



A Publication of the Primary and Ambulatory Care Strategic Healthcare Group

Editor's Note: The September 2002 MAP article "Billing for Physician Assistant Services" has been revised. Please disregard the earlier edition and replace it with this publication. This revised MAP will be posted <http://vaww.va.gov/primary> & <http://www.va.gov/primary-Documents> Library.

Message from the Office of Primary and Ambulatory Care

By W. Mark Stanton, M.D., MHS, Chief Consultant,
*Office of Primary and Ambulatory Care Strategic Healthcare Group,
located at VACO, Washington, DC*

Approximately two and a half years ago when I assumed the position of Chief Consultant of the Primary/Ambulatory Care Strategic Healthcare Group I set up separate divisions to focus in on Primary Care and Preventive Medicine. The intent was to establish and maintain a better system of communication between the two groups. Conference calls with the two divisions were set up and conducted every month.

As I became more engaged and responded to requests for my participation at various meetings, task forces and conferences it became apparent to me that the demands on my time were overwhelming and not serving the needs of the two groups. Once we had a Director for the NCHP on board I could ask that individual to carry on with the PM calls, which would free me to focus on the PC issues.

About a year ago I met with the VISN CMO's and asked if they would be comfortable with the re-establishment of the monthly PC calls while maintaining the PM calls. They unanimously agreed that affording them the opportunity to address their daily PC concerns and issues on a monthly basis would be valuable.

This office will therefore be initiating monthly conference calls to deal with PC issues beginning in October 2002. While the target is VISN-level Primary Care leaders, any VISN CMO is invited to call in. It may be possible in 2003 to include some site-level Primary Care leaders. Please feel free to call in, raise your concerns, ask questions, initiate discussions, and invite active participation so that together we can work on solving problems. (continued on page 2)

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The information about the Primary Care calls follows:

Every 1st and 3rd Wed at 1 pm. ET.
Dial in: 1-800-767-1750
Access Code: 28907
October 2
October 16
November 6
November 20
December 4
December 18

Please contact me if you have any items that you feel need to be addressed. Working together we can deliver better services to our veteran patients.



Optometry Service Update

By John C. Townsend, O.D.

*National Director of Optometry Service
located at VAMC, Fort Howard, MD*

The long awaited VHA Handbook 1121 entitled VHA Eye Care was approved and signed by Robert H. Roswell, M.D., Under Secretary For Health on July 5, 2002. This handbook is issued to facilitate the provision of optimal eye care in the veterans health care system. It has been developed to support the efforts of local Department of Veterans Affairs (VA) health care facilities to deliver consistent and predictable high quality eye care, and emphasizes the use of interdisciplinary teams in the provision of eye care based on the belief that, by working as a team, VA can provide better eye care for the patient.

The development of this handbook resulted from the cooperative efforts of James Orcutt, M.D., Ph.D., Ophthalmology Consultant, and many other individuals at VA Central Office who greatly improved the final document. Working as equal partners in providing support for VHA eye care, the Eye Care Performance Consultant Team (composed of the Ophthalmology Consultant and VHA Director of Optometry Service) is available for consultation to assist Department of Veterans Affairs facilities when there are network or facility questions concerning eye care. The goal of the VHA Eye Care Consultant Team is to ensure the continued improvement of VHA eye care as a whole.

Specific VHA Eye Care goals are:

1. Deliver the highest quality eye care to the greatest number of eligible veterans in a timely, compassionate and cost-effective manner.
2. Provide patient education and eye care counseling to patients and their families or significant others, and continuing medical education to staff as well as other health care providers and trainees, where appropriate.

3. Establish academically affiliated teaching programs to educate and train students, residents, and fellows.
4. Participate in educating and training eye care professionals.
5. Support eye and vision research in areas including management, quality improvement, education, rehabilitation, health services, and biomedical sciences.
6. Evaluate and improve new technologies for the delivery of eye care.
7. Contribute to a supportive setting for the integration of patient care, education, and research and development.
8. Provide support for the Department of Defense (DoD) in times of military necessity or national emergency.

VHA Directive 2002-039 entitled "Prescribing Hearing Aids and Eyeglasses" was approved and signed by the Under Secretary For Health on July 5, 2002. This new directive provides uniform criteria for prescribing hearing aids and eyeglasses (sensori-neural aids) to veteran patients. Our workgroup reviewed Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, which changed eligibility laws to allow VHA to furnish prosthetic appliances to veterans as well as published regulations (Title 38 Code of Federal Regulations (CFR) 17.149) in the Federal Register establishing such guidelines. This directive should reduce the wide variation in prescribing practices and lack of standardization so that veterans may have equity of access to these devices across the VHA health care system.

