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Medical

Book I

Title 38, Parts 17, 46, 47, 51–53,
58–64, 70, 71, and 200

Supplement No. 122

Covering period of *Federal Register* issues
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GENERAL INSTRUCTIONS

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Supplemental Materials for *Book I*

Code of Federal Regulations

Title 38, Parts 17, 46, 47, 51–53, 58–64, 70, 71, and 200

Medical

Supplement No. 122

5 July 2019

Covering the period of Federal Register issues
through July 1, 2019

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FILING INSTRUCTIONS

**Book I, Supplement No. 122
July 5, 2019**

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all prior supplements have been filed**

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HIGHLIGHTS

Book I, Supplement No. 122 July 5, 2019

Supplement Highlights references: Where substantive changes are made in the text of regulations, the paragraphs of *Highlights* sections are cited at the end of the relevant section of text. Thus, if you are reading §17.100, you will see a note at the end of that section which reads: “Supplement *Highlights* references—37(1).” This means that paragraph 1 of the *Highlights* section in Supplement No. 37 contains information about the changes made in §17.100. By keeping and filing the *Highlights* sections, you will have a reference source explaining all substantive changes in the text of the regulations.

Supplement frequency: Beginning 1 January 2000, supplements for this Book I will be issued *every month* during which a final rule addition or modification is made to the parts of Title 38 covered by this book. Supplements will be numbered consecutively as issued.

Modifications in this supplement include the following:

1. On 5 June 2019, the VA published a final rule effective 6 June 2019, to amend its regulations that govern VA health care. This final rule grants eligible veterans access to urgent care from qualifying non-VA entities or providers without prior approval from VA. This rulemaking implements the mandates of the VA MISSION Act of 2018 and increases veterans' ability to choose health care in the community. Changes:

- In §17.105, revised paragraph (c),
- In §17.108, revised paragraph (e),
- Added §17.4600.

2. On 5 June 2019, the VA published a final rule effective 6 June 2019, to amend its regulations that govern VA health care. This final rule grants eligible veterans access to urgent care from qualifying non-VA entities or providers without prior approval from VA. This rulemaking implements the mandates of the VA MISSION Act of 2018 and increases veterans' ability to choose health care in the community. Changes:

- In §17.38, revised paragraph (a)(1)(iv),
- In §17.46, revised paragraph (a),
- In §17.52, revised paragraph (c),
- Removed and Reserved §17.54,
- In §17.55, revised introductory text,
- In §17.56, added paragraph (e),
- In §17.108, revised paragraphs (b)(4) and (c)(4),
- In §17.110, revised paragraph (b)(4),
- In §17.111, revised paragraph (b)(3),
- In §17.1004, revised paragraph (b),
- Added §§17.4000 through 17.4040.

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- Authority:** 38 U.S.C. 501, and as noted in specific sections.
- Section 17.35 is also issued under 38 U.S.C. 1724
- Section 17.38 is also issued under 38 U.S.C. 1703.
- Section 17.46 is also issued under 38 U.S.C. 1710.
- Section 17.52 is also issued under 38 U.S.C. 1701, 1703, 1710, 1712, and 3104.
- Section 17.55 is also issued under 38 U.S.C. 513, 1703, and 1728.
- Section 17.56 is also issued under 38 U.S.C. 1703 and 1728.
- Section 17.105 is also issued under 38 U.S.C. 501, 1721, 1722A, 1724, and 1725A.
- Section 17.108 is also issued under 38 U.S.C. 501, 1703, 1710, 1725A, and 1730A.
- Section 17.110 is also issued under 38 U.S.C. 501, 1703, 1710, 1720D, 1722A, and 1730A.
- Section 17.111 is also issued under 38 U.S.C. 101(28), 501, 1701(7), 1703, 1710, 1710B, 1720B, 1720D, and 1722A.
- Section 17.125 is also issued under 38 U.S.C. 7304
- Section 17.169 is also issued under 38 U.S.C. 1712C.
- Sections 17.380, 17.390 and 17.412 are also issued under sec. 260, Pub. L. 114-223, 130 Stat. 857 and §236, div. J, Pub. L 115-141, 132 Stat. 348.
- Section 17.410 is also issued under 38 U.S.C. 1787.
- Section 17.415 is also issued under 38 U.S.C. 7301, 7304, 7402, and 7403.
- Sections 17.640 and 17.647 are also issued under sec. 4, Pub. L. 114-2, 129 Stat. 30.
- Sections 17.641 through 17.646 are also issued under 38 U.S.C. 501(a) and sec. 4, Pub. L. 114-2, 129 Stat. 30.
- Section 17.417 also issued under 38 U.S.C. 1701 (note), 1709A, 1712A (note), 1722B, 7301, 7330A, 7401-7403, 7406 (note).
- Section 17.655 also issued under 38 U.S.C. 501(a), 7304, 7405.
- Sections 17.4000 through 17.4040 also issued under 38 U.S.C. 1703, 1703B, and 1703C.
- Section 17.4100 et seq. is also issued under 38 U.S.C. 1703A.
- Section 17.4600 is also issued under 38 U.S.C. 1725A.
- Ed. Note:** Nomenclature changes to Part 17 appear at 61 FR 7216, Feb. 27, 1996

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§17.38 Medical benefits package.

