VA-DOD HEALTH CARE RESOURCES SHARING

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook contains instructions on how to develop Department of Veterans Affairs (VA)-Department of Defense (DOD) sharing agreements and TRICARE contracts, and it incorporates revisions necessary due to changes to the VA-DOD Sharing Law (see Title 38 United States Code 8111), Departmental policies, and VHA reorganizations.

2. SUMMARY OF CONTENTS/MAJOR CHANGES: Significant changes in this Handbook include:

a. VA facilities and military treatment facilities are required to consider entering into agreements or contracts with each other. The Secretary of Veterans Affairs and the Secretary of Defense enter into agreements or contracts with each other for the mutually beneficial coordination, use, or exchange of use of health care resources to improve access to, and quality and cost effectiveness of, health care provided by VHA and the Military Health System (see Public Law 107-314).

b. The Department's implemented guidelines for a standardized, uniform payment and reimbursement schedule for services provided to each Department's beneficiaries for VA-DOD agreements (see Public Law 107-314).

c. Types of DOD beneficiaries eligible for care in VA medical facilities (see Public Law 104-262) are clarified.

d. Instructions on how to develop contracts with DOD's TRICARE contractors.

e. Instructions on how VA medical facilities need to handle care for DOD beneficiaries seeking to utilize VA medical facilities for medical treatment under DOD's TRICARE for Life (TFL) Program.

f. The Veterans Integrated Service Networks (VISNs) role in developing VA-DOD agreements and TRICARE contracts.

g. Requiring a disclosure statement when a VA-DOD sharing agreement or TRICARE contract does not include full costs.

3. RELATED ISSUES. VHA Directive 1660 (to be published).

4. RESPONSIBLE OFFICE: The Medical Sharing Office (176) is responsible for the contents of this Handbook. Questions should be directed to 202-273-5608.

5. RESCISSIONS. VHA Handbook 1660.1, VA-DOD Health Care Resources Sharing, dated July 17, 1997; VHA Directive 99-027, Treatment of TRICARE Beneficiaries at VA Medical Facilities Through Agreements With Department of Defense Medical Care Support Contractors, dated June 22, 1999; and VHA Directive 2002-036, Guidance on VA's Role in TRICARE for Life, dated June 21, 2002, are rescinded.

6. RECERTIFICATION: This VHA Handbook is scheduled for re-certification on or before the last day of March 2009.

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VA-DOD HEALTH CARE RESOURCES SHARING

1. PURPOSE

This Veterans Health Administration (VHA) Handbook defines procedures that Department of Veterans Affairs (VA) medical facilities, Veterans Integrated Service Networks (VISNs), and other organizational components needed in order to develop health resources sharing agreements and TRICARE contracts with military treatment facilities (MTFs), Department of Defense (DOD) organizational components, and TRICARE Health Services and Support Contractors (HSSCs).

2. AUTHORITY

The VA-DOD Health Care Resources Sharing and Emergency Operations Act (Title 38 United States Code (U.S.C.) 8111).

3. SCOPE

VA-DOD sharing activities covered within the scope of this Handbook include: eligibility; VA medical center and VISN responsibilities; development of sharing agreements and TRICARE contracts; reimbursement and billing; approval of VA-DOD agreements and TRICARE contracts; construction, equipment; joint ventures; and education and training agreements. Sharing arrangements are never to reduce services or diminish the quality of care for veterans.

4. ELIGIBILITY

DOD beneficiaries eligible for care under 10 U.S.C. §1074 may be provided health care at VA facilities under VA-DOD sharing agreements and TRICARE contracts negotiated between VA medical facilities and MTFs, other DOD organizational components, and TRICARE contractors. These beneficiaries are active duty members of the armed services, military retirees, and dependents of active military and retirees. DOD beneficiaries treated at VA medical facilities may be referred by a MTF or by a TRICARE managed care support contractor.