We are developing Eye Care Panel Size recommendations detailing space, support staff and equipment requirements so that we may improve planning activities at local Department of Veterans Affairs health care facilities to better meet our veterans' current and future eye care needs.

For additional information contact: John C. Townsend, O.D., VHA, Director of Optometry Service, located on 202-273-9422.



Update on the Patient Financial Services System (PFSS)

By Jeffrey M. Robbins, DPM, *National Director, Podiatry Service, located at Cleveland, OH, and Karen A. Skanderson*, *Contractor, Office of Information & Resource Management, located at VACO, Washington, DC*

The Patient Financial Services System (PFSS) is the pilot phase of the future revenue cycle business model across VHA. The PFSS project seeks to improve the Revenue Program through the replacement of certain Vista applications with commercial software, consolidation of revenue functions, outsourcing on an as-needed basis, and business process redesign.

Through this initiative, VHA will pursue:

- Reducing Billing and Accounts Receivable (AR) backlogs;
- Increasing revenue; and
- Streamlining work efforts through standardized business processes.

Pilot Project

The PFSS Project entails the pilot of a commercial patient financial services system in a single VISN – VISN 10, the VA Healthcare System of Ohio. The overall project scope will include selecting a commercial software package, configuring the software to meet VHA's needs, and implementing the software in VISN 10. Testing and a post implementation review will follow the implementation to determine the ability of the software to meet VHA's business requirements. Selection of the software is expected to occur by the end of October 2002, with development of a conference room pilot beginning in early calendar year 2003.

Project Organization

The PFSS Project is centrally managed by the PFSS Project Office, which is located in and staffed by the VHA Business Office. The Business Office is orchestrating project management functions under the auspices of the Under Secretary for Health, and in collaboration with VISN 10. The Project organization includes:

- Board of Directors
- Project Director
- Project Management Team
- Functional and Technical Teams
- Subject Matter Experts
- Progress to Date

Project Management

- Received approval for project organization and Board of Directors from VHA Chief Business Officer. Appointed non-VISN 10 volunteers to serve in validation role for functional requirements.
- Coordinating efforts with HEC, HAC, and Office of Information to ensure all interests are represented.
- Preparing Vendor Questionnaire to send to all potential PFSS COTS solution vendors to obtain general corporate and product information.
- Conducting a formal project risk assessment.

Functional Requirements

- Completed Phases I and II of functional requirements definition. Reviewed and refined existing functional requirements; created database to store all functional and technical requirements; conducted in-person team meetings to prioritize all functional requirements.
- Validation teams are currently reviewing the functional requirements and functional teams are developing business rules.

Technical Requirements

- Identified and documented key technical issues and prioritized importance.
- Developed Technical Issue Analysis papers for all "Critical" and "High" importance technical issues in coordination with the VHA Office of Information System Design and Development team.
- Currently documenting Vista systems "As-Is" data flow model and VISN 10 hardware inventory.

Podiatry Service Participates in the 2002 VA Epidemiology Summer Session.

By Jeffrey M. Robbins, DPM

National Director, Podiatry Service, located at Cleveland, OH

The 2002 VA Epidemiology Summer Session For VA Researchers, Clinicians, and Administrators were held at the University of Washington, Seattle, WA June 24-28, 2002. This year 11 members of podiatry service participated in an effort to create a core research group to begin the process of promoting more clinical studies. This outstanding program was sponsored by the Boston, Durham and Seattle VA Epidemiologic Research and Information Centers, Cooperative Studies Program VA

Office of Research and Development Department of Veterans Affairs, VA Employee Education System, VA Puget Sound Health Care System and University of Washington, and VA Podiatry Services VA Central Office.

The goals of the course included:

- To provide state-of-the art information on epidemiological principles and methods to VA professionals working in administrative, clinical and research areas.
- To provide VA relevant examples that illustrates the application of epidemiological concepts.
- To assist participants to improve and apply epidemiological skills, professional effectiveness through small group problem solving.

The course included several tracks including:

- Clinical Epidemiology and Clinical Decision-Making.
- Outcomes and Effectiveness Research.
- Regression Modeling in Epidemiology.
- Evidence Based Medicine and Critical Reading of the Medical Literature.
- Grant writing for Epidemiologists.
- Clinical Trials.

