

**DEPARTMENT OF VETERANS AFFAIRS - DEPARTMENT OF DEFENSE
HEALTH CARE RESOURCES SHARING AGREEMENTS**

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive states policy for the use of tools that Department of Veterans Affairs (VA) medical facilities and Veterans Integrated Service Networks (VISN) may utilize to develop health care resources sharing agreements with military medical treatment facilities (MTF) and other Department of Defense (DoD) organizational components, including National Guard and Reserve units.

2. SUMMARY OF MAJOR CHANGES: This directive combines requirements from VHA Directive 1660, Health Care Resources Sharing with the Department of Defense, dated July 29, 2015, and VHA Handbook 1660.04(1), VA-DoD Health Care Resource Sharing Agreements, dated July 29, 2015. Updates to this directive include:

a. Additional responsibilities for the Under Secretary for Health; Assistant Under Secretary for Health for Operations; VA-DoD Medical Sharing Office Representative; VISN Director; and VA medical facility Director (see paragraph 5).

b. Added roles of Health Executive Committee Co-Chair, VISN VA-DoD Sharing Coordinator, VA medical facility VA-DoD Sharing Coordinator (see paragraph 5).

c. New Information in “Readiness and Contingency” (see paragraph 6).

d. Additional information on Sharing Agreements (see Appendices B-L).

3. RELATED ISSUES: VHA Directive 1660.06, VA-TRICARE Network Agreements, dated June 28, 2019.

4. RESPONSIBLE OFFICE: The VA-DoD Medical Sharing Office (10BOHA) is responsible for the content of this directive. Questions should be directed to VA-DoDMedicalSharing@va.gov or 202-461-4060.

5. RESCISSIONS: VHA Directive 1660, Health Care Resources Sharing with the Department of Defense, dated July 29, 2015; and VHA Handbook 1660.04(1), VA-DoD Health Care Resource Sharing Agreements, dated July 29, 2015, are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last day of November 30, 2027.

November 30, 2022

VHA DIRECTIVE 1660

**BY DIRECTION OF THE OFFICE OF THE
UNDER SECRETARY FOR HEALTH**

/s/ Maureen Marks, PhD
Acting Chief of Staff

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publications Distribution List on November 30, 2022.

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DEPARTMENT OF VETERANS AFFAIRS - DEPARTMENT OF DEFENSE HEALTH CARE RESOURCES SHARING AGREEMENTS

1. PURPOSE

This Veterans Health Administration (VHA) directive states standards on the Department of Veterans Affairs (VA) and Department of Defense (DoD) health care resource sharing agreement development and approval; outpatient and inpatient referral and consult management and care coordination, discharge management and emergency care; and Veteran installation base access requirements. **AUTHORITY:** Title 38 United States Code (U.S.C.) § 8111 and 10 U.S.C. § 1104.

2. BACKGROUND

a. 38 U.S.C. § 8111, Sharing of VA and DoD Health Care Resources, provides that VA and DoD must carry out certain enumerated activities that are intended to facilitate the mutually beneficial coordination, use or exchange of use of health care resources of the two departments.

b. This directive outlines the requirements applicable to VA when sharing health care resources supporting the National VA/DoD Health Care Guidelines Memorandum of Understanding (MOU) signed by the Under Secretary for Health.

3. POLICY

It is VHA policy to improve access to high quality, continuous and cost-effective health care through use of agreements that allow sharing of health care resources, that VA medical facilities and Veterans Integrated Service Networks (VISN) seek opportunities to enter into sharing agreements with DoD, and that these sharing agreements provide for the mutually beneficial use or exchange of use of health care resources while enhancing quality services routinely provided to Veterans. **NOTE:** *All standards for privacy, data management and informed consent must be assured throughout all sharing of resources and services.*

4. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for:

(1) Ensuring overall VHA compliance with this directive.

(2) Co-chairing the Health Executive Committee (HEC). The HEC is co-chaired by the Assistant Secretary of Defense for Health Affairs.

(3) Overseeing VHA health care organizations' cooperative efforts with DoD health care organizations, as well as all committees or work groups designated by the HEC co-chairs.

(4) Overseeing the development and implementation of the health care initiatives

consistent with the VA/DoD Joint Strategic Plan (JSP).

(5) Overseeing the VA/DoD Health Care Resource Sharing Program activities of VHA and all committees or work groups designated by the HEC co-chairs.

(6) Assigning all related VA/DoD health care resource sharing requirements to the Executive Director, Office of VA-DoD Health Affairs and Director, VA/DoD Medical Sharing Office (MSO), VHA as required.

b. **Chief of Staff.** The Chief of Staff is responsible for supporting the VA-DoD MSO with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **Executive Director, Office of VA-Department of Defense Health Affairs.** The Executive Director, Office of VA-DoD Health Affairs, is responsible for supporting the VA-DoD MSO with implementation and oversight of this directive by:

(1) Providing oversight of the VA-DoD MSO and policy development, as appropriate.

(2) Providing guidance and assistance with business plan development and implementation strategies.

(3) Developing strategic vision for coordination between DoD and VHA Central Office Program Offices, VISNs and VA medical facilities.

e. **Director, VA-Department of Defense Medical Sharing Office.** The Director, VA-DoD MSO is responsible for:

(1) Ensuring compliance with this directive through appropriate monitoring activities.

(2) Ensuring that all standards for privacy and data management are maintained pertaining to VA Form 10-1245c.

(3) Collaborating with VISNs and VA medical facilities, VHA Central Office Program Offices and DoD partners.

(4) Providing guidance and assistance in facilitating, identifying, developing and sustaining sharing opportunities at the VISN and VA medical facility levels.

(5) Reviewing and providing final approval of sharing agreements from the VISNs and VA medical facilities using VA Form 10-1245c found at: <https://go.max.gov/rsa> and assigning final federal resource sharing agreement number. **NOTE:** *The Director, VA-DoD MSO must provide a review response of any proposed sharing agreement within 45 calendar days of receipt. If action is not forthcoming at the end of the 45-day period, the sharing agreement may be executed by local leadership on the 46th day.*

(6) Determining the need for legal review of all sharing agreements by the VA Office of General Counsel on a case-by-case basis.

(7) Serving as VA's authoritative resource between VISNs, VA medical facilities and DoD regarding sharing agreements.

(8) Verifying and validating the self-identified collaboration level with the resource sharing sites.

f. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Ensuring that all standards for privacy, data management and informed consent are maintained throughout all sharing of resources.

(3) Designating a VISN VA-DoD Resource Sharing Coordinator to oversee initiatives and communicate with VA medical facilities Resource Sharing point of contacts, as required. **NOTE:** *The duties of the VISN VA-DoD Resource Sharing Coordinator are additional duties assigned to existing staff.*

(4) Reviewing proposed sharing agreements from the VISN and VA medical facility Directors and the VISN VA-DoD Sharing Agreement Coordinators. **NOTE:** *All sharing agreements must use VA Form 10-1245c found at: <https://go.max.gov/rsa>.*

(5) Submitting proposed sharing agreements to the Assistant Under Secretary for Health for Operations for awareness and the Director, VA-DoD MSO for approval.