5. VA MEDICAL CENTERS' AND VISNS' RESPONSIBILITIES

a. The VA-DOD Sharing Law (38 U.S.C. 8111) gives VA medical facilities and VISNs the flexibility to negotiate sharing agreements and TRICARE contracts covering a broad spectrum of health related activities. Since prospective agreements may affect health care resources within a VISN, VA medical centers need to consult with VISNs before submitting these agreements to the Medical Sharing Office (176) for approval. ***NOTE:*** *There are opportunities at every level for individuals and organizations to enhance health benefits for veterans and reduce costs to the government by minimizing duplication and more fully utilizing federal health care resources.*

b. VISNs may develop agreements (or TRICARE contracts) involving more than one VA medical center, or agreements involving regional services. VHA Central Office components

usually handle national agreements. However, VA medical facilities, or VISNs, may also enter into agreements that make available services nationally.

6. DEVELOPMENT OF VA-DOD AGREEMENTS AND TRICARE CONTRACTS

a. **Identify Points of Contact.** VA medical facilities and VISNs need to identify individuals to serve as points of contact (POC) with their DOD counterparts and TRICARE contractors. ***NOTE:*** *VA POCs need to seek to establish close working relationships with their counterparts.*

b. **Areas of Opportunity.** VA medical facilities may enter into VA-DOD agreements covering medical services and other hospital-related activities. TRICARE contracts, however, are more restrictive in that they cover only those medical services specified in DOD's agreement with its TRICARE contractors.

(1) Examples of current services covered in VA-DOD agreements are:

(a) Primary care,

(b) Ambulatory surgery,

(c) Orthotics,

(d) Prosthetics,

(e) Ophthalmology,

(f) Podiatry,

(g) Dialysis,

(h) Audiology,

(i) Otolaryngology,

(j) Radiology,

(k) Radiation therapy,

(l) Nuclear medicine,

(m) Urology,

(n) Research and development,

(o) Staffing support.

(p) Laundry and linen,

(q) Infectious and/or radioactive waste,

(r) Sterilization,

(s) Fire and safety,

(t) Medical and/or surgical supplies,

(u) Dental,

(v) Sanitation, and

(w) Transportation.

(2) VISNs may wish to explore the potential for VA-DOD sharing or TRICARE contracts on a local or regional basis. VISNs may relate to the military services and their MTFs, TRICARE Regional Offices, and coordinate with other VISNs considering sharing to assemble "networks" to encompass large geographic regions. Examples of sharing at a regional level are:

(a) Laboratory,

(b) Teleradiology and telemedicine,

(c) Substance abuse treatment,

(d) Mental health,

(e) Medical and/or surgical supplies,

(f) Graduate medical training,

(g) Consolidated mail order pharmacy services,

(h) Prosthetics and sensory aids,

(i) Integration of clinics and staffs,

(j) Improvement of integration at joint venture sites,

(k) Improvement in the coordination of information systems, and

(l) Encouragement of specialized "Centers of Excellence."

c. **Items to be Included in VA-DOD Agreement Discussions.** After potential areas for collaboration have been identified, VISN and/or medical center staff need to discuss projected costs, workload, and resources with their counterparts at MTFs, DOD TRICARE Regional Offices, or TRICARE contractors, as appropriate.

d. **VA-DOD Agreement Format**

(1) The Medical Sharing Office (176) recommends use of VA Form 10-1245c, VA-Department of Defense Sharing Agreement. The medical center or VISN Director and their DOD counterparts need to sign proposed agreements. After these signatures have been obtained, the proposed agreement is to be submitted to the Medical Sharing Office (176) and the appropriate DOD offices for approval. VHA officials most responsible for implementing agreements need to sign national VA-DOD agreements.

(2) Agreements must detail the resources to be provided, the cost per unit of those resources, the anticipated number of units, and performance and delivery requirements.