Each participant chose three course tracks prior to the start of the program. Each course ran for approximately 2 hours each day for five days. Homework assignments included both readings and problem solving designed to

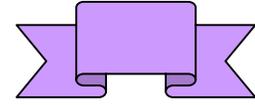
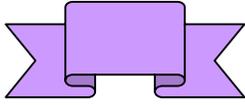
augment the course work. A cyber course is scheduled to be available by the fall of 2002.

For more information please contact Seattle Epidemiology Summer Session, VA Puget Sound Health Care System 1660 South Columbian Way (152E), Seattle, WA 98108, Phone: 206-764-2773.

URL: <http://www.eric.seattle.med.va.gov>



From the left: Gayle Reiber, Ph.D. Scientific Chairman ERIC and Marie Diener-West, Ph.D. Professor of Biostatistics, Bloomberg School of Public Health, Johns Hopkins University.



From the left bottom: Anthony Cresci, DPM, Jeffrey Page, DPM, Colleen Schwartz, DPM, Gregg Young, DPM, Top row: Dan Robinson, DPM, Lester Jones, DPM, Mark Hinkes, DPM, Jeffrey Robbins, DPM, James Wrobel, DPM, Marvin Waldman, DPM, Anna-Marie Edwards, DPM (not pictured).



Podiatry

Primary and Ambulatory Care Continuing Education Corner

By Rivkah Lindenfeld, *Clinical Product Line Manager*
Employee Education System, located at Northport Employee
Education Resource Center, Northport, NY

The following education interventions in Primary & Ambulatory Care are scheduled:

I. *Satellite Programs:*

1. **Title:** Challenges in Primary Care

Date: August 7, 2002 live Broadcast.

Please check program announcement for taped rebroadcast dates & times.

Time: 1:00-3:00 pm ET

Purpose: To discuss opportunities and challenges primary care providers and managers face in providing comprehensive service within an integrated health care delivery system.

2. **Title:** Clinic Process Management and Evaluation Part I

Date: August 28, 2002

Time: 1:00-3:00 pm ET. Please check program announcement for taped rebroadcast time & dates.

Purpose: To stimulate a new way of thinking in practice management for Primary & Ambulatory Care Clinicians.

3. **Title:** Clinic Process Management and Evaluation Part II

Date: October 1, 2002

Time: 1:00-3:00pm ET.

Please check program announcement for taped rebroadcast dates and times.

II. *Mini Residencies:*

1. **Title:** Primary Care ~ Mental Health

Date: September 16-20, 2002

Site: Charleston, SC VA Medical Center

Purpose: To provide an opportunity for Primary Care & Mental Health providers who wish to cross train, and help staff integrate mental health and primary care at their medical center.

Target Audience: MD's, NP's, PA's, and CNS'

NOTE: selection of participants is competitive, 8 participants will be selected.

2. **Title:** Women's Mental Health in Primary Care Setting

Date: September 18-20, 2002

Site: Boston, MA VA Medical Center

Purpose: To improve the knowledge skills and performance of DVA primary care clinicians in the management of health issues and health related behavioral problems experienced by women veterans in the primary care setting.

Target Audience: MD's, NP's, CNS', PA's, DO's currently involved in the delivery of primary care to women veterans.

NOTE: Selection of participants is competitive. Only fifteen (15) applicants will be selected.

III. Primary Care Consultation Program

Purpose: To provide medical centers assistance and facilitation to enhance the primary care program and implement VA care principles to reduce variation, and provide comprehensive service within an integrated health care delivery system.

Consultants: A select multidisciplinary trained group of field-based practitioners, who provide on-site consultation specifically tailored to the needs of the facility.

Consultations provided only by request.

For additional and more specific information about any of the above programs, please contact:

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Communities On-Line Learning About Guidelines (COLLAGE): An Interactive Website for VA Employees

By Dr. Daniel Muraida, *located at South Texas Veterans Health Care System*

Evidence-based clinical practice guidelines have become a linchpin in the VHA's efforts to optimize the quality of patient care. But the best evidence-based guidance is of little use if it is not well disseminated, understood, and implemented. A recent survey of randomly selected VA clinicians (response rate 37% (1436/3784)) showed that, of four VA guidelines (depression, diabetes, COPD, and ischemic heart disease) available for at least 18 months prior to the survey, only 60-70% of respondents were aware of these 4 guidelines while even fewer had read them (32-50%). The COLLAGE project is designed to facilitate or enhance the development of communities of practice in various aspects of guideline implementation. Coupled with COLLAGE's virtual workgroup capability, users can discuss issues and create new knowledge and processes that improve quality of care. On-line tools such as member directories, event calendars, list-serve archives, and discussion boards enhance this capability. The web site is divided into two major components: A general front page that addresses the informational needs of all VA employees; and customized web pages dedicated to communities of VA employees who share common

