

# BASIC



# ELIGIBILITY

## **BLOCK 1 UNIT 2. BASIC ELIGIBILITY OBJECTIVES**

In this block of information the instructor will address the following objectives:

- Define and Review the Elements of Basic Eligibility
- Learn about Enrollment & Enrollment Priority Groups
- Outline the Medical Benefits Package
- Review Enrollment Processing

**BLOCK 1 UNIT 2. BASIC ELIGIBILITY**

Eligibility for VA health care is dependent upon a number of variables, which may influence the final enrollment determination. The basic factors will be reviewed in this unit.

**WHAT IS A VETERAN?**

A veteran is a person who served in the active military naval or air service and who was discharged or released under conditions other than dishonorable. They may be former Reservists having served full-time for operational or support purposes (excludes active or inactive duty for training) or former National Guard if mobilized by Federal order.

**Note:** Active Duty for training is full-time duty in the Armed Forces performed by Reserves for training purposes or, in the case of members of the National Guard, full-time duty under title 32.



**Reference:** 38 USC 1.101(1)&(21), Definitions.

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**Character of Discharge**

Once active duty status is confirmed, the character of discharge must be determined. There are two types of discharge that are acceptable (as long as the minimum duty requirements are met) and several others that may require additional development before an eligibility determination can be made. The discharge types are:

- Honorable
- General Under Honorable Conditions
- Other Than Honorable
- Dishonorable
- Uncharacterized

A discharge under honorable conditions is binding on VA so Honorable and General Under Honorable Conditions discharges are both acceptable discharge types. A Dishonorable discharge is a bar to VA benefits. An uncharacterized discharge is normally given to individuals with brief service (less than 180 days) or a void enlistment. Veterans given Other Than honorable (OTH) and those upgraded from OTH to a General discharge will require VARO review and decision before routine care may be provided. Urgent or emergent care may be provided, as needed. Send a VA Form 7131, Request for Administrative or Adjudicative Action to obtain an administrative decision from the Regional Office.

Once a decision is made on an OTH discharge, VARO will annotate HINQ and VIS with HVA (Honorable for VA purposes) or DVA (Dishonorable for VA purposes). It is a good idea to check HINQ or VIS prior to sending a VA Form 7131 as it is unnecessary if a decision was made previously on the Veteran's OTH discharge.

**References:** VHA Handbook 1601A.01, Intake Registration; VHA Handbook 1601A.03, Enrollment Determinations; CBO Procedure Guide 1601A, Eligibility and Enrollment; M21-1 Part IV, Chapter 11, "Special Determinations and Administrative Decisions; 38 CFR 3.12.

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### Minimum Duty Requirements

In addition to proper discharge type, Veterans must have met minimum duty requirements. Persons enlisted in the Armed Forces after 9/7/80 or who entered on active duty after 10/16/81, are not eligible for Veterans Health Administration (VHA) benefits unless they completed:

- 24 months continuous active Service or
- The full period for which they were called or ordered to active duty



Individuals who served prior to those two dates are only required to serve a single day.

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### Excluded From Minimum Duty Requirements

There are three exclusions from the minimum duty requirement. They are:

- **Early Out**
- **Hardship**
- **Disability**

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### Early Out

A discharge under 10 U.S.C. 1171, is an "early-out" discharge available to enlisted persons only (and not to officers), which must be granted within 90 days before the expiration of the term of enlistment or extended enlistment. Only the Army has a minimum 2-year period of enlistment. It is most important that the DD Form 214, Report of Separation from Active Duty, be reviewed very carefully to determine if a discharge under 10 U.S.C. 1171, has been granted when an Army veteran has less than 24 months active duty service.

The majority of Army discharges under 10 U.S.C. 1171, will have the narrative reason "Overseas Returnee" on the DD Form 214. If the individual served at least 21 months active duty and the narrative reason for separation on the DD Form 214 shows "Oversee Returnee," it will be accepted as proof of discharge under 10 U.S.C. 1171.