(a) Subject to paragraphs (b) and (c) of this section, the following hospital, outpatient, and extended care services constitute the “medical benefits package” (basic care and preventive care):

(1) *Basic care.*

- (i) Outpatient medical, surgical, and mental healthcare, including care for substance abuse.
- (ii) Inpatient hospital, medical, surgical, and mental healthcare, including care for substance abuse.
- (iii) Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.
- (iv) Emergency care in VA facilities; and emergency care in non-VA facilities in accordance with sharing contracts or if authorized by §17.52(a)(3), §17.53, §17.54, §§17.120 through 17.132, or §§17.4000 through 17.4040.
- (v) Bereavement counseling as authorized in §17.98.
- (vi) Comprehensive rehabilitative services other than vocational services provided under 38 U.S.C. chapter 31.
- (vii) Consultation, professional counseling, marriage and family counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran or the individual in whose household the veteran certifies an intention to live, as necessary and appropriate, in connection with the veteran’s treatment.
- (viii) Durable medical equipment and prosthetic and orthotic devices, including eyeglasses and hearing aids as authorized under §17.149.
- (ix) Home health services authorized under 38 U.S.C. 1717 and 1720C.
- (x) Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.
- (xi) (A) Hospice care, palliative care, and institutional respite care; and
(B) Noninstitutional extended care services, including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care.
- (xii) Payment of beneficiary travel as authorized under 38 CFR part 70.
- (xiii) Pregnancy and delivery services, to the extent authorized by law.

- (xiv) Newborn care, post delivery, for a newborn child for the date of birth plus seven calendar days after the birth of the child when the birth mother is a woman veteran enrolled in VA health care and receiving maternity care furnished by VA or under authorization from VA and the child is delivered either in a VA facility, or in another facility pursuant to a VA authorization for maternity care at VA expense.
- (xv) Completion of forms (e.g., Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, non-VA disability program forms) by healthcare professionals based on an examination or knowledge of the veteran's condition, but not including the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

(2) *Preventive care, as defined in 38 U.S.C. 1701(9), which includes:*

- (i) Periodic medical exams.
- (ii) Health education, including nutrition education.
- (iii) Maintenance of drug-use profiles, drug monitoring, and drug use education.
- (iv) Mental health and substance abuse preventive services.
- (v) Immunizations against infectious disease.
- (vi) Prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature.
- (vii) Genetic counseling concerning inheritance of genetically determined diseases.
- (viii) Routine vision testing and eye-care services.
- (ix) Periodic reexamination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

(b) *Provision of the “medical benefits package”.* Care referred to in the “medical benefits package” will be provided to individuals only if it is determined by appropriate healthcare professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

(1) *Promote health.* Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment, and prevent future disease.

(2) *Preserve health.* Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.

(3) *Restoring health.* Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.

(c) In addition to the care specifically excluded from the “medical benefits package” under paragraphs (a) and (b) of this section, the “medical benefits package” does not include the following:

(1) Abortions and abortion counseling.

(2) In vitro fertilization. Note: See §17.380.

(3) Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

(4) Gender alterations.

(5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to veterans who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house).

(6) Membership in spas and health clubs. (Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1710A, 1721, 1722, 1782, 1786)

[64 FR 54217, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 73 FR 36798, June 30, 2008; 75 FR 54030, Sept. 3, 2010; 76 FR 11339, Mar. 2, 2011; 76 FR 78571, Dec. 19, 2011; 82 FR 6275, Jan. 19, 2017; 84 FR 26306, June 5, 2019]

Supplement *Highlights* references: 37(1). Book I, 9(1), 41(1), 57(1), 61(2), 66(1), 104(3), 122(2).

§17.39 Certain Filipino veterans.

(a) Any Filipino Commonwealth Army veteran, including one who was recognized by authority of the U.S. Army as belonging to organized Filipino guerilla forces, or any new Philippine Scout is eligible for hospital care, nursing home care, and outpatient medical services within the United States in the same manner and subject to the same terms and conditions as apply to U.S. veterans, if such veteran or scout resides in the United States and is a citizen or lawfully admitted to the United States for permanent residence. For purposes of these VA health care benefits, the standards described in 38 CFR 3.42(c) will be accepted as proof of U.S. citizenship or lawful permanent residence.

(b) Commonwealth Army Veterans, including those who were recognized by authority of the U.S. Army as belonging to organized Filipino guerilla forces, and new Philippine Scouts are not eligible for VA health care benefits if they do not meet the residency and citizenship requirements described in §3.42(c). (Authority: 38 U.S.C. 501, 1734)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0091.)

[67 FR 41179, June 17, 2002, as amended at 71 FR 6680, Feb. 9, 2006]

Supplement *Highlights* references: Book I, 10(1), 32(1).

§17.44 Hospital care for certain retirees with chronic disability (Executive Orders 10122, 10400 and 11733).

Hospital care may be furnished when beds are available to members or former members of the uniformed services (Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey, now National Oceanic and Atmospheric Administration hereinafter referred to as NOAA, and Public Health Service) temporarily or permanently retired for physical disability or receiving disability retirement pay who require hospital care for chronic diseases and who have no eligibility for hospital care under laws governing the Department of Veterans Affairs, or who having eligibility do not elect hospitalization as Department of Veterans Affairs beneficiaries. Care under this section is subject to the following conditions:

(a) Persons defined in this section who are members or former members of the active military, naval, or air service must agree to pay the subsistence rate set by the Secretary of Veterans Affairs, except that no subsistence charge will be made for those persons who are members or former members of the Public Health Service, Coast Guard, Coast and Geodetic Survey now NOAA, and enlisted personnel of the Army, Navy, Marine Corps, and Air Force.