expertise, goals, issues and tasks in the implementation of guidelines. Through collaboration with the National VA Clinical Practice Guideline Council and the Office of Quality and Performance and funded by the Health Services Research & Development Service, COLLAGE maintains the most up-to-date resources for guideline implementation available within the VA. COLLAGE is easily accessible through the intranet at: vawww.collage.research.med.va.gov. If you are interested in developing a web site within COLLAGE for your own VA group please contact Dr. Daniel Muraida (Daniel.Muraida@med.va.gov). Telephone: 210-617-5300, extension 6736.

VA Medical Care Co-payments in Brief

By Nancy Howard, *Program Analyst, Office of Policy and Procedures, located at VACO, Wash, DC*

Public Laws 99-272 and 101-508 gave VA authority to assess co-payments to veterans for certain medical care and services received through the VA health care system. Veterans, whose income and assets are above nationally published income thresholds, are assessed co-payments. PL 106-117 gave VA authority to make changes to the outpatient, medication, and long term care co-payments.

Inpatient, outpatient and long-term care co-payments are assessed to nonservice-connected veterans. Medication co-payments are not assessed to veteran's rated 50% or greater service-connected, veterans who meet the low-income exemption or for medications dispensed for a service-connected condition.

The following paragraphs briefly describe all the co-payments.

A. Inpatient Hospital Care

Veterans who must pay the co-payment are those meeting the following conditions:

- Nonservice-connected disability (except WWI veterans, former POWs and veterans with a Purple Heart) **and**
- Income above \$24,304 (if single), \$29,168 (if married) plus \$1,630 for each additional dependent **or**
- Net Worth (assets) that when combined with income, exceeds \$80,000.

Amount of co-payment

- \$10 for each day of care, **plus**
- \$812 (the Medicare deductible) for the first 90 days of care and \$406 for subsequent 90-day periods of care. This amount changes on an annual basis.

B. Outpatient Care

Veterans who must pay this co-payment are those meeting the following conditions:

- Nonservice-connected disability (except WWI veterans, former POWs and veterans with a Purple Heart) **and**
- Income above \$24,304 (if single), \$29,168 (if married) plus \$1,630 for each additional dependent **or**
- Net Worth (assets) that when combined with income, exceeds \$80,000.

Amount of co-payment

- \$15 for each basic care outpatient visit
- \$50 for each specialty care outpatient visit
- \$0 for preventive screenings, immunizations, lab tests, flat film radiology and EKGs.

C. Medications

Veterans who must pay this co-payment

Veterans in priority groups 2 through 7 must pay this co-payment whenever they obtain medication from VA on an outpatient basis for treatment of a nonservice-connected disability. The exceptions (veterans not required to pay the co-payment) are:

- Veterans with a service-connected disability rated 50% or more (Priority 1); and
- Veterans with income below \$9,556 (if single), \$12,516 (if married) plus \$1,630 for each additional dependent (veterans on a VA pension).

Amount of co-payment

- \$7 for each 30-day supply of medication, including over-the-counter medications

- The total amount of co-payments payable in a calendar year is capped at \$840 for priority groups 2 through 6. There is currently no cap for priority group 7.

D. Extended Care Services

Veterans who must pay this co-payment are those meeting all of the following three conditions:

- Nonservice-connected disability, **and**
- Income above \$9,556, **and**
- Have (together with their spouse) available resources to pay the co-payment, taking into consideration assets, income, and subtracting expenses like a mortgage, car payment, insurance, taxes, medical bills, and a \$20 a day allowance for the veteran and a \$20 a day allowance for the spouse.

Amount of co-payment

After the first 21 days of care in any 12-month period beginning on the first day of care:

- Up to the maximum of \$97 for each day of nursing home care
- Up to the maximum of \$15 for each day of adult day health care
- Up to the maximum of \$5 for each day of domiciliary care
- Up to the maximum of \$97 for each day of institutional respite care
- Up to the maximum of \$15 for each day of non-institutional respite care
- Up to the maximum of \$97 for each day of institutional geriatric evaluation
- Up to the maximum of \$15 for each day of non-institutional geriatric evaluation

* Actual co-payment will vary from veteran to veteran and is based on the financial information that the veteran provides VA.