(6) Ensuring that, prior to utilization of a sharing agreement, the agreement is approved and signed by all necessary authorities.

(7) Reviewing all new major clinical equipment purchases or new clinical services to be provided in order to determine if the clinical equipment or services could be shared with DoD. **NOTE:** *If sharing is determined to be appropriate, the VISN and VA medical facility Directors may consider utilizing the Joint Incentive Fund as a potential funding mechanism for joint VA-DoD projects.*

(8) Reviewing sharing agreements between the VISN, VA medical facility Directors and DoD annually to determine the outcomes of such arrangements. Outcomes should apply VHA Performance metrics and measure:

(a) Increased access and capacity (workload, appointments and procedures) for Veterans.

(b) Decreased waiting time for appointments for Veterans.

(c) Decreased expenditures for non-VA medical care.

(d) Reduction in duplicative functions.

(9) Participating as a TRICARE Network Provider Agreements with DoD Managed Care Support Contractor (MCSC) to provide care to DoD beneficiaries as VA resources allow. **NOTE:** *Some actions may occur at either or both the VISN and VA medical facility level. In some situations, sharing activities will take place primarily at the VA medical facility level with the VISN providing oversight and additional guidance.*

(10) Approving additional health care resources that exceed the need of the VA medical facility's primary beneficiaries before submission of the sharing agreement to the VA-DoD MSO, as outlined in Appendix D.

g. Veterans Integrated Service Network, VA-Department of Defense Resource Sharing Coordinator. The VISN, VA-DoD Resource Sharing Coordinator is responsible for:

(1) Assisting the VISN Director, in ensuring that all standards for privacy, data management and informed consent are maintained throughout all sharing of resources and services.

(2) Communicating to Veterans information about health care resource sharing, including the reasons for the resource sharing (e.g., improving the access to, and quality and cost effectiveness of, VA health care).

(3) Identifying opportunities for VISN sharing agreements using VA Form 10-1245c found at: <https://go.max.gov/rsa>.

(4) Developing and approving sharing agreements.

(5) Negotiating opportunities for sharing health care resources with DoD in the market area by leveraging any of the following:

(a) A review of access to care metrics and non-VA care expenditures for recapture.

(b) The ability to co-locate services with DoD to promote economies of scale and avoid duplicative costs.

(c) Leveraging existing underutilized capital (e.g., land, building, major equipment or utilities) and non-capital (e.g., staff, administrative services or clinical services) capacity to deliver health care services.

(d) Potential expansion or enhancement of services through joint projects with DoD.

(e) New facility construction requirements, especially those for community-based outpatient clinics.

(f) Veteran and DoD beneficiary population needs.

(6) Coordinating with DoD on incorporating the analysis and evaluation of strategic health care planning issues for the local market(s), or across the health system.

(7) Coordinating VA's participation in the joint evaluation of VISN and VA medical facility level sharing agreements annually to determine the outcomes of such arrangements. Outcomes should apply VHA Performance metrics and measure:

(a) Increased access and capacity (workload, appointments and procedures) for Veterans.

(b) Decreased waiting time for appointments for Veterans.

(c) Decreased expenditures for non-VA care.

(d) Reduced duplicative functions.

(8) Developing and submitting proposed sharing agreements (VA Form 10-1245c) to the VISN Director for review and concurrence.

h. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring overall VA medical facility compliance with this directive and appropriate corrective action is taken if non-compliance is identified.

(2) Ensuring that all standards for privacy, data management and informed consent are maintained throughout all sharing of resources and services.

(3) Designating a VA medical facility VA-DoD Resource Sharing Coordinator to oversee initiatives and to communicate, as required, with other health care resource sharing points of contacts. **NOTE:** *The duties of the VA medical facility VA-DoD Resource Sharing Coordinator are additional duties assigned to existing staff.*

(4) Negotiating the scope and responsibilities of a potential sharing agreement with the appropriate DoD facility Commander.

(5) Reviewing and submitting proposed sharing agreements to the VISN Director for review. **NOTE:** All sharing agreements must use VA Form 10-1245c found at: <https://go.max.gov/rsa>.

(6) Reviewing all new major clinical equipment purchases or new clinical services to be provided to determine if the clinical equipment or services could be shared with DoD. **NOTE:** If so, VISN and VA medical facility Directors may consider utilizing the Joint Incentive Fund as a potential funding mechanism for joint VA-DoD projects.

(7) Overseeing the review of VA medical facility sharing agreement with DoD annually to determine the outcomes of such arrangements. Outcomes should apply VHA Performance metrics and measure:

(a) Increased access and capacity (workload, appointments and procedures) for Veterans.

(b) Decreased waiting time for appointments for Veterans.

(c) Decreased expenditures for non-VA care.

(d) Reduced duplicative functions.

(8) Ensuring that sharing agreements that involve DoD personnel furnishing care in VA facilities contain appropriate terms addressing the following matters:

(a) Responsibility for patient care and maintaining the administrative and professional supervision of all military personnel insofar as their presence affects the operation of the VA medical facility. **NOTE:** VA Medical Facility Directors may delegate supervision to an administrative or clinical preceptor as appropriate.

(b) Reviewing and, if appropriate, endorsing any readiness and training schedules provided by the military unit commander. This review includes:

1. Verifying the licensure and certification of each active duty, National Guard and Reserve medical personnel for professional and technical qualifications.

2. Formal privileging of DoD personnel by the usual VA medical facility mechanisms. **NOTE:** See VHA Handbook 1100.19, *Credentialing and Privileging*, dated October 15, 2012, or successor document for more information.

(c) Ensuring that personnel have been informed of applicable VA health systems administrative and clinical rules and regulations with which they are expected to comply.

(d) Requiring the military unit commander to withdraw any DoD person for unsatisfactory performance or behavior, if so requested by the VA Medical Center Director or designee.

(e) Ensuring the military unit commander provides the names and qualifications of DoD personnel assigned to work with VA staff. **NOTE:** *Some actions may occur at either or both the VISN and VA medical facility level. In some situations, sharing activities will take place primarily at the VA medical facility level with the VISN providing additional guidance and oversight.*

(9) Ensuring both reimbursements earned and costs incurred are recorded in the gross amounts.

j. **VA Medical Facility, VA-DoD Resource Sharing Coordinator.** The VA medical facility VA-DoD Resource Sharing Coordinator is responsible for:

(1) Assisting the VA medical facility Director in ensuring that all standards for privacy, data management and informed consent are maintained throughout all sharing of resources and services.

(2) Communicating to Veterans information about the resource sharing, including the reason for resource sharing (e.g., improving the access to, and quality and cost effectiveness of, VA health care).

(3) Identifying opportunities for local sharing agreements using VA Form 10-1245c.

(4) Negotiating opportunities for sharing health care resources with DoD within or outside the VA medical facility catchment area by leveraging any of the following:

(a) Nonaccess to care metrics and non-VA care expenditures for recapture.

(b) The ability to co-locate services with DoD to promote economies of scale and avoid duplicative costs.

(c) Leveraging existing underutilized capital (e.g., land, building, major equipment or utilities) and non-capital (e.g., staff, administrative services or clinical services) capacity to deliver health care services.

(d) Potential expansion or enhancement of services through joint projects with DoD.