If an Army veteran served at least 21 months and any other narrative reason for separation (including one considered to be for the convenience of the Government) is shown on the discharge form, an inquiry to the regional office of jurisdiction will be initiated for a determination as to whether or not the separation was under 10 U.S.C. 1171. Other narrative reasons the Army may use for discharges under 10 U.S.C. 1171, include:

- Assignment to installation or unit scheduled for inactivation or permanent change of station;
- Separation from medical holding detachment/company;
- Physical disqualification for duty in MOS (Military Occupational Specialty);
- Acceptance into ROTC (Reserve Officer Training Corps) Program; and
- Secretarial authority.

**Note:** If an Army veteran served less than 21 months and none of the other exceptions listed above apply, the individual is not eligible for VA medical benefits.

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**Hardship**

Parenthood or Dependency may be considered a hardship depending upon the authority that separated the individual. The dependency is the critical factor - the need is to take care of a family member, or because of the burden of taking care of a child as a sole parent or service member with child married to another service member is causing a hardship to the extent is interfering with normal duties or assignment availability. Pregnancy, in itself, is not considered a hardship. Also, keep in mind that hardship is not always specified on the DD 214.

**Example:**

- For Branch of Service Army, **Chapter 5, AR 635-200** Parenthood or dependency **is not** an exception because it is a discharge for the convenience of the Government for an individual that is not complying with Army policies, rules and regulations.
- If discharge is under authority of **Chapter 6, AR 635-200**, Parenthood or Dependency **is** a hardship for Army Personnel.
- **AR 635-200 Chapter 8** dealing with separation for pregnancy does not fall under the purview of Title 10, Section 1173 justification **is not** considered an exception. An unwed service member or a service member that becomes pregnant is immediately given an option (choice) to either initiate a family care plan and remain in the service as a sole parent or service member with child married to another service member or to be discharged
  - If they elect the discharge, they are granted an honorable discharge.
  - If they don't meet the 24-month service requirement, they do not meet the requirements for VA health care.

**Note:** The problem HEC staff often encounter is the lack of an authority being placed on the DD 214 or the wording in the narrative reason varies. If you are not sure or if no authority is indicated, question the Veteran, give the benefit of doubt, explain the consequences and submit a 7131 to VARO for clarification.

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**Disability**

Individuals who are discharged with a disability that was incurred or aggravated in line of duty or veterans with compensable SC disability do not have to meet the minimum duty requirement.

**Reference:** 38 USC 5303A, Minimum active-duty service requirement.

***Proceed to Progress Check***

**BLOCK 1 UNIT 3. BENEFITS BEFORE AND AFTER ENROLLMENT****WHAT WERE THE BENEFITS AVAILABLE TO A VETERAN BEFORE ENROLLMENT SYSTEM?****Before Enrollment**

The benefits available to enrolled Veterans today are much different than the benefits available prior to establishing an enrollment system. Our system of benefits was more local. Eligibility determinations were made locally so, at times, Veterans were given different determinations at different locations. Hospitalization was the primary medical benefit for NSC Veterans prior to enrollment. Only SC Veterans were eligible for ongoing care, NSC Veterans could only get time-limited, condition-specific outpatient care related to their need for hospitalization.

Moreover, while no veterans were denied entry into the system, benefits were administered “by the benefit” meaning that a Veteran might get different benefits according to their location or the time they applied as budgets varied from year to year.



VA began to change in the 1980s in response to changes in medical practice – not all conditions required hospitalization so outpatient care for NSC Veterans was expanded slightly through the Ambulatory Care Program but it was still related to the need for hospitalization because that was the only authority available at the time. Also, benefits and practice changes were made in response to funding methodology changes such as the introduction of Diagnostic Related Groups (DRGs) and the Veterans Equitable Resource Allocation (VERA) funding model. VA no longer funded medical centers based on patient days of care and the number of outpatient visits but used these new models to fund based on the amount of medical care provided to each individual patient.



Outpatient care for NSC Veterans was gradually expanded during the late 1980s and early 1990s until eligibility reform was enacted.