Please Note: The income and co-payment amounts listed may change on an annual basis. These amounts are current for calendar year 2002.

For additional information regarding co-payments, contact your local Revenue Coordinator.



Health Insurance Billing Information

By Nancy Howard, *Program Analyst, Office of Policy and Procedures, located at VACO, Washington, DC*

Public Law (PL) 99-272, enacted April 1986, gave VA authority to seek reimbursement from third party health insurers for the cost of medical care furnished to insured nonservice-connected veterans. PL 101-508, enacted November 1990, expanded VA's recovery program by providing authority to seek reimbursement from third party payers for the cost of medical care provided to insured service-connected veterans treated for nonservice-connected conditions.

VA is prohibited by law from billing Medicare and Medicaid for services provided to veterans. VA does, however, submit claims to Medicare supplemental carriers. VA does not submit a claim for any condition that has been rated by VA as a service-connected condition.

For billing purposes, a determination of the service-connected (SC) and nonservice-connected (NSC) treatment needs to be made by the health care provider rendering the treatment. Billing staff or administrative personnel cannot make this determination. The Revenue Office has issued guidance that if a condition has not been formally rated as service-connected by the Veterans Benefits Administration (VBA), it should be considered as a nonservice-connected condition and is billable to the insurance carrier for reimbursement.

The encounter form should contain a question asking if the condition being treated was service-connected. To assist the health care provider in making this determination, the veteran's SC conditions are printed on the encounter form. They may also be found in CPRS. If the condition being treated is not listed as a service-connected condition, health care providers should document this as NSC treatment and the encounter can be submitted for reimbursement.

VA submits claims to all health insurance carriers for the cost of care provided to all veterans for treatment of their nonservice-connected conditions. VA uses the same billing forms and abides by the same claims submission procedures and requirements as private sector health care providers. On a nationwide basis, VA has 160 facilities that are involved in the claims submission process to over 4,000 insurance carriers. In many instances, the insurance carrier has its own unique requirements that vary from state to state regarding claims submission. VA staff must be familiar with these individual requirements to assure complete and accurate claims are submitted to these carriers. During FY01, VA submitted over 24.1 million claims to insurance carriers.

Since the inception of this program, VA collections have increased from \$24.0 million in FY 1987 to \$836 million

through June 2002 for first and third party reimbursements. Collections for FY 2002 are anticipated to exceed \$1.2 billion. Record collections for one month of \$123 million were recorded in May 2002. Since the programs inception in FY1987, the Revenue program has collected over \$7.1 billion. Prior to FY 1997 funds that were collected were deposited in Treasury accounts. Since FY 1997, medical centers have been able to retain the money they collected and have collected \$3.8 billion that has been retained locally and used to enhance patient care.

The VHA Revenue Office recently released new software to all sites to implement Electronic Data Interchange (EDI). This software will allow VA to automatically transmit claims to third party health insurance carriers for the treatment provided. This will be done through WebMD, the clearinghouse VA is using to transmit claims.

VA is also working with Centers for Medicare and Medicaid Services (CMS) to develop the Medicare Remittance Advice (MRA) software. This software will allow VA to submit a claim electronically to a Medicare supplement plan. This adjudication process will be streamlined with this project. VA claims will be routed through a CMS appointed fiscal intermediary and will be processed as if they had been sent to Medicare for payment. The claims will then be routed to the Medicare supplement carrier with an explanation of benefits (EOB). The EOB details what the Medicare coverage would have been if the claim had been actually processed through Medicare. This EOB will provide Medicare supplemental carriers with the data they can use to determine the exact financial reimbursement due VA for the claim.

Billing for Physician Assistant Services

By Joseph Streff, *PA Advisor to the Under Secretary for Health, located at Milwaukee, WI* and **Nancy Howard**, *Program Analyst, Office of Policy and Procedures, located at VACO, Washington, DC*

In response to multiple inquiries regarding billing for services provided by Physician Assistants (PA's), we are providing the following information. The guidance provided addresses billing insurance carriers and co-payment issues and should not be construed as guidance on employment issues related to Physician Assistants.

Health Insurance Claims Submission

In April 1999, VA published final regulations in the Federal Register listing the health care providers for whom VA would submit claims for professional fees under reasonable charges. Physician Assistants are among the health care providers for whom VA would submit a claim.