(3) Agreements must include any special arrangements such as transportation and meals.

e. **Acquiring or Increasing Health Care Resources.** Medical centers and/or VISNs may consider acquiring or increasing health care resources that exceed the needs of the facility's primary beneficiaries, but that serve the combined needs of both departments. Sharing agreements requiring additional capacity must cite the combined workload of the participating facilities. Approval for additional resources must be obtained from the VISN Director before submission of the agreement or contract. If new medical resources are to be obtained by VA, multi-year commitments ordinarily need to be obtained from DOD facilities. The justification must cite the combined workload of the participating facilities. "Piggy-back" agreements may be developed that take advantage of the fact that one Department has obtained favorable prices from a vendor. Supplemental staffing agreements allowing facilities to offer a fuller range of services than could otherwise be provided may also be utilized.

f. **TRICARE Medical and Surgical Services.** VHA Central Office and TRICARE HSSCs negotiate the terms of standard provider contracts for medical and surgical services that serve as the basis for negotiations for facility-specific TRICARE contracts. VHA Central Office must negotiate all "standard" contracts for all TRICARE contracts. These "standard" contracts do not address specific services to be provided or reimbursement rates. Local negotiations determine specific services and reimbursement rates. Unlike VA-DOD sharing agreements, there is no mandated discount reimbursement rate off the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC).

g. **TRICARE Mental Health and Substance Abuse Services.** VHA and the TRICARE HSSC mental health subcontractors have agreed on "standard" language for agreements involving mental health and substance abuse services.

h. **TRICARE Pharmacy Services.** VA medical centers and VISNs, and the TRICARE Regional HSSC contractors, or the HSSC contractors' designated pharmacy subcontractors, may

enter into agreements to provide outpatient prescriptions at the VA medical center's cost for the prescription items plus a reasonable fee to cover dispensing costs. Prescriptions should only be filled for those TRICARE beneficiaries receiving care at the VA facility. ***NOTE:*** *VA facilities seeking to negotiate pharmacy agreements need to contact VHA's Pharmacy Benefits Management Strategic Healthcare Group (119) early in the negotiation process for assistance.*

i. **Dental Services.** VA medical care facilities planning to enter into VA-DOD dental sharing agreements need to, in consultation with the Chief of their Dental Service, determine whether there is sufficient capacity to do so. As with all VA-DOD Sharing Agreements, VA facilities may not reduce services or diminish the quality of care for veterans.

(1) A cost analysis needs to be performed to ensure that the proposed rate covers the VA medical center's cost for providing such care. If VA medical care facilities have the capacity and desire to enter into sharing agreements, they need to determine the amount of workload they can provide.

(2) The Military Medical Support Office (MMSO) has developed a template they would like VA medical centers to use. VA facilities need to review the MMSO template to ensure that payments for dental services are based at the 75th percentile of the local zip code areas, and that they are acceptable for their facilities. This review must occur before agreements are fully developed to eliminate the time-consuming process of requesting a waiver for higher fees.

7. BILLING AND REIMBURSEMENTS FOR VA-DOD AGREEMENTS

a. Medical centers are responsible to ensure that direct costs are covered and that the sharing agreements are valid business arrangements.

(1) If the reimbursement rate for clinical services is determined to be less than the local direct cost as defined by the Decision Support System (DSS) fixed direct, variable labor, and variable supply costs for the health service under consideration, a waiver needs to be sought.

(2) Other cost estimation methods may be used to determine full costs for other types of services (e.g., space, laundry, etc.). Building depreciation, interest on net capital investment and VHA Central Office overhead must be excluded from the cost estimates.

(3) VA medical centers are responsible for ensuring that costs are covered and that the sharing agreements are valid business arrangements.

(4) Documentation of the cost analysis needs to be included in the agreement's file.