(e) New facility construction requirements, especially those for community-based outpatient clinics.

(f) Veteran and DoD beneficiary population needs.

(5) Coordinating with DoD on incorporating the analysis and evaluation of strategic health care planning issues for the local market(s) or across the health system.

(6) Coordinating VA's participation in the joint evaluation of VA medical facility-level sharing agreements annually to determine the outcomes of such arrangements. Outcomes should apply VHA Performance metrics and measure.

(a) Increased access and capacity (workload, appointments and procedures) for Veterans.

(b) Decreased waiting time for appointments for Veterans.

(c) Decreased expenditures for non-VA care.

(d) Reduced duplicative functions.

(7) Developing and submitting proposed sharing agreements (VA Form 10-1245c) to the VA medical facility Director for review or concurrence.

(8) Notifying the VA-DoD MSO Representative that a sharing agreement extension is needed, if applicable.

5. READINESS AND CONTINGENCY

Agreements or commitments between DoD and VA may not compromise the readiness and mobility/contingency availability of DoD organizational personnel.

6. TRAINING

There are no formal training requirements associated with this directive.

7. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

8. REFERENCES

a. P.L. 108-375.

b. 10 U.S.C. § 1071.

c. 10 U.S.C. § 1104.

d. 38 U.S.C. § 1701, § 1705, § 1710, § 1782, § 1783 and § 1784A.

e. 38 U.S.C. § 7302.

f. 38 U.S. Code § 8110.

g. 38 U.S.C. § 8111.

h. 42 U.S.C. §§ 2651 – 2653.

- i. 32 C.F.R. 108.4.
- j. VHA Directive 1660.06 VA-TRICARE Network Agreements, dated June 28, 2019.
- k. VHA Directive 1820, Enhanced Sharing Use of Space Program, dated November 7, 2017.
- l. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.
- m. DoD Instruction 6010.23, DoD and Department of Veterans Affairs (VA) Health Care Resource Sharing Program.
- n. DoD Manual 5200.08, "Physical Access Control to DoD Installations, Volume 3" January 2, 2019.
- o. TRICARE Operations Manual 6010.56-M, available at: <https://manuals.health.mil/>.
- p. TRICARE Policy Manual, available at: <https://manuals.health.mil/>.
- q. VA-DoD Medical Sharing Office website, available at: https://vaww.va.gov/VADODHEALTH/VA_DoD_Medical_Sharing_Office.asp. **NOTE:** *This is an internal VA website that is not available to the public.*
- r. VA-Form 10-1245c available at: <https://go.max.gov/rsa>. **NOTE:** *Additional VA-DoD sharing agreement templates (e.g., competency, space permit) are found within the toolbox tab.*
- s. VHA Office of Integrated Veteran Care fact sheet, available at: https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/search/DoD. **NOTE:** *This is an internal VA website that is not available to the public.*
- t. Health Affairs Memorandum for Assistant Secretary of Air Force, Army and Navy, "Revision to Department of Defense and Department of Veterans Affairs Reimbursement Rate for Health Care Resource Sharing", March 2019.
- u. Memorandum of Understanding Between the Department of Veterans Affairs and Department of Defense Military Health System, "Health Care Resources Sharing Guidelines," April 2020.
- v. Memorandum of Understanding Between the Department of Veterans Affairs and Department of Defense National for Sharing Personal Information, March 2014.
- w. VA Accounting Classification Structure Volume II-Chapter 1 Appendix A and B, December 2017.
- x. VA Financial Policy Volume XIII, Chapter 1 – Cost Centers, May 2020.

y. VA Financial Policy Volume XIII, Chapter 2 - Budget Object Class Codes, June 2020.

z. VA Financial Policy Volume XIII, Chapter 3 - Managerial Cost Accounting, December 2019.

aa. VA Financial Policy Volume IV, Chapter 1 - Revenues and Expenses, June 2021.

ELIGIBILITY AND DUAL ELIGIBILITY

1. Under a sharing agreement authorized under 38 U.S.C. § 8111, military medical treatment facilities (MTF) and other Department of Defense (DoD) organizational components may provide health care, on a referral basis, to Department of Veterans Affairs (VA) beneficiaries eligible under title 38 of the United States Code (other than under sections 1782, 1783, 1784 or 8111) or any other provision of law for care or services in VA medical facilities. Conversely, a sharing agreement authorized under 38 U.S.C. § 8111, VA medical facilities may provide health care, on a referral basis, to a member or former member of the Armed Forces who is eligible for care under 10 U.S.C. § 1074 or 10 U.S.C. § 1104. As a service under the Department of Homeland Security, Coast Guard active duty Service members generally are not within the scope of the foregoing eligibility criterion. However, there is a limited exception when the Coast Guard operates as a service under the Department of the Navy pursuant to Congressional or Presidential authorization.

2. VA-DoD beneficiaries provided care under a sharing agreement are the responsibility of the agency making the referral. All questions regarding eligibility and financial responsibility for care provided to these beneficiaries must be referred and resolved by the designated officials of the referring agency.

3. DUAL ELIGIBILITY

Some Veterans are eligible for both VA and TRICARE benefits:

a. During the enrollment (registration) process, VA medical facility staff must inform dual-eligible beneficiaries that it is the dual-eligible beneficiary's responsibility, at each episode of care, to identify which benefit (VA or TRICARE) they intend to use. **NOTE:** *The Enrollment Coordinators or designee must counsel the dual-eligible beneficiary prior to care being received. If the dual-eligible beneficiary is seeking treatment from VA for a service-connected condition, the VA benefit must be used rather than TRICARE.*

b. If a dual-eligible beneficiary is seeking care for a service-connected condition in a VA medical facility, the beneficiary must receive care using their Veteran benefit. VA is prohibited from billing TRICARE for treatment of a service-connected condition.

c. If a dual-eligible beneficiary is seeking care for a nonservice-connected condition in a VA medical facility, the beneficiary may elect to receive that care under either the Veteran's benefits or TRICARE benefits for that episode of care.

d. For Reserve Component Service Members serving on orders to active duty for greater than 30 days, DoD eligibility will take precedence over VA eligibility for care and all applicable TRICARE rules will apply.