Medical centers were advised that services provided by a PA are billable to the insurance carrier if the PA is providing the care within the scope of their practice and the payer covers the services provided by the PA. The services provided by the PA are billed either under the PA's name or, under the name of the PA's supervising physician depending on the particular rules of the payer. However, there may be some insurance carriers who do not cover the services provided by a PA. In those instances, if the insurance carrier does not recognize the services of the PA, VA cannot require the insurance carrier to recognize the PA services and provide reimbursement for professional fees to VA.

It is **imperative** that medical centers check several processes prior to submitting a claim for PA services or initiating a refund:

a. The medical center needs to contact the insurance carrier to determine if the insurance carrier considers PA provided care as a covered service. If so, the medical center should then determine that the PA is providing care within the scope of his/her practice, and that the documentation supports the care provided, how the services of the PA are billed, and whether the PA or supervising physician is identified on the claim. If these processes are in place and the billing was appropriate, there is nothing to refund.

b. If it is determined that the insurance carrier does not cover the services of a PA, then the medical center should obtain this information in writing. Any money received from the insurance carrier for PA provided services should be reviewed and refunds initiated as appropriate.

Certain payers do not separately credential or issue provider numbers to PA's and require that the services of a PA be billed under the name of the PA's supervising physician.

Under Medicare guidelines, the VA does not allow "incident to" billing. Other payers may state that services of a PA could be billed "incident to", however, the meaning these insurance carriers place on "incident to" may differ from Medicare's definition. VA sites should ask these insurance carriers as to their particular billing rules and requirements. Specific questions to ask to help determine whether to bill PA services under the physician's name include:

1. Is the supervising physician required to treat the patient on the first visit?
2. Must the supervising physician be on site when the PA delivers care?
3. Does the supervising physician need to treat an established patient who presents with a new medical condition?

If the payer indicates yes to any of these questions, then those requirements would have to be followed in order for the services of the PA to be covered. If the payer answers no to all of these questions, VA can bill for the services of the PA by using the supervising physician's name and identifying information on the claim. When sites ask payers these questions, they should document a point of contact name and phone number. The Revenue Office will be providing additional information to Revenue coordinators and billing staff on identification of the supervising physician's name to be placed on bills.

When the services of a PA are non-billable, it may be appropriate to submit a claim for the facility portion of the care. However, not all CPT codes have facility charges developed for use at this time. It is not appropriate to use the professional charges for facility charges in this situation.

Co-payment Information

Upon enrollment, veterans in certain income categories sign the VAF 10-10EZ agreeing to make co-payments to the VA for all care that they receive. Veterans in certain priority groups are assessed co-payments for each episode of care and treatment, on an inpatient and outpatient basis regardless of the health care provider. Co-payments are also charged without regard to the veteran having or not having health insurance.

If you have additional questions, please contact your local Revenue Coordinator. You can also direct your inquiry the Revenue Office, VA Central Office to Gwyn Smith at 202-273-8219 or Nancy Howard at 202-273-8198. Or you may contact Joseph O. Streff, PA Advisor to the VHA, 414-384-2000 ext. 42014.

Revised August 28, 2002



Which Veterans Pay For Which Services at VA Healthcare Facilities

(NOTE: This chart does not include Long Term Care Co-payment Information.
They are addressed on a separate chart.)

	Inpatient Co-payment	Outpatient Co-payment	Medication Co-payment*	Insurance Billing	Insurance Balanced Billing	Insurance Deductible/ Co-payment
Priority Group 1	No	No	No	Yes – if care was for NSC condition	No	No
Priority Groups 2, 3**, 4**	No	No	Yes – If less than 50% SC & medication is for NSC condition	Yes – if care was for NSC condition	No	No
Priority Group 5	No	No	Yes	Yes – if care was for NSC condition	No	No
Priority Group 6 (WWI, Mexican Border & 0% SC Compensable)	No	No	Yes	Yes – if care was for NSC condition	No	No
Priority Group 6 (Veterans receiving care for exposure or experience***)	No***	No***	No***	Yes – if care was for NSC condition	No	No
Priority Group 7	Yes	Yes	Yes	Yes – if care was for NSC condition	No	No

*An annual medication co-payment cap has been established for veterans enrolled in priority groups 2-6. Medications will continue to be dispensed when the co-payment cap is met. An annual medication co-payment cap was not established for veterans enrolled in priority group 7.

**Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of PL 106-117 on November 30, 1999

**Priority Group 7 veterans who are determined to be Catastrophically Disabled and who are placed in Priority Group 4 for treatment are still subject to the co-payment requirements as a Priority Group 7 veteran.