(b) Under this section, the term chronic diseases shall include chronic arthritis, malignancy, psychiatric disorders, poliomyelitis with residuals, neurological disabilities, diseases of the nervous system, severe injuries to the nervous system, including quadriplegia, hemiplegia and paraplegia, tuberculosis, blindness and deafness requiring definitive rehabilitation, disability from major amputation, and other diseases as may be agreed upon from time to time by the Under Secretary for Health and designated officials of the Department of Defense and Department of Health and Human Services. For the purpose of this section, blindness is defined as corrected visual acuity of 20/200 or less in the better eye, or corrected central visual acuity of more than 20/200 if there is a field defect in which the peripheral field has contracted to such an extent that its widest diameter subtends the widest diameter of the field of the better eye at an angle no greater than 20°.

(c) In the case of persons who are former members of the Coast and Geodetic Survey, care may be furnished under this section even though their retirement for disability was from the Environmental Science Services Administration or NOAA.

[34 FR 9340, June 13, 1969, as amended at 39 FR 1841, Jan. 15, 1974; 47 FR 58247, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§17.45 Hospital care for research purposes.

Subject to §17.102(g), any person who is a bona fide volunteer may be admitted to a Department of Veterans Affairs hospital when the treatment to be rendered is part of an approved Department of Veterans Affairs research project and there are insufficient veteran-patients suitable for the project.

[35 FR 11470, July 17, 1970. Redesignated at 61 FR 21965, May 13, 1996; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights Reference*: 86(1).

**§17.46 Eligibility for hospital, domiciliary or nursing home care of persons
discharged or released from active military, naval, or air service.**

(a) In furnishing hospital care on or before June 6, 2019, under 38 U.S.C. 1710(a)(1), VA officials shall:

(1) If the veteran is in immediate need of hospitalization, furnish care at VA facility where the veteran applies or, if that facility is incapable of furnishing care, arrange to admit the veteran to the nearest VA medical center, or Department of Defense hospital with which VA has a sharing agreement under 38 U.S.C. 8111, which is capable of providing the needed care, or if VA or DOD facilities are not available, arrange for care on a contract basis if authorized by 38 U.S.C. 1703 and 38 CFR 17.52; or

(2) If the veteran needs non-immediate hospitalization, schedule the veteran for admission at VA facility where the veteran applies, if the schedule permits, or refer the veteran for admission or scheduling for admission at the nearest VA medical center, or Department of Defense facility with which VA has a sharing agreement under 38 U.S.C. 8111.

(b) Domiciliary care may be furnished when needed to:

(1) Any veteran whose annual income does not exceed the maximum annual rate of pension payable to a veteran in need of regular aid and attendance, or

(2) Any veteran who the Secretary determines had no adequate means of support. An additional requirement for eligibility for domiciliary care is the ability of the veteran to perform the following:

- (i) Perform without assistance daily ablutions, such as brushing teeth; bathing; combing hair; body eliminations.
- (ii) Dress self, with a minimum of assistance.
- (iii) Proceed to and return from the dining hall without aid.
- (iv) Feed Self.
- (v) Secure medical attention on an ambulatory basis or by use of personally propelled wheelchair.
- (vi) Have voluntary control over body eliminations or control by use of an appropriate prosthesis.
- (vii) Share in some measure, however slight, in the maintenance and operation of the facility.
- (viii) Make rational and competent decisions as to his or her desire to remain or leave the facility.

[24 FR 8328, Oct. 4, 1959, as amended at 30 FR 1787, Feb. 9, 1965; 32 FR 13813, Oct. 4, 1967; 34 FR 9340, June 13, 1969; 39 FR 1841, Jan. 15, 1974; 45 FR 6935, Jan. 31, 1980; 51 FR 25064, July 10, 1986; 52 FR 11259, Apr. 8, 1987; 53 FR 9627, Mar. 24, 1988; 53 FR 32391, Aug. 25, 1988; 56 FR 5757, Feb. 13, 1991. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 84 FR 26306, June 5, 2019]

Supplement *Highlights Reference*: 122(2).

Use of Public or Private Hospitals

§17.52 Hospital care and medical services in non-VA facilities.

(a) When VA facilities or other government facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing care or services required, VA may contract with non-VA facilities for care in accordance with the provisions of this section. When demand is only for infrequent use, individual authorizations may be used. Care in public or private facilities, however, subject to the provisions of §§17.53, 17.54, 17.55 and 17.56, will only be authorized, whether under a contract or an individual authorization, for:

(1) Hospital care or medical services to a veteran for the treatment of:

- (i) A service-connected disability; or
- (ii) A disability for which a veteran was discharged or released from the active military, naval, or air service or
- (iii) A disability of a veteran who has a total disability permanent in nature from a service-connected disability, or
- (iv) For a disability associated with and held to be aggravating a service-connected disability, or
- (v) For any disability of a veteran participating in a rehabilitation program under 38 U.S.C. ch. 31 and when there is a need for hospital care or medical services for any of the reasons enumerated in §17.47(i).

