VA.

The benefits of having private health insurance include:

- ▶ It may reduce or eliminate your VA copayments
- ▶ It does not affect your eligibility for VA care
- ▶ It allows VA to directly bill your insurance company for care for a nonservice-connected condition

VA can bill your health insurance for care for a non-service connected condition, whether that care is provided directly by VA or through a community provider. You are required to provide information to VA about your health insurance coverage, including coverage provided under your spouse's policies.

While many Veterans qualify for free health care services based on a VA compensable service-connected condition or other special eligibilities, most Veterans are required to complete a financial assessment or means test at the time of enrollment to determine if they qualify for free health care services. Veterans whose income exceeds VA income limits, as well as those who choose not to complete the financial assessment at the time of enrollment, must agree to pay required VA copayments for health care services to become eligible for VA health care services. The copayment amount is based on the type of health care service you receive and your financial situation.

You also have the option to use a High Deductible Health Plan (HDHP) for medical care and services for nonservice-connected conditions. HDHPs are usually linked to a Health Savings Account (HSA), which can be used to pay VA copayments. VA can bill your insurance company directly or can be reimbursed using a linked Health Reimbursement Account (HRA).

TRICARE

If you are eligible for VA care and TRICARE and seek treatment at a VA health care facility for nonservice-connected conditions, you can choose whether to use your VA benefits or TRICARE benefits for each visit. Our staff will ask you which benefit you want to use prior to each visit, and if you choose to use TRICARE benefits, you, as the beneficiary, will be asked to complete a TRICARE Affirmation Form. In many instances, VA costs and benefits for nonservice-connected conditions will be different from TRICARE costs and benefits. Covered cost shares, benefits, and services will vary depending on your TRICARE plan, and our staff can assist you with determining the best option for each visit.

INDIAN HEALTH SERVICE (IHS) AND TRIBAL HEALTH PROGRAMS (THP) REIMBURSEMENT AGREEMENTS

VA partners with the Indian Health Service (IHS) and Tribal Health Program (THP) to provide eligible Alaska Native and American Indian Veterans with easier access to health care. VA has entered into reimbursement agreements with IHS and THP under which VA reimburses IHS and THP for direct care services provided to eligible Veterans in IHS and THP facilities.

Through these reimbursement agreements, eligible Veterans can expect the following:

- ▶ VA reimburses IHS and THP the costs of direct health services provided in VA's medical benefits package.
- ▶ Choice of provider: Eligible Veterans can choose to receive care from an IHS, THP, or a VA medical facility.
- ▶ Pharmacy: VA reimburses IHS and THP medical facilities for the cost of prescription medication dispensed by IHS and THP.
- ▶ No copayment: VA copayments do not apply to direct care services delivered by an IHS or THP medical facility to eligible American Indian/Alaska Native (AI/AN) Veterans under the reimbursement agreements.

To learn more about VA's health benefits and partnership with IHS and THP health care facilities, visit <https://www.VA.gov/communitycare> or email us at tribal.agreements@va.gov.



Some Veterans are eligible for both TRICARE and VA benefits; this is called “dual eligibility.”

MEDICARE AND MEDICAID

While VA bills other health insurance for care for non-service connected conditions, VA does not bill Medicare or Medicaid for such care.

When a Veteran receives emergency community care for non-service connected illnesses, the community provider must bill the other health insurance, including Medicare or Medicaid, prior to billing VA. In these instances, you will be responsible for any cost shares, including copayments and deductibles, required by the insurance.

You may choose to sign up for Medicare for several reasons:

- ▶ VA health care benefits eligibility may change over time, so having access to both Medicare and VA health benefits could provide you with more robust health care coverage.
- ▶ Having Medicare means you're covered if you need to go to a non-VA hospital or doctor—so you have more options to choose from.
- ▶ If you delay signing up for Medicare Part B (coverage for doctors and outpatient services) and then need to sign up later because you lose your VA health care benefits or need more choice in care options, you'll pay a penalty. This penalty gets bigger each year you delay signing up—and you'll pay it every year for the rest of your life.
- ▶ If you sign up for Medicare Part D (coverage for prescription drugs), you'll be able to use it to get medicine from non-VA doctors and fill your prescriptions at your local pharmacy instead of through the VA mail-order service. But you should know that VA prescription drug coverage is better than Medicare coverage—and there's no penalty for delaying Medicare Part D.



What if I Have a Sensitive Diagnosis?

VA is no longer required to obtain written authorization from you to disclose while billing your private health insurance information about health care you received in connection with a sensitive diagnosis, which includes drug or alcohol abuse, alcoholism, HIV/HIV testing, and sickle cell anemia. VA has provided notice of the change, which VA began implementing on January 28, 2019, to Veterans whose requests not to disclose this information to bill their other health insurance for these particular conditions were granted.

Sensitive diagnosis information may be included in a claim or in copies of a Veteran's medical record.

How Do I Use VA's Access Standards and Standards for Quality?