(5) A disclosure statement is required if full costs are not recovered. The disclosure statement (for VA-DOD agreements only) must include a reason for not charging full costs. The statement needs to include language such as: "current policy encourages increased sharing between VA and DOD by charging CMAC less than 10 percent."

b. VA medical facilities must bill, or pay, for outpatient clinical services provided to individuals referred under VA-DOD sharing agreements at the CHAMPUS Maximum Allowable Charge (CMAC) rate less 10 percent. ***NOTE:*** *CMAC rates are located at: http://www.tricare.osd.mil/ebc/rm_home/ubo_documents_rates_tables_cmac.cfm.*

(1) Billing facilities must only bill the net amount after the 10 percent discount.

(2) Paying facilities will pay the net amounts billed in full.

NOTE: *Currently, there are no fixed inpatient rates. Guidance on inpatient rates will be provided when DOD implements Diagnosis Related Group (DRG) rates.*

c. Requests for waivers larger or smaller than the discount rate for outpatient services must contain the following information:

(1) VA facility name, and location;

(2) VA POC, i.e., the name, telephone number, and e-mail address;

(3) MTF name and location;

(4) MTF POC, i.e., the name, telephone number, and e-mail address;

(5) Date of request;

(6) Description of waiver and proposed alternative rate;

(7) Reason for waiver request;

(8) Benefits derived: include significant tangible and intangible factors;

(9) Impact if waiver is disapproved;

(10) Calculations used to determine desired discount. Include data source; and

(11) Facility Director and Commander signatures of both facilities.

d. VA facilities must forward waiver requests through the VISN Director to the Medical Sharing Office (176). The Medical Sharing Office has 5 business days upon receipt to review and forward the request to the VA-DOD Financial Work Group (FMWG). The FMWG reviews the request and requests additional information if necessary. The FMWG must provide a decision within 30 calendar days from receipt of all pertinent information.

e. Joint Ventures and exempted co-located facilities may negotiate rates less than CMAC less 10 percent adjusting the rates to reflect the value of non-monetary contributions such as shared space or staff. ***NOTE:*** *Consult the Medical Sharing Office (176), for a current list of exempted facilities.*

f. Separate pharmacy rates and service charge fees must be established periodically.

g. The Health Care Financing Administration (HCFA) Form 1500 or Universal Billing (UB) 92s must be used for billing, generally, on a monthly basis. *VA's Financial Services Center strongly recommends use of the Intra-governmental Payment and Collection (IPAC) system whether sending or receiving payments and collections*.

(1) Quarterly billing is allowable for agreements involving low volume or costs. In agreements where each agency provides some service to the other, each facility must render the other a bill for the gross amount; the facility billing the lesser amount pays the difference.

(2) The medical center must ensure that both reimbursements earned and costs incurred are recorded in the gross amounts, before calculating the difference and the net payment due.

(3) Charges or payments need to be directed to the DOD component entering into the agreement.

(4) All bills must be signed by the appropriate VA official.

NOTE: *Billing procedures for regular VA-DOD agreements are described in M-1, Part 1, Chapter 15.*

h. The following revenue source codes apply to VA-DOD sharing agreements:

(1) **8014** - Non-medical sharing agreements; e.g., laundry, space, fire and police protection.

(2) **8017** - Sharing agreements for inpatient services; e.g., services which involve an overnight stay.

(3) **8018** - Sharing agreements for outpatient services; e.g., laboratory, physicals, etc.

(4) **8060** - This code is for retention of physicals and dental exams for Army Reserves performed under a FEDS_HEAL agreement. The FEDS_HEAL agreement may be extended in the future to include other Service Reserves as well as National Guard units.

i. Facilities must initially absorb the cost of providing reimbursable services for sharing agreements.

8. APPROVAL OF VA-DOD SHARING AGREEMENTS

a. **Approval Process.** The originator of the agreement (VA medical center, VISN, or organizational component) needs to submit one copy of the agreement to the Medical Sharing Office (176), VHA Central Office. ***NOTE:*** *Facilities need to follow VISN procedures regarding review of proposed agreements.* The Medical Sharing Office (176) must take action (approval or disapproval) on any proposed agreement within 45 days of receipt. If action is not communicated to the originator at the end of the 45-day period, the agreement is considered as approved on the 46th day. The Medical Sharing Office (176) must provide VISNs with copies of all approved local agreements affecting their respective regions.

b. **Renewals.** The Medical Sharing Office (176) must approve renewal proposals for all sharing agreements. Renewals may be written for up to 5 years.

c. **Amendments.** Amendments to existing agreements must be forwarded to the Medical Sharing Office (176) for approval. The same procedures described for initial agreements must be followed for amending agreements.