**VA Health Care Enrollment**

The Veterans' Health Care Eligibility Reform Act of 1996 (PL 104-262) enacted 10/1/96, required that VA establish a system of enrollment using priority groups 1 through 7 with 1 being the highest. It took two years to fully develop a national enrollment system so Veterans under active care from October 1, 1996 through September 30, 1998 were automatically enrolled for VA health care benefits.

**Note:** VistA has been in existence longer than enrollment so there are records in the VistA system for Veterans that were entered prior to the start of enrollment in 1996. Veterans who were registered prior to October 1996 but have not been treated since that time are considered new applicants even though there is a record in VistA.

Enrollment changed how we do business in some very significant ways.



- ✓ Enrollment is national, not local. Although registration still occurs at medical centers, enrollment only occurs once the VistA registration record transmits to the Health Eligibility Center (HEC) in Atlanta.
- ✓ All enrolled Veterans have access to a standard medical benefits package to eliminate variation across locations and time. This also means that we now administer benefits “by the person” rather than “by the benefit.” Local restriction of certain benefits included in the benefits package is not allowed. If the system cannot handle the demand, the Secretary of Veterans Affairs has the authority to restrict enrollment.
- ✓ Once enrolled, always enrolled.

Enrolled Veterans have access to all benefits included in the medical benefits package except for a few limited benefits listed below.

**Medical Benefits Package**



- Preventive Care Services
- Inpatient and Outpatient Diagnostics and Treatment
- Prescription Services (as prescribed by VA Physician)
- Long Term Care

Geriatric Evaluations  
 Adult Day Health Care  
 Respite Care  
 Home Health Care  
 Hospice/Palliative care  
 Nursing Home Care (limited benefits)  
 Veterans 70% or greater SC have mandatory access  
 Domiciliary Care (limited benefits)



- Limited Benefits (limitations and additional qualifying factors apply)



- Ambulance Service
- Eyeglasses and Hearing Aids
- Non-VA Care
- Prosthetics, Durable Medical Equipment and Rehabilitative Devices
- Dental Care
- Certain Counseling Services
- VA Foreign Medical Program

- General Exclusions:



**Plastic Surgery**

- Abortions and abortion counseling
- In vitro fertilization
- Drugs and Medical Devices not approved by the FDA
- Certain Cosmetic Surgeries
- Health club or spa membership
- Special private duty nursing
- Gender alteration
- Medical care for prisoners or inmates

**Reference:** 38 CFR 17.38(c), Medical Benefits Package

**Proceed to Progress Check**

**BLOCK 1 UNIT 4. PRIORITY GROUPS AND ENROLLMENT**

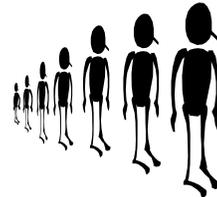
The enrollment system is managed by Priority Groups. By law, the Secretary of Veterans Affairs is required to review, on an annual basis, the patient enrollment system. The purpose of this review is to ensure that adequate resources are available to provide quality and timely health care to all enrolled veterans. When the demand for services exceeds VA's ability to provide such care, the Secretary is required to make enrollment adjustments.

**WHAT ARE THE CRITERIA FOR EACH PRIORITY GROUP?**

When a Veteran applies for health care, he/she is placed into one of eight priority groups. Priority Group 1 is the highest priority. Veterans eligible for more than one enrollment group are **always** placed in the highest priority group for which they qualify.