VA is establishing designated access standards based on the type of care you need, how long you have to wait to receive that care, and your average driving time to receive that care. These designated access standards vary based on the type of care you need (primary care, mental health care, non-institutional extended care services, or specialty care). The designated access standards define generally when VA must be able to schedule an appointment for you (within 20 days of the date of request for primary care, mental health care, or non-institutional extended care services; or within 28 days of the date of request) and how far you need to travel to receive this care (within 30 minutes average driving time for primary care, mental health care, or non-institutional extended care services, or within 60 minutes average driving time for specialty care). VA has a system for calculating your average driving time. You will need to contact VA so that we can determine if we are able to schedule an appointment for you with a VA provider in a manner that complies with these designated access standards. If VA cannot schedule an appointment for you with a VA provider that is within both the wait time and the average driving time standards, you are eligible for community care.

VA also is establishing standards for quality to ensure that the care you receive is timely, effective, safe, and Veteran-centered. For each of these areas, we will track specific quality measures. When we have designated a specific VA medical service line as not furnishing care that complies with these standards for quality, VA will notify you of your option to receive care in the community while VA works to improve that service line. Our performance on those quality measures can be tracked at <https://www.accesstocare.VA.gov> starting fall 2019.

Can Someone Help Me if I Have a Concern or Disagreement About my Health Care?

VA IS COMMITTED TO DELIVERING AN EXCELLENT HEALTH CARE EXPERIENCE EVERY TIME.

Your health care needs and the experience you have at VA are very important to us. Sometimes, communication between you and your health care team can be complex and lead to misunderstandings, or you may have concerns that seem difficult to resolve. Anytime you have a health concern or disagreement with your health care provider or team, you have the right to ask questions. The more information you have, the better you can move forward with getting the treatment you need.

The first step to resolving questions or complaints on clinical matters is to try to work directly with your health care team. Your team knows the most about you and your health care needs. Ask your health care team who you can talk to about your concern. You can also use My HealtheVet at www.myhealth.va.gov/mhv-portal-web/home to communicate directly with your health care team about your complaint.

If you have a complaint that cannot be resolved directly with your health care team, VA medical centers have patient advocates who can work with you to help resolve complaints. Patient advocates will work closely with your health care team and other VA employees to resolve your concerns and answer your questions to the greatest extent possible. The patient advocate can assist you and your health care team to find a resolution by making sure you are heard and your concerns are addressed.

Patient advocates have their contact information posted at every VA medical center. You can also find this information on the local VA medical center's website. Here are other common ways to contact the patient advocate:

- ▶ Call your local VA medical center and ask to talk with a patient advocate.
- ▶ Go to the patient advocate office in person.
- ▶ Communicate through My HealtheVet at www.myhealth.va.gov/mhv-portal-web/home and ask to speak with the patient advocate.

If you do not agree with a health care decision made by your provider that cannot be resolved, you have the right to file a clinical appeal. Typical examples of these issues are whether a particular drug should be prescribed, whether a specific type of physiotherapy should be ordered, and similar treatment decisions with which an attending provider, may be faced. Contact your patient advocate who can help you understand the process.

You can submit a written appeal request to your local patient advocate. Please include your name, the last four digits of your social security number, the decision are you appealing and the date that the decision was made by your provider. Only Veterans or their designated health care surrogate can file a clinical appeal. Unlike benefit appeals, a Veterans Service Organization or attorney does not represent a Veteran in this process, unless they are deemed to be the designated health care surrogate through a living will, advanced directive or other related documents.

For most other healthcare benefits decisions, such as emergency care reimbursement, you have 3 options for seeking review. You may file a supplemental claim, which requires new, relevant evidence; you may request higher level review of the same evidence by another VHA adjudicator; or you may appeal directly to the Board of Veterans' Appeals. More details can be found at <https://www.va.gov/health/appeals>.

VA offers three types of review, but not all types of review are available in every case. Below is a description of each type of review and an explanation when each type is available.

This chart describes availability of review options:

REVIEW OPTIONS	I AM A VETERAN, BENEFICIARY, OR OTHER PERSON WHO PAID FOR A VETERAN OR BENEFICIARY'S TREATMENT	I AM A SERVICE PROVIDER (NOT UNDER CONTRACT)	I AM A SERVICE PROVIDER (UNDER CONTRACT)
Supplemental Claim	Available	Not available	Not available. See contract terms
Higher-Level Review	Available	Not available	Not available. See contract terms
Appeal to the Board	Available	Available	Not available. See contract terms

- ▶ **Supplemental Claim.** If available, you should file a supplemental claim if VHA does not have all the evidence to accurately decide your claim.
- ▶ **Higher-Level Review.** If available, you should file a request for higher-level review if VHA has all the necessary evidence, but you would like VHA to take another look at the claim and see if a new decision can be supported.
- ▶ **Appeal to the Board of Veterans' Appeals.** You should appeal to the Board of Veterans' Appeals if you would like a Veteran's Law Judge to review your claim.

You may be able to get assistance with your claim from a VA recognized and accredited attorney, claims agent, or Veterans Service Organization (VSO). VSOs and their representatives are not permitted to charge fees or accept gifts for their services. Only VA-accredited attorneys and claims agents may charge fees for assisting in a claim for VA benefits, and only after VA has issued an initial decision on the claim and the attorney or claims agent has complied with the power-of-attorney and the fee agreement requirements.

Where Can I Get More Information?

Visit VA.gov for more information and to apply for enrollment in VA's health care system, or access your VA Welcome Kit at www.va.gov/welcome-kit. If you do not have access to the internet, you can call VA or visit your local VA medical facility for more information.

For additional information about MISSION Act, visit www.missionact.VA.gov/