9. BILLING AND REIMBURSEMENTS FOR TRICARE CONTRACTS

a. **CMAC and/or DRG Rates.** CMAC and/or DRG reimbursement rates need to be used when negotiating with TRICARE contractors. ***NOTE:*** *CMAC rates are available at: http://www.tricare.osd.mil/ebc/rm_home/ubo_documents_rates_tables_cmac.cfm.*

(1) For DRG rates, VA medical centers are currently advised to submit bills to the contractor using “Reasonable and Customary (R&C)” rates.

(2) As long as local direct costs are met, rates may be negotiated with TRICARE contractors at the local, prevailing standard CMAC and/or DRG rates.

(3) Rates agreed to may also be higher or lower than the standard rates.

(4) Disclosure Statement. VHA facilities and VISNs must monitor actual costs and revenues to ensure that revenues exceed costs on an on-going basis and are valid business arrangements. A disclosure statement is required if full costs are not recovered; and the disclosure statement must include reasons for not charging full costs.

b. **Third-Parties’ Claims for Services.** Based on DOD policy, beneficiary out-of-pocket cost shares may not be waived for services provided by VA. VA medical centers and/or VISNs are responsible for third-party collection, collection of agreed upon deductibles and co-payments, and eligibility verification. If VA determines it will not be able to collect from a third-party insurer for a TRICARE beneficiary's care, the beneficiary normally is referred

through the TRICARE health care finder to a private provider who is able to collect from the third-party insurer. ***NOTE:*** *VA medical care appropriations should not subsidize TRICARE workload.*

c. **Revenue Source Codes.** The following revenue source codes need to be used for revenue generated under a TRICARE contract:

(1) **8028** - Medical services contracts for inpatient services, i.e., services which involve an overnight stay.

(2) **8029** - Medical services contracts for outpatient services, e.g., lab work, physicals, etc.

(3) **8030** – First-party pharmacy co-pays and deductibles paid by TRICARE patients.

d. **Forwarding TRICARE Claims.** Forward TRICARE claims to the appropriate TRICARE fiscal intermediary (FI) for processing. An electronic copy of VA's "TRICARE and VA Training Guide," which standardizes administrative and billing processes, can be downloaded from the Veterans Health Information and Technology Architecture (VistA) University web page at: http://vaww.vistau.med.va.gov/vistau/tricare.

(1) VA medical centers are responsible for ensuring that costs are covered and that the sharing agreements are valid business arrangements. Documentation of the cost analysis needs to be included in the contract file. TRICARE billing guidance may be found at: http://www.tricare.osd.mil/claims.

(2) Collections from TRICARE contractors are available in the fiscal year they are received.

10. APPROVAL OF TRICARE CONTRACTS

a. **Approval Process for New Contracts**

(1) The medical center or VISN is to send the unsigned contract to the Medical Sharing Office (176), VA Central Office, for final approval by the Under Secretary for Health, or designee. ***NOTE:*** *Local veterans service organizations must be consulted prior to forwarding the proposed contract to the Medical Sharing Office.*

(2) The Under Secretary for Health must approve all new TRICARE contracts.

(3) The Under Secretary for Health must certify to the Secretary of Veterans Affairs that agreements involving TRICARE beneficiaries will not result in the denial of, or delay in, providing access to care for any veteran at that facility.

(4) TRICARE contracts submitted from the VA medical center, or VISN Director, to the Medical Sharing Office (176), VA Central Office, for approval must be unsigned and include a statement that:

(a) Consultation with local veterans groups has been completed; and

(b) The contract will not result in the denial of, or delay in, providing care at that facility to veterans.