(2) Medical services for the treatment of any disability of:

- (i) A veteran who has a service-connected disability rated at 50 percent or more,
- (ii) A veteran who has been furnished hospital care, nursing home care, domiciliary care, or medical services, and requires medical services to complete treatment incident to such care or services (each authorization for non-VA treatment needed to complete treatment may continue for up to 12 months, and new authorizations may be issued by VA as needed), and
- (iii) A veteran of the Mexican border period or World War I or who is in receipt of increased pension or additional compensation based on the need for aid and attendance or housebound benefits when it has been determined based on an examination by a physician employed by VA (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in VA facilities;

(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care or medical services in a facility over which the Secretary has direct jurisdiction or government facility with which the Secretary contracts, and for which the facility is not staffed or equipped to perform. and transfer to a public or private hospital which has the necessary staff or equipment is the only

feasible means of providing the necessary treatment, until such time following the furnishing of care in the non-VA facility as the veteran can be safely transferred to a VA facility;

(4) Hospital care for women veterans;

(5) Through September 30, 1988, hospital care or medical services that will obviate the need for hospital admission for veterans in the Commonwealth of Puerto Rico, except that the dollar expenditure in Fiscal year 1986 cannot exceed 85% of the Fiscal year 1985 obligations, in Fiscal year 1987 the dollar expenditure cannot exceed 50% of the Fiscal year 1985 obligations and in Fiscal year 1988 the dollar expenditure cannot exceed 25% of the Fiscal year 1985 obligations.

(6) Hospital care or medical services that will obviate the need for hospital admission for veterans in Alaska, Hawaii, Virgin Islands and other territories of the United States except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense of VA in government and non-VA facilities in each such State or territory shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by VA within the 48 contiguous States.

(7) Outpatient dental services and treatment, and related dental appliances, for a veteran who is a former prisoner of war and was detained or interned for a period of not less than 181 days.

(8) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran which developed during authorized travel to the hospital, or during authorized travel after hospital discharge preventing completion of travel to the originally designated point of return (and this will encompass any other medical services necessitated by the emergency, including extra ambulance or other transportation which may also be furnished at VA expense.

(9) Diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent VA outpatient clinics to obviate the need for hospital admission.

(10) For any disability of a veteran receiving VA contract nursing home care. The veteran is receiving contract nursing home care and requires emergency treatment in non-VA facilities.

(11) For completion of evaluation for observation and examination (O&E) purposes, clinic directors or their designees will authorize necessary diagnostic services at non-VA facilities (on an inpatient or outpatient basis) in order to complete requests from VA Regional Offices for O&E of a person to determine eligibility for VA benefits or services.

(b) The Under Secretary for Health shall only furnish care and treatment under paragraph (a) of this section to veterans described in §17.47(d).

(1) To the extent that resources are available and are not otherwise required to assure that VA can furnish needed care and treatment to veterans described in §17.47(a) and (c), and

(2) If the veteran agrees to pay the United States an amount as determined under 38 U.S.C. 1710. (Authority: 38 U.S.C. 1703, 1710 and 1712; sec. 19011-19012, Pub. L. 99-272)

(c) The provisions of this section shall not apply to care furnished by VA after June 6, 2019.

[51 FR 25066, July 10, 1986, as amended at 53 FR 32391, Aug. 25, 1988; 54 FR 53057, Dec. 27, 1989; 58 FR 32446, June 10, 1993. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 75 FR 78915, Dec. 17, 2010; 77 FR 70895, Nov. 28, 2012; 78 FR 76063, Dec. 16, 2013; 79 FR 54615, Sep. 12, 2014; 84 FR 26306, June 5, 2019]

Supplement *Highlights* references: 59(1), 74(1), 83(1), 86(1), 122(2).

§17.53 Limitations on use of public or private hospitals.

The admission of any patient to a private or public hospital at Department of Veterans Affairs expense will only be authorized if a Department of Veterans Affairs medical center or other Federal facility to which the patient would otherwise be eligible for admission is not feasibly available. A Department of Veterans Affairs facility may be considered as not feasibly available when the urgency of the applicant's medical condition, the relative distance of the travel involved, or the nature of the treatment required makes it necessary or economically advisable to use public or private facilities. In those instances where care in public or private hospitals at Department of Veterans Affairs expense is authorized because a Department of Veterans Affairs or other Federal facility was not feasibly available, as defined in this section, the authorization will be continued after admission only for the period of time required to stabilize or improve the patient's condition to the extent that further care is no longer required to satisfy the purpose for which it was initiated.

[39 FR 17223, May 14, 1974, as amended at 47 FR 58248, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996]

§17.54 [Removed and Reserved].

§17.55 Payment for authorized public or private hospital care.

Except as otherwise provided in this section, payment for public or private hospital care furnished on or before June 6, 2019, under 38 U.S.C. 1703 and §17.52, or at any time under 38 U.S.C. 1728 and §§17.120 and 17.128 or under 38 U.S.C. 1787 and §17.410, shall be based on a prospective payment system similar to that used in the Medicare program for paying for similar inpatient hospital services in the community. Payment shall be made using the Centers for Medicare & Medicaid Services (CMS) PRICER for each diagnosis-related group (DRG) applicable to the episode of care.