SHARING OF EXISTING CAPITAL INFRASTRUCTURE TO SUPPORT HEALTH CARE DELIVERY

1. The Department of Veterans Affairs (VA) should follow its department policies, processes/procedures, programs and systems as they pertain to joint strategic planning for sharing existing capital infrastructure to support health care delivery. **NOTE:** For more general information on VA-DoD sharing agreements, see: https://vaww.va.gov/VADODHEALTH/VA_DoD_Sharing_Agreement.asp. This is an internal VA website that is not available to the public.
2. It is the responsibility of VHA health care resource sharing leadership to effectively manage the sharing of existing capital infrastructure. Details of these existing capital infrastructure sharing activities will be specified and documented within the capital infrastructure permit (i.e., VA Form 6215 and DHA Form 226; available at: <http://www.va.gov/vaforms/>) and health care resource sharing agreement, VA Form 10-1245c. **NOTE:** When VA occupies DoD underutilized capital infrastructure as VA's appointed place of duty, it must obtain a VA Station ID following VA's Accounting Classification Structure Volume II-Chapter 1 Appendix A and B via (vafscaccountingsystemsoversight@va.gov). VA is also required to capture shared capital infrastructure in VA's Capital Asset Inventory tool, available at: <https://vaww.cai.va.gov>, managed by VA Office of Asset Enterprise Management or shared capital infrastructure in military medical treatment facilities (MTF) under DoD's Real Property Inventory as appropriate. **NOTE:** This is an internal VA website that is not available to the public.
3. Negotiating the various terms for use of underutilized existing space can be accomplished by leveraging guidance from and processes found in Veterans Health Administration (VHA) Directive 1820, Enhanced Sharing Use of Space Program, dated November 7, 2017. Reimbursement methodology will vary based on local partners need (see VHA Directive 1820, Appendix E, Section 3, "Determination of Fair Pricing" and Section 4, "Determination of a Negotiating Range". Examples include volume discounts, no cost (barter services for space), net neutral (only reimburse utilities)).
4. Building depreciation, interest on net capital investment and VHA Central Office overhead must be excluded from cost estimates. Refer to VHA Directive 1820.

PREPARING SHARING AGREEMENTS

1. IDENTIFY POINTS OF CONTACT

The Department of Veterans Affairs (VA) medical facilities and Veterans Integrated Service Networks (VISN) must identify individuals (i.e., VA/ Department of Defense (DoD) Resource Sharing Coordinator) to serve as points of contact with their DoD counterparts.

2. HEALTH CARE RESOURCES SHARING OPPORTUNITIES

VA medical facilities or VISNs may enter into VA-DoD health care resource sharing agreements, specifically VA Form 10-1245c, covering health care resources. Health care resources include hospital care, medical services, and rehabilitative services, as those terms are defined in paragraphs (5), (6) and (8), respectively, of 38 U.S.C. § 1701, services under 38 U.S.C. § 1782 and § 1783, any other health care service, and any health care support or administrative resource. Health care support and administrative resources are resources that are necessary for the operation of a VA or DoD medical facility and related to the provision of health care.

a. Sharing arrangements must never reduce services or diminish the quality of care for Veterans. Sharing opportunities may include inpatient, outpatient and other ambulatory care services or procedures; ancillary services; telehealth care; and training. Non-clinical services areas of opportunity for sharing may include, but are not limited to, capital infrastructure, staffing, laundry and emergency management.

b. VISNs proposing VA-DoD sharing opportunities on a local or regional basis must contact the military services or the military medical treatment facilities (MTF), in coordinating with other VISNs to consider sharing through “networks” to encompass large geographic regions. **NOTE:** *With respect to TRICARE Regional Network activities, refer to VHA Directive 1660.06, VA-TRICARE Network Agreements, dated June 28, 2019.*

c. Examples of current health care resources covered in VA-DoD sharing agreements are:

- (1) Ambulatory surgery.
- (2) Orthotics.
- (3) Prosthetics.
- (4) Ophthalmology.
- (5) Podiatry.

- (6) Dialysis.
- (7) Audiology.
- (8) Otolaryngology.
- (9) Radiology.
- (10) Radiation therapy.
- (11) Substance abuse treatment services.
- (12) Post-traumatic stress disorder/Mental health services.
- (13) Staffing support.
- (14) Laundry and linen services.
- (15) Infectious and radioactive waste.
- (16) Sterilization.
- (17) Fire and safety.
- (18) Medical and surgical supplies.
- (19) Sanitation.
- (20) Transportation.
- (21) Use of medical equipment or existing capital infrastructure.
- (22) Laboratory services.
- (23) Teleradiology and telemedicine services.
- (24) Prosthetics and sensory aids.

3. ITEMS TO BE INCLUDED IN SHARING AGREEMENT DISCUSSIONS

After health care resource sharing opportunities have been identified, VISN or VA medical facility staff must discuss with the appropriate VA-DoD Sharing Coordinator projected costs, workload capture, reimbursement, resources and any other financial performance indicators.

4. ACQUIRING OR INCREASING HEALTH CARE RESOURCES

VISNs and VA medical facilities may consider acquiring or increasing health care resources that exceed the needs of the facility's primary beneficiaries, provided it will serve the combined needs of both VA and DoD.

a. Approval for additional health care resources must be obtained from the VISN Director before submission of the sharing agreement to the Director, VA-DoD Medical Sharing Office.

b. VA shall obtain a commensurate commitment from DoD for any increase or additional capacity secured by VA for the use and benefit of DoD.

c. Sharing agreements requiring additional capacity must cite the combined workload of the participating facilities. **NOTE:** *VA -DoD sharing partners must explore submitting a joint incentive fund proposal for joint procurement.*

d. Joint procurements may be developed that take advantage of the fact that one department has obtained favorable prices from a vendor. Consult with acquisition and legal staff prior to completing negotiations with DoD.

5. DENTAL SERVICES

a. Due to VA's specific eligibility requirements and limited capacity to furnish dental services to Veterans, VA medical facilities planning to enter into VA-DoD dental sharing agreements must consult with their Chief of Dental Service to determine whether there is sufficient capacity to enter into a sharing agreement. As with all VA-DoD health care resource sharing agreements, VA medical facilities may not reduce services or diminish the quality of care for Veterans.

b. A cost analysis must be performed locally to ensure that the proposed rate reflects the VA medical facility's cost for providing such care.

6. PERSONNEL SUPPORTING THE DELIVERY OF HEALTH CARE IN MEDICAL FACILITIES OF THE OTHER DEPARTMENT

a. The health care resources shared under VA/DoD sharing agreements may, encompass the sharing of personnel to support the delivery of health care and enhance competency in administrative or clinical skill maintenance. This includes attendance of, receiving and application of relevant instructional activities at either DoD MTFs or VA medical facilities, provided no educational institution is involved, and no academic credit is awarded. **NOTE:** *Sharing of personnel to support the delivery of health care is accomplished by utilizing the VA/DoD Competency annex to the VAF 10-1245c.*

(1) Sharing of personnel to support the delivery of health care and enhance competencies must be conducted in either a VA medical facility or DoD MTF.

(2) Sharing of personnel to support the delivery of health care and enhance competencies can include administrative services or direct patient care. **NOTE:**

Simulation training, medical facility classrooms and online courses through the Talent Management System are excluded.

(a) If a sharing agreement encompasses personnel of one department furnishing care in a medical facility of the other department, the terms of the sharing agreement must provide that staff onboarding, including credentialing and privileging activities, are under the direct supervision of the appropriate VA or DoD staff designated by the VA medical facility Director or DoD MTF Commander to conduct and monitor the shared activities. The terms of the sharing agreement must also provide that the roles of personnel furnishing care in medical facilities of the other department are limited to those specified in the agreement.

(b) Sharing of personnel to support the delivery of health care and enhance competencies must include the occupational categories pertaining to the subject to the agreements and the number of shared personnel in each category.

7. EDUCATION TRAINING AFFILIATION AGREEMENTS

For more information on accredited education training affiliation agreements for health professional trainees (e.g., physician residents, psychology interns, nurse anesthetists) leading to a degree, license, continuing education credit for licensure, registration or certification, to include military trainees rotating to VA medical facilities, please refer to the Office of Academic Affiliations (OAA) accredited health professional training program or visit <http://www.va.gov/oaa/agreements.asp>.