**Priority Group 6 – Health insurance and all applicable co-payments will be billed when the care is for conditions not related to the veterans exposure or experience.

Special Categories of Veterans – (i.e., Agent Orange, Ionizing Radiation, Persian Gulf, women veterans receiving military sexual trauma counseling) are subject to means test co-payments when the treatment is not related to their exposure or experience. The initial registry examination and follow-up visits to receive results of the examination are not billed to the health insurance carrier. However, care provided not related to exposure, if it is nonservice-connected will be billed to the insurance carrier.

Medication Co-payment Exemption – All veterans receiving prescriptions for NSC conditions who meet the low-income criteria are exempt from the medication co-payment.

Long Term Care Co-payments – Changes to Long Term Care Co-payments are effective June 17, 2002 and are displayed on a separate chart.

UPDATED JUNE 18, 2002



ENROLLMENT PRIORITIES

Priority Group 1:

- Veterans with service-connected conditions rated 50 percent or more disabling.

Priority Group 2:

- Veterans with service-connected conditions rated 30 to 40 percent or more disabling.

Priority Group 3:

- Veterans who are former POWs.
- Veterans who are awarded the Purple Heart.
- Veterans with service-connected conditions rated 10 or 20 percent disabling.
- Veterans discharged from active duty for a disability incurred or aggravated in the line of duty.
- Veterans awarded special eligibility classification under 38 U.S.C., Section 1151.

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits.
- Veterans who have been determined by VA to be catastrophically disabled.

Priority Group 5

- Nonservice-connected veterans, whose income and net worth are below the established dollar threshold.
- Zero percent service-connected veterans, whose income and net worth are below the established dollar threshold.

Priority Group 6

Includes all other eligible veterans who are not required to make a co-payment for their medical care, including:

- World War I and Mexican Border War veterans.
- Veterans solely seeking care for disorders associated with exposure to a toxic substance, radiation, or for disorders associated with service in the Gulf War, or;
- For any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.
- Compensable zero percent service-connected veterans.

Priority Group 7

- Nonservice-connected veterans and zero percent non-compensable service-connected veterans with income and net worth above the established threshold and who agree to pay specified co-payments.



Which Veterans Pay For Long Term Care Services and Co-payments Provided by VA Healthcare Facilities

Changes to Long Term Care Co-payments are effective June 17, 2002. A veteran receiving long term care services may also be responsible for additional co-payments for services received as an inpatient, outpatient or for medications.

(NOTE: This chart does not include Inpatient, Outpatient and Medication Co-payment Information. They are addressed on a separate chart.)

	Nursing Home Co-pay	Domiciliary Co-pay	Adult Day Health Care Co-pay	Geriatric Evaluation Co-pay	Respite Care Co-pay	Long Term Care Health Insurance Billing	Insurance Balanced Billing	Insurance Deductible Co-payment
Priority Groups 1, 2	No	No	No	No	No	Yes – if care was for NSC condition	No	No
Priority Groups 3, 4*	Maybe	Maybe	Maybe	Maybe	Maybe	Yes – if care was for NSC condition	No	No
Priority Group 5**	Yes	Yes	Yes	Yes	Yes	Yes – if care was for NSC condition	No	No
Priority Group 6***	Maybe	Maybe	Maybe	Maybe	Maybe	Yes – if care was for NSC condition not related to exposure or experience	No	No
Priority Group 7****	Yes	Yes	Yes	Yes	Yes	Yes – if care was for NSC condition	No	No

Exemptions from long term care co-payments include: veterans who have been continuously receiving extended care services on or before November 30, 1999; veterans with a compensable service-connected disability; and veterans whose annual income is less than the single veteran pension rate.

***Veterans with service-connected disabilities enrolled in Priority group 3 are exempt from long-term care co-payments. However, other priority group 3 and 4 veterans will be required to submit financial information to determine the co-payment responsibilities.**

**** Veterans whose income is above the single base pension level and below the means test income threshold will be required to provide a detailed financial assessment of income, assets and expenses to determine the co-payment responsibilities.**

*****Priority 6 veterans who are 0% compensable service-connected are exempt from long-term care co-payments. Other priority 6 veterans will be assessed co-payments when the services provided are not related to their exposure or experience. Certain veterans enrolled in priority group 6 (Mexican Border War and WW I veterans) are required to submit financial information to determine the co-payment responsibilities.**

****** A detailed financial assessment of income, assets and expenses will be conducted to determine the co-payment responsibilities of nonservice-connected veterans and 0% noncompensable service-connected veterans.**