**Priority Groups****Priority Group 1** (The highest priority group)

- Rated service-connected disability is 50% or more
- Unemployable due to VA service-connection

**Priority Group 2**

- Rated service-connected disability is 30% or 40%

**Priority Group 3**

- Veterans who are Former Prisoners of War (POWs)
- Veterans awarded a Purple Heart medal
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with VA-rated service-connected disabilities 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"
- Veterans awarded the Medal of Honor

**Priority Group 4**

- Receiving aid and attendance or housebound benefits
- Determined by VA to be catastrophically disabled

**Priority Group 5**

- NSC and 0% Non-compensable SC veterans with income and net worth below established VA Means Test thresholds
- Veterans in receipt of VA pension benefits
- Veterans eligible for Medicaid benefits



**Priority Group 6**

- Compensable 0% service-connected veterans
- Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki
- Veterans exposed to the defoliant Agent Orange while serving in the Republic of Vietnam between 1962 and 1975
- Veterans of the Persian Gulf War that served between August 2, 1990 and November 11, 1998
- Project 112/SHAD participants
- Veterans who served in a theater of combat operations after November 11, 1998 as follows:



- Veterans discharged from active duty on or after January 28, 2003, who were enrolled as of January 28, 2008 and veterans who apply for enrollment after January 28, 2008, for 5 years post discharge
- Veterans discharged from active duty before January 28, 2003, who apply for enrollment after January 28, 2008, until January 27, 2011

**Priority Group 7**

- Veterans with income and/or net worth above the VA national income threshold and income below the geographic income threshold who agree to pay copays



**Note:** When the National Defense Authorization Act went into effect the sub-priorities for PG7 were discontinued.

**Priority Group 8**

- Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and the Geographic Means Test Income threshold
  - Sub-priority **a & b**: Noncompensable 0% SC veterans enrolled as of January 16, 2003 and who have remained enrolled since that date, continuous enrollment rules, or 10% expanded enrollment
  - Sub-priority **c & d**: NSC veterans enrolled as of January 16, 2003 and who have remained enrolled since that date, continuous enrollment rules, or 10% expanded enrollment



**Priority Group 8**

- Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and the Geographic Means Test Income threshold
  - Sub-priority **e**: Noncompensable 0% SC veterans applying for enrollment after January 16, 2003
  - Sub-priority **g**: NSC veterans applying for enrollment after January 16, 2003

**Reference:** 38 CFR 17.36(b), Categories of veterans eligible to be enrolled

Link to the Priority Group Fact Sheet:

<http://www.va.gov/healtheligibility/Library/pubs/EPG/EnrollmentPriorityGroups.pdf>



Effective January 17, 2003, VA published 38 CFR 17.36 which suspended NEW enrollment of NSC veterans whose household income exceeded the national means test threshold. This regulation also established a new Priority Group 7 and introduced the Geographic Means Test (GMT) Threshold. Veterans already enrolled prior to January 17, 2003, remained enrolled, only new applicants were subject to possible rejection.

NSC Veterans who household income exceeds the applicable means test threshold and the GMT threshold by more than 10% or Veterans who decline to provide household financial information are placed into Priority Group 8e or 8g and rejected for enrollment.

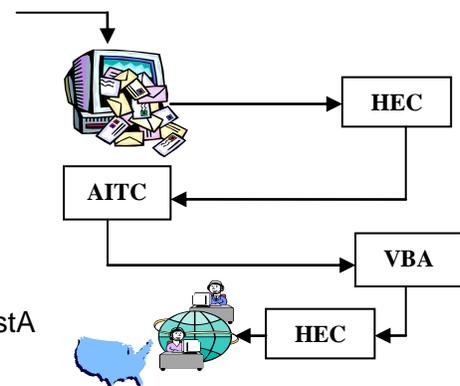
**HEC Enrollment Processing**



Unlike VistA where medical center and clinic users are connected directly to the local computer, VistA actions and changes are sent to the HEC via a messaging system, processed, and returned via messaging. No real-time processing is possible. For example, the process for an initial application is illustrated below:

Process initial application in VistA

- Transmits to HEC
- HEC queries IT Austin (AIRC)
- AIRC Austin queries VBA
- Information returned to HEC shared with VistA



**Note:** If VBA has no data on file HEC will use verified data from the site if it reflects 0% SC non-compensable or NSC.