(a) Payment shall be made of the full prospective payment amount per discharge, as determined according to the methodology in subparts D and G of 42 CFR part 412, as appropriate.

(b) (1) In the case of a veteran who was transferred to another facility before completion of care, VA shall pay the transferring hospital an amount calculated by the HCFA PRICER for each patient day of care, not to exceed the full DRG rate as provided in paragraph (a) of this section. The hospital that ultimately discharges the patient will receive the full DRG payment.

(2) In the case of a veteran who has transferred from a hospital and/or distinct part unit excluded by Medicare from the DRG-based prospective payment system or from a hospital that does not participate in Medicare, the transferring hospital will receive a payment for each patient day of care not to exceed the amount provided in paragraph (i) of this section.

(c) VA shall pay the providing facility the full DRG-based rate or reasonable cost, without regard to any copayments or deductible required by any Federal law that is not applicable to VA.

(d) If the cost or length of a veteran's care exceeds an applicable threshold amount, as determined by the HCFA PRICER program, VA shall pay, in addition to the amount payable under paragraph (a) of this section, an outlier payment calculated by the HCFA PRICER program, in accordance with subpart F of 42 CFR part 412.

(e) In addition to the amount payable under paragraph (a) of this section, VA shall pay, for each discharge, an amount to cover the non-Federal hospital's capital-related costs, kidney, heart and liver acquisition costs incurred by hospitals with approved transplantation centers, direct costs of medical education, and the costs of qualified nonphysician anesthetists in small rural hospitals. These amounts will be determined by the Under Secretary for Health on an annual basis and published in the "Notices" section of the *Federal Register*.

(f) Payment shall be made only for those services authorized by VA.

(g) Payments made in accordance with this section shall constitute payment in full and the provider or agent for the provider may not impose any additional charge on a veteran or his or her health care insurer for any inpatient services for which payment is made by the VA.

(h) Hospitals of distinct part hospital units excluded from the prospective payment system by Medicare and hospitals that do not participate in Medicare will be paid at the national cost-to-charge ratio times the billed charges that are reasonable, usual, customary, and not in excess of rates or fees the hospital charges the general public for similar services in the community.

(i) A hospital participating in an alternative payment system that has been granted a Federal waiver from the prospective payment system under the provisions of 42 U.S.C. section 1395f(b)(3) or 42 U.S.C. section 1395ww(c) for the purposes of Medicare payment shall not be subject to the payment methodology set forth in this section so long as such Federal waiver remains in effect.

(j) Payments for episodes of hospital care furnished in Alaska that begin during the period starting on the effective date of this section through the 364th day thereafter will be in the amount determined by the HCFA PRICER plus 50 percent of the difference between the amount billed by the hospital and the amount determined by the PRICER. Claims for services provided during that period will be accepted for payment by VA under this paragraph (k) until December 31 of the year following the year in which this section became effective.

(k) Notwithstanding other provisions of this section, VA, for public or private hospital care covered by this section, will pay the lesser of the amount determined under paragraphs (a) through (j) of this section or the amount negotiated with the hospital or its agent.

[55 FR 42852, Oct. 24, 1990. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 63 FR 39515, July 23, 1998; 65 FR 66637, Nov. 7, 2000; 84 FR 26306, June 5, 2019]

Supplement *Highlight* references: Book A–30(1); Book I–2(2), 122(2).

§17.56 VA payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care.

(a) Except for health care professional services provided in the state of Alaska (see paragraph (b) of this section) and except for non-contractual payments for home health services and hospice care, VA will determine the amounts paid under §§17.52 or 17.120 for health care professional services, and all other medical services associated with non-VA outpatient care, using the applicable method in this section:

(1) If a specific amount has been negotiated with a specific provider, VA will pay that amount.

(2) If an amount has not been negotiated under paragraph (a)(1) of this section, VA will pay the lowest of the following amounts:

(i) The applicable Medicare fee schedule or prospective payment system amount (“Medicare rate”) for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities), subject to the following:

(A) In the event of a Medicare waiver, the payment amount will be calculated in accordance with such waiver.

(B) In the absence of a Medicare rate or Medicare waiver, payment will be the VA Fee Schedule amount for the period in which the service was provided. The VA Fee Schedule amount is determined by the authorizing VA medical facility, which ranks all billings (if the facility has had at least eight billings) from non-VA facilities under the corresponding procedure code during the previous fiscal year, with billings ranked from the highest to the lowest. The VA Fee Schedule amount is the charge falling at the 75th percentile. If the authorizing facility has not had at least eight such billings, then this paragraph does not apply.

(ii) The amount negotiated by a repricing agent if the provider is participating within the repricing agent’s network and VA has a contract with that repricing agent. For the purposes of this section, repricing agent means a contractor that seeks to connect VA with discounted rates from non-VA providers as a result of existing contracts that the non-VA provider may have within the commercial health care industry.

(iii) The amount that the provider bills the general public for the same service.