8. MEALS AND QUARTERS

The health care resources shared under a sharing agreement may, in appropriate cases, include meals, quarters, laundry services, and/or medical apparel worn by personnel of the other department.

LEVELS OF SHARING COLLABORATION

1. CHARACTERISTICS

Levels of sharing collaboration replaces the term Joint Venture. The term Joint Venture is no longer used to distinguish a particular level of resource sharing collaboration between the Department of Defense (DoD) and Department of Veterans Affairs (VA) facilities. Levels of resource sharing are now broken down into five distinct levels of sharing collaboration consisting of:

a. Level 0 - Separate facilities without shared resources. Separate health care facilities in different locations that do not have a sharing agreement for shared clinical or non-clinical resources.

b. Level 1 – Separate facilities with intermittent sharing of independent medical or non-medical health care resources. Separate health care facilities in different locations with a sharing agreement identifying intermittent medical or non-medical services allowing either department beneficiaries to receive select clinical services at either one or both facilities. This can also include sharing agreements for non-clinical administrative services but does not include sharing of human capital resources. Reimbursement methodology utilized is bi-directional billing (at rates established in accordance with the Memorandum of Understanding Between the Department of Veterans Affairs and Department of Defense Military Health System, “Health Care Resources Sharing Guidelines,” April 2020).

c. Level 2 – Separate facilities with sharing of independent medical or non-medical health care resources. Separate health care facilities in different locations or on the same Federal property with a sharing agreement identifying medical or non-medical services allowing either department beneficiaries to receive select services at either one or both facilities. This can also include sharing agreements for non-clinical administrative services or facility space but does not include sharing of human capital resources. Reimbursement methodologies utilized are bi-directional billing (at rates established in accordance with the Memorandum of Understanding Between the Department of Veterans Affairs and Department of Defense Military Health System, “Health Care Resources Sharing Guidelines,” April 2020).

d. Level 3 – Separate facilities with sharing of independent medical or non-medical resources to include shared (non-embedded) clinical or non-clinical staff to support operations. Separate health care facilities in different site locations or on the same federal property with a sharing agreement identifying services allowing either department beneficiaries to receive select services at either one or both facilities. This can also include sharing agreements for select ancillary services, e.g., pharmacy, lab, radiology, etc., facility space or non-clinical administrative services utilizing shared (non-embedded) staff in support of facility operations. Reimbursement methodologies utilized are bi-directional billing (at rates established in accordance with the Memorandum of

Understanding Between the Department of Veterans Affairs and Department of Defense Military Health System, "Health Care Resources Sharing Guidelines," April 2020).

e. Level 4 – Partial co-occupancy of facilities with sharing of dependent services that may include a mix of clinical, ancillary support or non-clinical health care resources with embedded staff. Use of a co-located single health care facility where one department occupies underutilized existing space, or there is a joint capital investment for new space. Both departments may provide separate and joint outpatient, inpatient and ancillary services for the beneficiaries identified in a sharing agreement. This level also includes embedded multidisciplinary full-time equivalent clinical and administrative staff and may utilize unique technical interfaces and healthcare Information Technology (IT) products that supports both departments' beneficiaries. Reimbursement methodologies utilized are bi-directional billing (at rates established in accordance with the Memorandum of Understanding Between the Department of Veterans Affairs and Department of Defense Military Health System, "Health Care Resources Sharing Guidelines," April 2020).

f. Level 5 – Fully integrated health care facility. Single integrated health care facility with integrated governance and full sharing of clinical, ancillary, administrative and facility operations.

2. APPROVAL PROCESS

Resource sharing site leadership will be able to self-identify their level of sharing collaboration in accordance with the characteristics and descriptions identified in paragraph 1. The Veterans Health Administration VA-DoD Medical Sharing Office and DoD VA Program Office (DVPO), DoD Health Affairs will utilize the Resource Sharing Levels of Collaboration Self-Identification Chart (available at: <http://www.va.gov/vaforms/>) to verify and validate the self-identified collaboration level with the resource sharing site.

SHARING AGREEMENTS PROCESS

1. Department of Veterans Affairs (VA) medical facilities and Department of Defense (DoD) military medical treatment facilities (MTF) have jointly developed and must follow a prescribed process for approval of proposed sharing agreements.

2. COMPLETING VA-FORM 10-1245c, DEPARTMENT OF VETERANS AFFAIRS/DEPARTMENT OF DEFENSE SHARING AGREEMENT

a. All VA-DoD health care resource sharing agreements must use electronic VA Form 10-1245c, VA/DoD Sharing Agreement. **NOTE:** VA Form 10-1245c can be found at: <https://go.max.gov/rsa>.

(1) **Local Operating Procedure.** Each VA Form 10-1245c must include a Local Operating Procedure (LOP) as an addendum. The LOP is a document that is incorporated into VA Form 10-1245c and used by both VA and DoD to provide facility details and information to improve communication between the parties to a sharing agreement. The LOP will include, at a minimum, a permanent business office address and current direct phone numbers of local DoD and VA point of contacts (POC) by functional position to include but not limited to: referral managers, care coordinators, claims process and billing personnel, along with providing site-specific care procedural instructions. The LOP will include any additional procedural details the parties agree to.

(a) VA facilities are responsible for reviewing and updating POCs and procedures at least annually and sooner when changes occur in their LOP. Changes to LOPs constitute amendments to the sharing agreement into which they are incorporated and must be processed as such. Additionally, VA facilities are responsible for ensuring that POC information refers to an office of responsibility and adheres to the Memorandum of Understanding Between the Department of Veterans Affairs and Department of Defense Military Health System, "Health Care Resources Sharing Guidelines," April 2020.

(b) All sharing agreements in existence on the date this directive is published will be allowed to expire before use of the electronic VA form 10-1245c becomes mandatory. However, an LOP must be included in all sharing agreements (including those existing on the date this directive is published) upon amendment or renewal.

b. Sharing agreements must detail the resources to be shared. Agreements start on Block 9 of VA Form 10-1245c and may be continued on an addendum if list of services is larger than space provided.

c. Sharing agreements may be written for up to 5 years.

d. Sharing agreements must include any special arrangements (e.g., medical equipment sterilization and transportation).

e. If, after execution of a sharing agreement, the parties identify additional health care resources that they would like to include in the agreement, such additions to the existing sharing agreement must be processed as amendments.

3. REVIEW AND APPROVAL

a. VA medical facilities must contact their Veterans Integrated Service Network (VISN) VA-DoD Resource Sharing Coordinator for review and concurrence of the proposed sharing agreement. Subsequent to VISN concurrence, all sharing agreements must be electronically submitted to and approved by the VA-DoD Medical Sharing Office (MSO) and awareness provided to VHA's Network Support via the resource sharing database, available at <https://go.max.gov/rsa>. The VA-DoD MSO provide review results by email. **NOTE:** *The VA-DoD MSO will determine the need for legal review of all sharing agreements by the VA Office of General Counsel on a case-by-case basis.*

b. Upon the Department of Veterans Affairs Central Office (VACO) approval, proposed sharing agreements may be signed by local VISN Directors or VA medical facility Directors. Any additional supporting documentation needed can be scanned and submitted electronically to the email addressee, "VA/DoD Sharing Agreements at vhacoshaagr.vhacoshaagr@va.gov" **NOTE:** *The VA-DoD MSO will provide VISNs and VA medical facilities a copy of the numbered local agreement in their respective regions upon request. All local sharing agreements can also be found on at <https://go.max.gov/rsa>.*

c. The VA-DoD MSO must provide a review response of any proposed sharing agreement within 45 calendar days of receipt. If action is not forthcoming at the end of the 45-day period, the sharing agreement may be executed by local leadership on the 46th day.