(5) After the Under Secretary for Health has approved the contract, the Medical Sharing Office (176), forwards the approved-proposed contract to the medical center Director, or VISN Director, for signature.

b. **Renewals, Modifications or Amendments.** Once approved, TRICARE contracts can be modified, extended, or amended without going through the formal approval process described in subparagraph 10a. However, modifications to existing contracts still need to be sent to the Medical Sharing Office (176), for review and approval.

11. SELECTING VA OR TRICARE BENEFITS

Some TRICARE beneficiaries may be eligible for both veterans and TRICARE benefits.

a. If a veteran is seeking care for a service connected condition in a VA medical facility, the veteran must receive that care under that veteran's benefits. VA may not bill TRICARE for treatment of a service connected condition.

b. If a veteran is seeking care for a non-service connected condition in a VA medical facility, the veteran may receive that care under either the veteran's benefits or TRICARE benefits. ***NOTE:*** *"TRICARE Training Guide," Appendix E, "VA/TRICARE Dual Eligibility" at http://vaww.vistau.med.va.gov/vistau/tricare.*

12. TRICARE FOR LIFE (TFL)

a. **TRICARE for Life (TFL).** Public Law 106-398 expanded TRICARE benefits to cover all military retirees, spouses, and survivors aged 65 and older who are eligible for Medicare Part A (for hospitalization payments) and enrolled in Medicare Part B.

b. **DOD's Policy for Care Provided at VA.** Medicare is not authorized to pay VA; therefore, DOD has a separate policy for payment for TFL services to VA medical facilities that is different from private sector providers.

(1) TFL-eligible DOD beneficiaries using VA medical facilities receive all TRICARE covered benefits.

(2) Beneficiaries choosing to utilize TFL benefits through VA providers must self-refer. TRICARE functions as first-payer for services and benefits covered by TRICARE.

(3) VA services provided through TFL are subject to cost-sharing requirements, such as annual deductibles and co-payments. Based on DOD policy, TFL beneficiary out-of-pocket cost shares may not be waived for services provided by VA.

(4) If the beneficiary has other health insurance (OHI), TRICARE is the second payer after OHI.

c. **Terms of TRICARE Reimbursement**

(1) VA health care facilities with TRICARE contracts (participating in TRICARE managed care networks) may be TFL providers, if space is available. TRICARE network discounts can only be applied when the discount arrangement specifically includes the TFL population. TRICARE reimburses these facilities at TRICARE "Extra" rates.

(2) Non-network VA facilities also may be TFL providers if they obtain an authorization statement from a TRICARE managed care support contractor. TRICARE reimburses non-network facilities at TRICARE "Standard" rates. The facility must bill OHI, if applicable, before billing TRICARE for covered services.

d. **Cost Sharing.** Both "Extra" and Standard" rates require significant cost-sharing on the part of the TFL. These amounts are subject to change. VA is responsible for collecting all TRICARE Extra or Standard co-payments and deductibles.

e. **Eligibility for VA Services**

(1) TFL beneficiaries, including non-veterans, may receive VA care if space is available. TFL beneficiaries (including dually eligible veterans) requesting to be seen as TFL beneficiaries must be honored upon verification of their enrollment in TRICARE.

(2) Medical facilities must provide information on current cost-sharing requirements for DOD beneficiaries considering utilizing TFL benefits at VA only at the time the potential TFL beneficiary first presents for care. This information is to include cost-sharing information for:

(a) TFL services provided by the private sector,

(b) TFL services that would be provided by VA facilities, and

(c) A veteran who is seen as a veteran by VA.