(b) For physician and non-physician professional services rendered in Alaska, VA will pay for services in accordance with a fee schedule that uses the Health Insurance Portability and Accountability Act mandated national standard coding sets. VA will pay a specific amount for each service for which there is a corresponding code. Under the VA Alaska Fee Schedule, the amount paid in Alaska for each code will be 90 percent of the average amount VA actually paid in Alaska for the same services in Fiscal Year (FY) 2003. For services that VA provided less than eight times in Alaska in FY 2003, for services represented by codes established after FY 2003, and for unit-based codes prior to FY 2004, VA will take the Centers for Medicare and Medicaid Services’ rate for each code and multiply it times the average percentage paid by VA in Alaska for Centers for Medicare and Medicaid Services-like codes. VA will increase the amounts on the VA Alaska Fee Schedule annually in accordance with the published national Medicare

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Economic Index (MEI). For those years where the annual average is a negative percentage, the fee schedule will remain the same as the previous year. Payment for non-VA health care professional services in Alaska shall be the lesser of the amount billed or the amount calculated under this subpart.

(c) Payments made by VA to a non-VA facility or provider under this section shall be considered payment in full. Accordingly, the facility or provider or agent for the facility or provider may not impose any additional charge for any services for which payment is made by VA.

(d) In a case where a veteran has paid for emergency treatment for which VA may reimburse the veteran under §17.120, VA will reimburse the amount that the veteran actually paid. Any amounts due to the provider but unpaid by the veteran will be reimbursed to the provider under paragraphs (a) and (b) of this section. (Authority: 38 U.S.C. 1703, 1728)

(e) Except for payments for care furnished under 38 U.S.C. 1725 and §17.1005, under 38 U.S.C. 1728 and Sec. §17.120 and 17.128, or under 38 U.S.C. 1787 and §17.410, the provisions of this section shall not apply to care furnished by VA after June 6, 2019, or care furnished pursuant to an agreement authorized by 38 U.S.C. 1703A

[63 FR 39515, July 23, 1998, as amended at 65 FR 66637, Nov. 7, 2000; 70 FR 5927, Feb. 4, 2005; 75 FR 78915, Dec. 17, 2010; 84 FR 26306, June 5, 2019]

Supplement *Highlights* references: Book A–30(1). Book I–2(2), 26(1), 59(1), 122(2).

§17.104 Terminations and suspensions.

Any proposal to suspend or terminate collection action on any charges or claim for \$20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows;

(a) *Of charges for medical services.* If the debt represents charges made under §17.101 (a) or (b) questions concerning suspension or termination of collection action shall be referred to the Chief of the Fiscal activity of the station for application of the collection standards in §1.900, *et seq.* of this chapter, or

(b) *Of other debts.* If the debt is of a type other than those contemplated in paragraph (a) of this section, questions concerning suspension or termination of collection action shall be referred in accordance with the same referral procedures for compromise offers (except the Fiscal activity shall make final determinations in terminations or suspensions involving claims of \$150 or less pursuant to the provisions of §1.900, *et seq.* of this chapter.)

[34 FR 7807, May 16, 1969, as amended at 39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

§17.105 Waivers.

Applications or requests for waiver of debts or claims asserted by the Department of Veterans Affairs in connection with the medical program generally will be denied by the facility Fiscal activity on the basis there is no legal authority to waive debts, unless the question of waiver should be referred as follows:

(a) *Of charges for medical services.* If the debt represents charges made under §17.102, the application or request for waiver should be referred for disposition under §1.900, *et seq.* of this chapter to the field facility Committee on Waivers and Compromises which shall take final action, or

(b) *Of claims against third persons and other claims.* If the debt is of a type contemplated in §17.103(b), the waiver question should be referred in accordance with the same referral procedures for compromise offers in such categories of claims, or

(c) *Of charges for copayments.* If the debt represents charges for outpatient medical care, inpatient hospital care, medication or extended care services copayments made under §§17.108, 17.110, 17.111 or 17.4600 of this chapter, the claimant must request a waiver by submitting VA Form 5655 (Financial Status Report) to a Fiscal Officer at a VA medical facility where all or part of the debt was incurred. The claimant must submit this form within the time period provided in §1.963(b) of this chapter and may request a hearing under §1.966(a) of this chapter. The Fiscal Officer may extend the time period for submitting a claim if the Chairperson of the Committee on Waivers and Compromises could do so under §1.963(b) of this chapter. The Fiscal Officer will apply the standard “equity and good conscience” in accordance with §§1.965 and 1.966(a) of this chapter, and may waive all or part of the claimant’s debts. A decision by the Fiscal Officer under this provision is final (except that the decision may be reversed or modified based on new and material evidence, fraud, a change in law or interpretation of law, or clear and unmistakable error shown by the evidence in the file at the time of the prior decision as provided in §1.969 of this chapter) and may be appealed in accordance with 38 CFR parts 19 and 20.

(d) *Other debts.* If the debt represents any claim or charges other than those contemplated in paragraphs (a) and (b) of this section, and is a debt for which waiver has been specifically provided for by law or under the terms of a contract, initial action shall be taken at the station level for referral of the request for waiver through channels for action by the appropriate designated official. If, however, the question of waiver may also involve a concurrent opportunity to negotiate a compromise settlement, the application shall be referred to the Committee on Waivers and Compromises.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0165.)

[39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 69 FR 62204, Oct. 25, 2004; 84 FR 26017, June 5, 2019]

Supplement Highlights reference: 122(1).

Copayments

§17.108 Copayments for inpatient hospital care and outpatient medical care.