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**Cancel/Decline**

Veterans may cancel or decline enrollment at any time. The Veteran must submit a signed and dated request on VA Form 119, Report of Contact. Veterans that cancel or decline enrollment who later seek to re-enroll must reapply for enrollment as new enrollee and are subject to the enrollment restriction which could result in rejection if their household income exceeds the applicable threshold.

Only HEC staff can process a request to cancel or decline enrollment. Once the cancel/decline is verified, HEC staff can override the enrollment status. HEC staff can also override enrollments that are incorrect in the system for certain reasons:

- Enrollment Rejection Overrides



- Proof of prior enrollment (before 1/17/03)
- Continuous Enrollment (CE rules are ignored by software if MT was edited MT CoPay Exempt or GMT CoPay Required)
- Proof of administrative error

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**Enrollment Notifications**

While it is the responsibility of the medical centers to notify applicants who are not eligible, HEC send written notification to Veterans of their enrollment or rejection along with benefits information and/or appeal rights, as appropriate. Below is a list of letters currently being used along with a link to the HEC web site where the actual text can be viewed.

- 600C Welcome Enrollment
- 600D Welcome Letter with Potential Pension Eligibility
- 604A GMT Letter
- 623A Rejected, Below EGT
- 623D Enrollment Reassessment
- 630D Purple Heart
- 164-16CC Creditable Coverage
- 641C One Time NDAA Notification
- 680B Notification to Reapply



Sample letters web site: <http://vaww4.va.gov/hec/Library/Letters/>

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**Eligibility Updates via HEC**

When registrations occur at medical facilities, the VistA record transmits to HEC. If all of the information in the record is complete, passes the consistency checks, and contains a valid eligibility verification, HEC’s computer will accept the record, place it in a ‘verified’ status, and retransmit the record to all sites that have seen that Veteran with the eligibility information locked.

Why is verified eligibility information locked down?

- Uniformity across the system
- Misinterpretations of proof of military service documents and administrative errors
- Responsible for performing a second level review of all eligibility
- Once verified by VAMC staff, HEC is responsible for all future updates

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**Contacting HEC**

When assistance is needed to update a record that is in a verified status or if help is needed to make an eligibility determination, contact HEC. There are several ways to contact HEC:

- **Methods**
  - Email to VHA HEC Alert mail group via Microsoft (MS) Outlook (always encrypt messages with PKI)



- Fax 404-828-5060  
Use the HEC Fax Coversheet to indicate what is being requested. The coversheet can be obtained at <http://vaww.va.gov/hec/Library/contact.asp> Be sure to attach any verifying documents such as DD214, DD215, WD AGO, official documentation, court orders, death certificates, etc.



- U.S. Postal Service (mail)  
2957 Clairmont Rd. NE, Suite 200  
Atlanta, GA 30329-1647

- Phone – for immediate assistance call HEC staff at 404-828-5257




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**Timing Eligibility Updates via HEC**

When a site emails or faxes a request to update eligibility/enrollment to HEC, the update should be seen in VistA within 2 business days.

The calculation or removal of a Combat End Date (CED) may take more than one day because the "routine" for the CED runs at midnight.

If HEC staff needs clarification on a request or are experiencing a system issue that keeps the record from updating or transmitting to VistA, the affected site will receive a phone call or email from HEC staff explaining situation.



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#### No Need to Contact HEC

When a site verifies eligibility on the "initial" visit of the veteran and the primary eligibility is 0% SC or NSC AND VBA's electronic data does not have the veteran receiving compensation or pension AND HEC has no "record" on this veteran, the HEC system will create an appropriate verified or rejected or pending enrollment record based on site's data. For Veterans in receipt of a VA monetary benefit (pension or SC disability compensation) HEC will update and verify based on the VBA record.

When a VAMC requests a HINQ, the system will simultaneously update VistA and HEC. So there is no need to send the HINQ to HEC for an update (we realize the bulletin that gets generated states to send it *but* you can ignore that particular one).

If the HINQ does not update VistA within 24 hours *then* site should send a request to HEC.



***(Proceed to Progress Check)***

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## PROGRESS CHECK