4. AMENDMENTS

An amendment offers the opportunity to modify the existing terms and conditions of the current agreement. The same procedures described for initial sharing agreements must be followed for amending sharing agreements. Amendments retain the same number.

5. RENEWALS

A renewal renews the period of performance of the agreement for a new date range, not to exceed 5 years and offers the partners an opportunity to make any relevant changes to the terms of the agreement. The same procedures described for initial sharing agreements must also be followed for renewing sharing agreements. Renewals retain the same number with an additional or changed suffix. For example, 2002-FRS-0023 becomes 2002-FRS-0023A.

7. EXTENSIONS

An extension offers the opportunity to extend their current agreement, if the extension is requested prior to the agreement's expiration date. VA medical facility VA-DoD resource sharing coordinators can request an extension at <https://go.max.gov/rsa> to initiate the process.

8. TERMINATION OF AGREEMENTS

Termination by either party must be accomplished in accordance with the terms of the applicable sharing agreement. Sharing agreements must require written notification. Termination of any clinical or administrative services (if applicable) in the sharing agreement or any part therein, shall occur 90 days following the date of the written notification to terminate, unless a date is provided which is greater than the 90-day date. Termination of any capital infrastructure or infrastructure support services for space shared pursuant to the agreement (if applicable) or any part therein, shall occur 365 days following the date of the written notification to terminate, unless a date is provided which is greater than the 365 day date.

9. NATIONAL EMERGENCIES

Either party may develop, modify, suspend or terminate all or part of this agreement in case of mission requirement/response to national emergencies in accordance with 38 U.S.C. § 8111A. **NOTE:** *For additional information, please see 38 U.S. Code § 8110 - Operation of Medical Facilities.*

REFERRAL AND CONSULT MANAGEMENT

1. DEPARTMENT OF VETERANS AFFAIRS TO DEPARTMENT OF DEFENSE REFERRALS

All referrals sent by the Veterans Health Administration (VHA), Veterans Affairs Medical Facility (VAMF) to the military medical treatment facility (MTF) will:

a. Follow Chapter 3 (Care Coordination) of VHA Office of Integrated Veteran Care (OIVC) Field Guidebook. **NOTE:** *OIVC field guidebook is found on VHA's intranet SharePoint site at, <https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx>. This is an internal VA website that is not available to the public.*

b. Have a VA consult number clearly annotated on the referral or consult.

c. Clearly delineate the scope of the standardized episode of care (SEOC).

d. Identify any specific base access requirements.

e. Be delivered to the receiving MTF by the most efficient method (e.g., Joint Legacy Viewer (JLV), fax) that is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended.

f. During normal working hours, VAMF to MTF referrals are coordinated by the local VAMF OIVC with the MTF referral managers who coordinate the appointment scheduling with the patient and notify the VAMF of the appointment and enter the appointment into both Agencies respective appointment systems. The titles of all coordinating points of contacts (POC) and current phone numbers will be identified and listed within the Local Operating Procedure (LOP) guide.

2. VETERANS HEALTH ADMINISTRATION REFERRALS FROM DEPARTMENT OF DEFENSE TO DEPARTMENT (VIA TRICARE MANAGED CARE SUPPORT CONTRACTOR PURCHASED CARE PROCESS)

The VAMF will ensure all VAMF referred care sent by the MTF to the VAMF will:

a. Have a TRICARE authorization number clearly annotated on the referral or consult.

b. Clearly define the scope of the episode of care (evaluate or evaluate and treat).

c. Deliver to the receiving VAMF by the most efficient method (e.g., JLV, fax) that is in compliance with the HIPAA.

d. The MTF will work with the TRICARE Managed Care Support Contractor (MCSC) to obtain appropriate authorization for the “directed VAMF referral”. Once the authorization is received from the MCSC, the MTF will notify the VAMF in the most efficient HIPAA-compliant method. As the accepting organization, the VAMF will coordinate the appointment scheduling with the patient, notify the TRICARE MCSC/MTF and enter the appointment into its EHR.

e. During normal working hours, MTF to VAMF referrals are coordinated by the MTF and VAMF; after hours the MTF AOD will verify eligibility determination and authorization. The titles of coordinating POCs and current phone numbers will be identified and listed within the resource sharing partners’ LOP guide, which may also include more detailed procedures for care. Upon proper coordination by the MTF with VAMF and written acknowledgement of authorization for care, outpatient referrals will be forwarded as a “directed referral” to the TRICARE MCSC in accordance with the terms of the network provider agreement and Chapter 8, Section 5 of the TRICARE Operations Manual 6010.56-M, as amended.

3. VETERANS HEALTH ADMINISTRATION REFERRALS FROM DEPARTMENT OF DEFENSE TO DEPARTMENT (VIA JOINTLY RESOURCED SHARED CLINICAL SERVICE PROCESSES)

All VHA or MTF referred care sent to their resources partner will:

- a. Have a referral number or unique identifiable number (UIN) clearly annotated on the referral or consult.
- b. Clearly define the scope of the episode of care (evaluate or evaluate and treat).
- c. Deliver to the receiving VAMF or MTF by the most efficient method (e.g., JLV, fax) that is in compliance with the HIPAA.
- d. The VAMF will work with the MTF to obtain appropriate authorization for the “directed VAMF referral”. The VAMF will be notified by the MTF in the most efficient HIPAA-compliant method. As the accepting organization, the VAMF will coordinate the appointment scheduling with the patient, notify the MTF and enter the appointment into its EHR.
- e. During normal working hours, MTF to VAMF referrals are coordinated by the MTF and VAMF; after hours the MTF AOD will verify eligibility determination and authorization. The titles of coordinating POCs and current phone numbers will be identified and listed within the resource sharing partners’ LOP guide, which may also include more detailed procedures for care.

DISCHARGE MANAGEMENT

1. DOD BENEFICIARIES DISCHARGED FROM DEPARTMENT OF VETERANS AFFAIRS TO MILITARY MEDICAL TREATMENT FACILITY

The discharging Department of Veterans Affairs (VA) medical facility (VAMF) will coordinate with the military medical treatment facility (MTF) to facilitate discharge planning and post follow-up care the DoD beneficiary per Veterans Health Administration (VHA) policy. VAMF will provide follow-up instructions in the discharge note to the MTF point of contact (POC) via Joint Legacy Viewer (JLV), fax or other Health Insurance Portability and Accountability Act (HIPAA) compliant method as outlined in the local operation procedure (LOP) within 72 hours after patient discharge from the VA medical facility. The VAMF's Patient Administration Department will provide a copy of the discharge summary to the MTF in compliance with records management and protection of health information standards.