(a) *General.* This section sets forth requirements regarding copayments for inpatient hospital care and outpatient medical care provided to veterans by VA.

(b) *Copayments for inpatient hospital care.*

(1) Except as provided in paragraphs (d) or (e) of this section, a veteran, as a condition of receiving inpatient hospital care provided by VA (provided either directly by VA or obtained by VA by contract, provider agreement, or sharing agreement), must agree to pay VA (and is obligated to pay VA) the applicable copayment, as set forth in paragraph (b)(2), (b)(3), or (b)(4) of this section.

(2) The copayment for inpatient hospital care shall be, during any 365-day period, a copayment equaling the sum of:

(i) \$10 for every day the veteran receives inpatient hospital care, and

(ii) The lesser of:

(A) The sum of the inpatient Medicare deductible for the first 90 days of care and one-half of the inpatient Medicare deductible for each subsequent 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period, or

(B) VA's cost of providing the care.

(3) The copayment for inpatient hospital care for veterans enrolled in priority category 7 shall be 20 percent of the amount computed under paragraph (b)(2) of this section.

(4) For inpatient hospital care furnished through the Veterans Choice Program under §§17.1500 through 17.1540, or the Veterans Community Care Program under §§17.4000 through 17.4040, the copayment amount at the time of furnishing such care or services by a non-VA entity or provider is \$0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraphs (b)(2) or (3) of this section.

Note to §17.108(b): The requirement that a veteran agree to pay the copayment would be met by submitting to VA a signed VA Form 10-10EZ. This is the application form for enrollment in the VA healthcare system and also is the document used for providing means-test information annually.

(c) *Copayments for outpatient medical care.*

(1) Except as provided in paragraphs (d), (e), or (f) of this section, a veteran, as a condition for receiving outpatient medical care provided by VA (provided either directly by VA or obtained by VA by contract, provider agreement, or sharing agreement), must agree to pay VA (and is obligated to pay VA) a copayment as set forth in paragraph (c)(2) or (c)(4) of this section.

(2) The copayment for outpatient medical care is \$15 for a primary care outpatient visit and \$50 for a specialty care outpatient visit. If a veteran has more than one primary care encounter on the same day and no specialty care encounter on that day, the copayment amount is the copayment for one primary care outpatient visit. If a veteran has one or more primary care encounters and one or more specialty care encounters on the same day, the copayment amount is the copayment for one specialty care outpatient visit.

(3) For purposes of this section, a primary care visit is an episode of care furnished in a clinic that provides integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to, diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, and patient and caregiver education. Each patient's identified primary care clinician delivers services in the context of a larger interdisciplinary primary care team. Patients have access to the primary care clinician and much of the primary care team without need of a referral. In contrast, specialty care is generally provided through referral. A specialty care outpatient visit is an episode of care furnished in a clinic that does not provide primary care, and is only provided through a referral. Some examples of specialty care provided at a specialty care clinic are radiology services requiring the immediate presence of a physician, audiology, optometry, magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan, nuclear medicine studies, surgical consultative services, and ambulatory surgery.

(4) For outpatient medical care furnished through the Veterans Choice Program under §§17.1500 through 17.1540, or the Veterans Community Care Program under §§17.4000 through 17.4040, the copayment amount at the time of furnishing such care or services by a non-VA entity or provider is \$0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraph (c)(2) of this section.

Note to §17.108(c): The requirement that a veteran agree to pay the copayment would be met by submitting to VA a signed VA Form 10-10EZ. This is the application form for enrollment in the VA healthcare system and also is the document used for providing means-test information annually.

(d) *Veterans not subject to copayment requirements for inpatient hospital care or outpatient medical care.* The following veterans are not subject to the copayment requirements of this section:

- (1) A veteran with a compensable service-connected disability.
- (2) A veteran who is a former prisoner of war.
- (3) A veteran awarded a Purple Heart.
- (4) A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty.
- (5) A veteran who receives disability compensation under 38 U.S.C. 1151.
- (6) A veteran whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that the veteran's continuing eligibility for care is provided for in the judgment or settlement described in 38 U.S.C. 1151.

- (7) A veteran whose entitlement to disability compensation is suspended because of the receipt of military retirement pay.
- (8) A veteran of the Mexican border period or of World War I.
- (9) A military retiree provided care under an interagency agreement as defined in section 113 of Public Law 106-117, 113 Stat. 1545.
- (10) A veteran who VA determines to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a).
- (11) A veteran who VA determines to be catastrophically disabled, as defined in 38 CFR 17.36(e).
- (12) A veteran receiving care for psychosis or a mental illness other than psychosis pursuant to §17.109.
- (13) A veteran who was awarded the Medal of Honor.