NOTE: *For additional information concerning TFL consult: http://www.tricare.osd.mil./ Cost-sharing information can be found at:http://www.tricare.osd.mil/tfl/matrix.html.*

13. JOINT VENTURES, CONSTRUCTION, AND EQUIPMENT

a. **Construction.** VHA officials must coordinate facilities' construction, alteration, or acquisition plans with their DOD counterparts with VA facilities located within 50 miles of a MTF and with a total construction expenditure request of $2,000,000 or more. This coordination is to determine if the VA facility or the MTF would be interested in sharing the new or renovated

facility. ***NOTE:*** *Economies of scale lead to more efficient use of Federal facilities at all levels of medical care.*

b. **Management**

(1) The "host" of a joint venture needs to focus on providing for the most acute or intense patient care needs. Management of the joint venture facility becomes less complex if the highest acuity patient care needs are taken care of first.

(2) Providing care for less sick patients can be done at marginal cost after the needs of the most acutely ill have been met.

NOTE: *Close attention needs to be paid to addressing potential management and administrative issues before they arise.*

c. **Coordination of Equipment Purchases.** VHA facilities must coordinate acquisition of major equipment in excess of $400,000 with MTFs within 50 miles in accordance with VA Acquisition Regulations (VAAR) Subpart 817.70. This coordination is to determine if the VA facility or the MTF has similar equipment, which can be shared or if the VA facility or MTF would be interested in sharing the equipment.

14. EDUCATION AND TRAINING AGREEMENTS

a. **Scope.** Military units and individuals (including Reserve and National Guard) may receive training and education at VA facilities, as part of their reserve assignments, provided no educational institution is involved and no academic credit is awarded. Students from a military-sponsored academic institution, such as from state-approved and accredited schools of practical nursing, medical technologists programs, and schools of nurse anesthesia, must use a Memorandum of Affiliation provided by VA's Office of Academic Affiliations, not a VA-DOD agreement. ***NOTE:*** *No VA stipend, fee, or salary may be provided to trainees under VA-DOD agreements.*

b. **Training Must Be Integrated in VA Care.** Agreements covered under this Handbook are only for training that is fully integrated into the VA medical system. The Office of Academic Affiliations (14) coordinates medical residents training involving military medical personnel separately. Training includes providing direct patient care, use of VA medical center classrooms, on-line courses or additional opportunities coordinated through the Employee Educational System (EES). Satellite programs may be available for viewing by both active duty and Reserve or National Guard medical personnel who are then eligible to receive continuing education credit for licensure through EES. Training courses may also be broadcast to DOD components throughout the world. Roles of military personnel are limited to those specified in the agreement. Competency and privileging activities of military personnel in VA medical facilities are under the direct supervision of VA staff designated by the VA medical center Director.

c. **Agreements with No Reimbursements to Either Party.** Education and training agreements with no reimbursement for services delivered are considered as in effect when signed by both parties at the local level, unless the parties entering into the agreement have indicated otherwise. Approval from the Medical Sharing Office (176) is not necessary; however, the agreements must be submitted to the Medical Sharing Office so that a current list of active agreements can be maintained.

d. **Responsibilities of the Medical Center Director.** The medical center Director is responsible for:

(1) Retaining full 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 facility.

(2) Reviewing and approving the education and training schedule provided by the military unit commander. This review includes verifying the licensure and certification of each active duty, Guard and reserve medical trainee for professional and/or technical qualifications and formal privileging of trainees by the usual VA health care facility mechanisms.

(3) Ensuring that military personnel have been informed of applicable rules and regulations with which they are expected to comply.

(4) Requiring the military unit commander to withdraw any trainee for unsatisfactory performance or behavior.

(5) Requiring the military unit commander to provide the names and qualifications of military supervisors assigned to work with VA staff.

e. **Meals and Quarters.** Under a separate agreement, VA may furnish meals, quarters, laundry services, and medical wearing apparel for trainees (see M-1, Pt. I, Ch. 2).

f. **Sharing Agreement Requirements.** The sharing agreement must include categories of health occupations, the numbers of trainees in each category, and a statement that the responsibilities described in subparagraph 14b have been fulfilled.