2. VETERANS DISCHARGED FROM MILITARY MEDICAL TREATMENT FACILITY TO DEPARTMENT OF VETERANS AFFAIRS

The discharging MTF will coordinate with the VAMF to facilitate discharge planning and post follow-up care for the Veteran per Department of Defense (DoD) policy. The MTF will provide follow-up instructions in the discharge note to the VAMF POC via JLV, fax or other HIPAA compliant method as outlined in their LOP within 72 hours after patient discharge from the MTF. The MTF Patient Administration Department will provide a copy of the discharge summary to the VAMF in compliance within records management and protection of health information standards.

3. SPECIAL DISCHARGE CIRCUMSTANCES

Specific after hour and special discharge instructions should be developed if specific processes are required and outlined in their LOP.

EMERGENCY SERVICES

1. Veterans Health Administration (VHA) will comply with applicable Federal laws, including 38 U.S.C. § 1784A, that require examination and/or treatment of individuals in emergency departments, regardless of whether Emergency Services at the applicable Department of Veterans Affairs (VA) medical facility (VAMF) are within the scope of an existing VA/Department of Defense (DoD) Sharing Agreement (VA Form 10-1245c). VA facilities must follow all VA and VHA policies and procedures regarding access to emergency care.

2. DEPARTMENT OF VETERANS AFFAIRS BENEFICIARY SEEN AT A DEPARTMENT OF DEFENSE EMERGENCY DEPARTMENT

a. Upon notification from the military medical treatment facility (MTF) staff that a potential VA beneficiary has been seen the MTF Emergency Department (ED) within 72 hours of patients initial episode of care or admission, VAMF OIVC staff will verify patient's eligibility for VA medical benefits and utilize the "DoD Treatment Facility Hospital Notification Note" template in the VA electronic health record (EHR) **NOTE: 72 hour notification processes are required to be identified in the applicable LOP subject to validation by the VHA.** VAMF IVC staff will determine and document eligibility for medical care payment. Within 72 hours, VAMF IVC will notify MTF staff in writing of its eligibility determination. **NOTE: After hours the VAMF Administrative Officer of the Day (AOD) will be contacted to verify eligibility determination and approval.**

(1) If VA confirms the patient is an eligible VA beneficiary, VA will provide written care coordination directions and approval for any required inpatient admission.

(2) If VA determines the patient is not an eligible VA beneficiary, VA will notify MTF in writing the patients ineligible.

b. If VA is not notified within 72 hours after the initiation of ED care or admission, the patient's eligibility for VA medical benefits may not be confirmed or determined until after the episode of care has been validated during the monthly DoD-VA workload and reconciliation review.

3. DOD BENEFICIARY SEEN AT A VA EMERGENCY DEPARTMENT

VA staff will verify eligibility of DoD beneficiaries treated in a VA ED by either:

a. Contacting their partnering MTF AOD within 72 hours of patients initial episode of care or admission

b. Contacting the appropriate TRICARE managed care support Contractor (MCSC) in the region. In the event of inpatient admission, VA must notify the appropriate TRICARE MCSC within 24 hours or by the next business day following an ED inpatient admission,

but no later than 72 hours of the admission. **NOTE:** *The DoD beneficiary may be responsible for TRICARE co-pay or cost share based on their TRICARE health plan.*

4. NON-EMERGENCY CARE

a. If a VA beneficiary is treated in a DoD ED for non-emergency, or unauthorized care, the VA beneficiary may be financially responsible for charges incurred in the course of their treatment. **NOTE:** *Veteran are notified of their possible financial responsibility by the treating MTF for non-emergency, or unauthorized care.*

b. If a TRICARE beneficiary is treated in a VA ED for non-emergency, unauthorized care, the TRICARE beneficiary may be financially responsible for charges incurred in the course of their treatment. TRICARE follows “prudent layperson standards” for determining if a medical emergency exists (refer to TRICARE Policy Manual Chap 2, Section 4.1, Paragraphs 5.4 - 5.5 and 6.0, as amended). The treating facility will direct the patient back to their respective primary care physician or enrolled VA medical facility for follow up care or evaluation.

PHARMACY SERVICES

1. INPATIENT PHARMACY

The servicing facility will provide inpatient medication as part of the referred inpatient episode of care. Upon discharge and if determined to be medically necessary, the beneficiary will be provided initial post-procedure or discharge prescriptions with no refills. If the beneficiary requires refills, they must follow-up with their enrolled Referring Provider for continuation of pharmaceutical care.

2. OUTPATIENT PHARMACY

a. **Department of Veterans Affairs Beneficiaries.** When referring Department of Veterans Affairs (VA) beneficiary to a military medical treatment facility (MTF) for clinical services, pharmacy services are authorized for that episode of care based on the treating providers determination of urgent/emergent and medical necessity. Prescriptions are authorized for up to a 14-day supply with no refills. Medication refills must be filled by the referring VA medical facility. ***NOTE: Refer to Veteran Prescription Benefits Reference Sheet.***

b. **DoD Beneficiaries.** Refer to VHA's current TRICARE policies, processes/procedures, Veterans Health Administration (VHA) Directive 1660.06, VA-TRICARE Network Agreements, dated June 28, 2019 for additional pharmaceutical service information.

FINANCIAL

1. The standardized Department of Veterans Affairs (VA)/Department of Defense (DoD) health care resource sharing rate for health care services rendered is the TRICARE Reimbursement Rate (TRR) less a 20% deduction. In accordance with the Memorandum of Understanding Between the Department of Veterans Affairs and Department of Defense Military Health System, "Health Care Resources Sharing Guidelines," April 2020, billing guidelines reflected in the Defense Health Agency Uniform Business Office (DHA UBO) User Guide, VA-DoD Resource Sharing Billing section, remain in effect (the pharmacy rate file less 20% will be used). The only exceptions are facilities participating in Reimbursement Pilot studies (e.g., Advance Payment), or granted an approved waiver.

2. REIMBURSEMENT AND RATE SETTING METHODOLOGY

All DoD and VA health care resource sharing agreements will be executed under the authority of 38 U.S.C. 8111 and documented on the VA Form 10-1245c.

3. DEPARTMENT OF VETERANS AFFAIRS ACCEPTANCE OF DEPARTMENT OF DEFENSE TO "DIRECTED" REFERRED CARE.

Any VA accepted directed referred care from DoD will refer to VHA's current TRICARE policies, processes/procedures, Veterans Health Administration (VHA) Directive 1660.06, VA-TRICARE Network Agreements, dated June 28, 2019 for additional information.

4. DEPARTMENT OF VETERANS AFFAIRS TO DEPARTMENT OF DEFENSE REFERRED CARE

Prior to a military medical treatment facility (MTF) submitting medical bills or claims to the VA for referred care, DoD facilities will ensure that:

- a. Health care rendered to VA patients has a corresponding VA referral.
- b. The care provided is within the scope of the VA referral.
- c. Substantiating documentation is properly recorded and retained. **NOTE:** *Medical bills that do not meet all of these criteria will be considered errors and rejected if submitted to VA for payment.*

2. WAIVER

Where use of the standard TRR less 20% would be fiscally insufficient to cover marginal costs for providing health care to VA beneficiaries, MTF and VA may request a waiver to exempt them from applying the set standard TRR less 20%. The determination on approval/disapproval of waiver requests will be made by the VA/DoD

Health Executive Committees, Health Care Operations Business Line (HEC HCOBL) co-chairs.