Updated June 18, 2002



Continuing Education Modules Cover the Unique Health Issues of Veterans

By Connie Raab, Director, Public Health Communications, Office of Public Health and Environmental Hazard, located at VACO, Washington, DC

Ten independent study modules, available through VA's Veteran's Health Initiative (VHI), provide in-depth information about important and unique health issues of veterans. Health care providers can go online to read the modules and earn continuing education credit. Limited copies are also available in facility libraries. Topics include:

- Agent Orange
- Cold Injury
- Gulf War
- Hearing Impairment
- Post Traumatic Stress Disorder
- Prisoners of War
- Radiation
- Spinal Cord Injury
- Traumatic Amputation and Prosthetics
- Visual Impairment

The VHI modules are available on the VA Intranet at <http://vaww.va.gov/vhi/> and the VA Learning Catalog at <http://vaww.ees.lrn.va.gov/> and on the Internet at www.va.gov/vhi. The Veterans Health Initiative is a collaboration between the Office of Public Health and Environmental Hazards and the Employee Education System. The ultimate goal of the VHI is to improve care for veterans.

Summary of Article: “Wait Reduction: Improving Operational and Financial Performance in Outpatient Services”

Summary Prepared by: *Mildred Eichinger, RN., MPH, Clinical Program Manager, Primary and Ambulatory Care Strategic Healthcare Group, located at VACO, Washington, DC*

A recent (July/August 2002) article in Healthcare Executive written by Julie T. Chyna, a senior editor, discusses “Wait Reduction: Improving Operational and Financial Performance in Outpatient Services.” Although the article does not mention VA healthcare services, the problems, opportunities for improvements and reducing costs in the outpatient setting are issues that should be considered to improve delivery of services in the VHA health care system.

Technology has allowed quick and easy access to health care information. The VA and community hospitals offer seminars, group clinics and in general have provided opportunities to gain knowledge about health care issues to anyone who is interested. To those individuals who participate the payoff is a broad understanding about their own health. Knowing more raises the expectations of the quality of care patients will receive. An informed patient puts pressure on the providers to deliver better and total care while at the same time provide quicker service along the continuum of care. The patient, if not satisfied, can shop around for those higher standards.

Waiting times for patients, both in the community and in VHA are a source of frustration for both patients and all those who serve in any capacity to deliver healthcare services. Several initiatives have been implemented in VHA to help shorten the waiting times and improve operational efficiency.

In August 2001, the Primary and Ambulatory Care Strategic Healthcare Group published the Practice Management in Veterans Health Administration Guide. The intent of the publication was to present: (1) information on references, resources and useful tools; and (2) a guide to evaluate day-to-day operations and to train staff. The publication (available on <http://vaww.va.gov/primary/> & <http://www.va.gov/primary> - Document Library) provides strategies and tools to understand, evaluate and improve the operational processes in the outpatient setting.

Chapters in the Guide address specific clinic management issues such as: Scheduling, panel management, continuity of care, telephone services 24/7, performance improvement and monitoring, compliance, shared healthcare decision-making, budget and finance, data gathering and comparison before and after changes to measure improvements.

The “Wait Reduction” article includes a flowchart: “Mapping Opportunities for Improvement” provided by Martin Karpel, FACHE, Chief Executive Officer, Karpel Consulting Group, Inc. the article describes:

Phase I: Initial Assessment; Phase II: Benchmarking and Process Improvement; and III: Application. This may prove useful as you perform your own process evaluation.

The article is worth reading. It offers some practical insights into improving every day operational processes. If you are a member of American College of Healthcare Executives you may be able to access the complete text of the article at www.ache.org. If you have difficulty finding the article contact your local VA librarian for assistance.



Schedule for MAP articles

FLOW	3 rd Q/2002			4 th Q/2002			1 st Q/2003			2 nd Q/2003		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Articles Submitted	19			19			18			17		
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Comments to OPAC		31			30			29				
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Hard Copies Delivered			17			16			16			24

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**It is clearly my intent to continue with the significant contributions made through the newsletter. Please feel free to contact me electronically if you have any ideas or recommendations for future newsletters.*

Articles may be submitted electronically at any time to Mildred Eichinger and/or Renee Hodges.

Website <http://vaww.va.gov/primary>



We welcome your articles related to any current issues in the area of healthcare in general or specifically in the field of ambulatory and primary care. Contact Mildred Eichinger at 202-273-8552 or Renee Hodges at 202-273-8558 if you have any questions.