3. SHARED SERVICES NOT COVERED IN THE VA AND DOD REIMBURSEMENT AND RATE SETTING METHODOLOGY

When sharing administrative services, existing space or human capital resources, negotiations will occur locally between the MTF and VA, to include any reimbursable costs (if applicable) and captured in the appropriate section of VA Form 10-1245C.

NOTE: *Local sharing partners will ensure the applicable reimbursement will not conflict with the National Reimbursement Methodology.*

4. GENERAL PROVISIONS

a. VA and DoD currently use the Department of the Treasury's Interagency Payment and Collection (IPAC) system for interagency billing and payments.

b. As set forth in the Memorandum of Understanding Between the Department of Veterans Affairs and Department of Defense Military Health System, "Health Care Resources Sharing Guidelines," April 2020, VA and DoD have agreed that the agency performing the work or providing the services must bill the receiving agency within 30 calendar days after the month in which performance occurred. Reimbursement for medical claims must be paid by the receiving agency upon presentation of a clean claim. The receiving agency must remit payment no more than 30 days from receipt of a clean claim. **NOTE:** *"Clean claim" is defined as a claim with no defect, impropriety or special circumstance warranting a delay in payment, including incomplete documentation.*

c. As set forth in the Memorandum of Understanding Between the Department of Veterans Affairs and Department of Defense Military Health System, "Health Care Resources Sharing Guidelines," April 2020, VA and DoD have agreed to follow their Departments' respective policies pertaining to obligating and de-obligating funds, based on current rates at time of the obligation and will ensure their respective internal control systems are adequate; information is reliable and valid; applicable laws, regulations and policies are followed; resources are safeguarded and managed economically and efficiently; and operations are effective and efficient.

d. Non-clinical cost estimation methods must be used for types of services not covered by Center for Medicare and Medicaid Services (CMS) rates, such as existing space, laundry and staff support.

e. Costs of any shared ancillary, special services such as Pharmacy, Laboratory, Prosthetics and Durable Medical Equipment must be evaluated using the same cost assessments found in the DHA UBO Billing Guidelines, available at: <https://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Billing>.

f. As additional and relevant Department financial policies are developed, modified and approved, updated language will be included in appropriate policies, handbooks, directives, manuals or instructions.

5. BUDGET OBJECT CODES AND COST CENTERS

The following budget object code and cost center codes apply to VA-DoD sharing agreements:

a. **Budget Object Code. 2590:** VA/DOD SHARING AGREEMENT.

b. Cost Centers

(1) **8321:** U.S. ARMY HOSPITALS.

(2) **8322:** U.S. AIR FORCE HOSPITALS.

(3) **8323:** U.S. NAVY HOSPITALS.

(4) **8324:** NATIONAL CAPITAL REGION HOSPITALS.

6. REVENUE SOURCE CODES

The following revenue source codes apply to VA-DoD sharing agreements:

a. **8014.** Non-medical sharing agreements.

b. **8017.** Sharing agreements for inpatient services.

c. **8018.** Sharing agreements for outpatient services.

d. **8028.** TRICARE-Inpatient Care.

e. **8029.** TRICARE-Outpatient Care.

f. **8030.** TRICARE-All Other.

g. **8085.** DoD-IDES.

h. **8086.** DoD-Spinal Cord Injury -Inpatient (IP).

i. **8087.** DoD-Spinal Cord Injury -Outpatient (OP).

j. **8088.** DoD-Spinal Cord Injury –Other Revenue (OT).

k. **8089.** DoD-Brain Injury-IP.

l. **8090.** DoD-Brain Injury -OP.

- m. 8091. DoD-Brain Injury -OT.
- n. 8092. DoD-Blind Rehad-IP.
- o. 8093. DoD-Blind Rehad -OP.
- p. 8094. DoD-Blind Rehad -OT.
- q. 8095. TRICARE Pharmacy.
- r. 8096. TRICARE Active Duty Dental.

7. THIRD PARTY BILLINGS AND COLLECTIONS

a. **Federal Medical Care Recovery Act, Title 42 United States Code § 2651- § 2653 or Recovery by the U.S. of the Cost of Certain Care and Services 38 U.S.C. § 1729.** DoD will forward any claim information for care which third parties are responsible due to tort liability, coverage under a health care contract or a worker's compensation law or plan or automobile reparations insurance. VA will provide a point of contact and address for this information.

b. This section outlines the VHA Office of Finance Revenue Operations (OF RO) first party copay and third party revenue activities conducted by regional Consolidated Patient Accounts Centers (CPAC). Upon receipt of data report by OF RO identifying all required third party billing information of paid DoD Sharing Agreement claims, Regional CPACs will:

(1) Review data reports to assess and apply first party copayment charges as determined by Veterans' eligibility.

(2) Upon advance notice of scheduled appointments with DoD MTF, conduct precertification with the Veteran's other health insurance (OHI) as appropriate.

(3) Review data reports to conduct Service Connection/Special Authority (SC/SA) validation.

(4) Review data reports to create third party claims for non-SC/SA episodes of care to Veterans OHI.

(5) Retrieve medical documentation as required by third party payers.

DEPARTMENT OF DEFENSE BASE/INSTALLATION ACCESS REQUIREMENTS

1. The Department of Defense (DoD) provides overarching policy guidance on physical access control to military installations. However, it is locally managed by the installation commander and depending on the type and mission of the installation, required credentials to access the installation may vary by site. Additional information may be found in enclosure 1, reference k, DoD Manual 5200.08, Physical Access Control to DoD Installations, Volume 3, available at:
https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodm/520008_vol3.pdf?ver=2019-01-02-074152-967.
2. For the Department of Veterans Affairs (VA) beneficiaries seeking care at a military medical treatment facility (MTF), installations that have electronic physical access controls (ePACS) with Identity Matching Engine for Security and Analysis (IMESA) functionality may allow the Veteran's Health Identification Card (VHIC) as an acceptable source of identity and purpose to access the installation but may also require other forms of acceptable identification to establish identity and purpose. A VHIC must be issued to each eligible Veteran whose eligibility and enrollment status has been verified by VA and who requests a VHIC. The local VA medical facility is responsible for completing the request for a VHIC. **NOTE:** *A VHIC is not required to maintain enrollment or to obtain care in the VA health care system. Installations that use ePACS without IMESA, and installations that are not ePACS enabled will require other forms of identification such as DoD Common Access Cards (CAC), DoD Uniformed Services Identification Cards, local or regional DoD non-CAC credentials, compliant driver's license or identification cards issued by a State or District of Columbia, U.S. or foreign passport or other credentials that bear a photograph and deemed acceptable by the installation.*
3. In all cases the VA will use all strategic communication vehicles available to inform Veterans who seek care from an MTF that they must have in their possession acceptable credentials for access to the MTF and allow enough lead time to access the installation before any scheduled MTF appointment.