(e) *Services not subject to copayment requirements for inpatient hospital care, outpatient medical care, or urgent care.* The following are not subject to the copayment requirements under this section or, except for §17.108(e)(1), (2), (4), (10), and (14), the copayment requirements under §17.4600:

- (1) Care provided to a veteran for a noncompensable zero percent service-connected disability;
- (2) Care authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Gulf War veterans, post-Gulf War combat-exposed veterans, or Camp Lejeune veterans pursuant to §17.400;
- (3) Special registry examinations (including any follow-up examinations or testing ordered as part of the special registry examination) offered by VA to evaluate possible health risks associated with military service;
- (4) Counseling and care for sexual trauma as authorized under 38 U.S.C 1720D;
- (5) Compensation and pension examinations requested by the Veterans Benefits Administration;
- (6) Care provided as part of a VA-approved research project authorized by 38 U.S.C. 7303;
- (7) Outpatient dental care provided under 38 U.S.C. 1712;
- (8) Readjustment counseling and related mental health services authorized under 38 U.S.C 1712A;
- (9) Emergency treatment paid for under 38 U.S.C. 1725 or 1728;
- (10) Care or services authorized under 38 U.S.C. 1720E for certain veterans regarding cancer of the head or neck;

- (11) Publicly announced VA public health initiatives (e.g., health fairs) or an outpatient visit solely consisting of preventive screening and immunizations (e.g. influenza immunization, pneumococcal immunization, hypertension screening, hepatitis C screening, tobacco screening, alcohol screening, hyperlipidemia screening, breast cancer screening, cervical cancer screening, screening for colorectal cancer by fecal occult blood testing, and education about the risks and benefits of prostate cancer screening);
- (12) Weight management counseling (individual and group);
- (13) Smoking cessation counseling (individual and group);
- (14) Laboratory services, flat film radiology services, and electrocardiograms;
- (15) Hospice care;
- (16) In-home video telehealth care; and
- (17) Mental health peer support services.

(f) *Additional care not subject to outpatient copayment.* Outpatient care is not subject to the outpatient copayment requirements under this section when provided to a veteran during a day for which the veteran is required to make a copayment for extended care services that were provided either directly by VA or obtained for VA by contract.

[66 FR 63448, Dec. 6, 2001, as amended at 66 FR 64904, Dec. 14, 2001; 67 FR 21998, May 2, 2002; 68 FR 60854, Oct. 24, 2003; 70 FR 22596, May 2, 2005; 71 FR 2464, Jan. 17, 2006; 73 FR 20532, Apr. 16, 2008; 73 FR 65260, Nov. 3, 2008; 75 FR 54030, Sept. 3, 2010; 76 FR 52274, Aug. 22, 2011; 77 FR 13198, Mar. 6, 2012; 78 FR 28143, May 14, 2013; 79 FR 57414, Sep. 24, 2014; 79 FR 65584, Nov. 5, 2014; 79 FR 70940, Nov. 28, 2014; 84 FR 7815, March 5, 2019; 84 FR 26017, June 5, 2019; 84 FR 26306, June 5, 2019]

Supplement *Highlights* references: 21(1), 27(1), 31(1), 40(1), 57(1), 64(1), 68(1), 77(1), 86(2), 88(2), 89(1), 120(1), 122(1), 122(2).

§17.110 Copayments for medication.

(a) *General.* This section sets forth requirements regarding copayments for medications provided to veterans by VA. For purposes of this section, the term “medication” means prescription and over-the-counter medications, as determined by the Food and Drug Administration (FDA), but does not mean medical supplies, oral nutritional supplements, or medical devices. Oral nutritional supplements are commercially prepared nutritionally enhanced products used to supplement the intake of individuals who cannot meet nutrient needs by diet alone.

(b) *Copayments.*

(1) *Copayment amount.* Unless exempted under paragraph (c) of this section, a veteran is obligated to pay VA a copayment for each 30-day or less supply of medication provided by VA on an outpatient basis (other than medication administered during treatment).

(i) For each 30-day or less supply of Tier 1 medications, the copayment amount is \$5.

(ii) For each 30-day or less supply of Tier 2 medications, the copayment amount is \$8.

(iii) For each 30-day or less supply of Tier 3 medications, the copayment amount is \$11.

Note to Paragraph (b)(1)(iii): Example for determining copayment amount. The ratio of the prescription drug component of the Medical Consumer Price Index for September 30, 2005, to the corresponding Index for September 30, 2001 (304.8) was 1.1542. This ratio, when multiplied by the original copayment amount of \$7 equals \$8.08, and the copayment amount beginning in calendar year 2006, rounded down to the whole dollar amount, was set at \$8.

(iv) For purposes of this section:

(A) *Multi-source medication* is any one of the following:

(1) A medication that has been and remains approved by the FDA--

(i) Under sections 505(b)(2) or 505(j) of the Food, Drug, and Cosmetic Act (FDCA, 21 U.S.C. 355), and that has been granted an A-rating in the current version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (the Orange Book); or

(ii) Under section 351(k) of the Public Health Service Act (PHSA, 42 U.S.C. 262), and that has been granted an I or B rating in the current version of the FDA's Lists of Licensed Biological Products with Reference Product Exclusivity and Biosimilarity or Interchangeability Evaluations (the Purple Book). FDA determines both therapeutic equivalence for drugs and interchangeability for biological products.

(2) A medication that--

(i) Has been and remains approved by the FDA pursuant to FDCA section 505(b)(1) or PHSA section 351(a);

(ii) Which is referenced by at least one FDA-approved product that meets the criteria of paragraph (b)(1)(iv)(A)(1) of this section; and

(iii) Which is covered by a contracting strategy in place with pricing such that it is lower in cost than other generic sources.

(3) A medication that--

(i) Has been and remains approved by the FDA pursuant to FDCA section 505(b)(1) or PHSA section 351(a); and

(ii) Has the same active ingredient or active ingredients, works in the same way and in a comparable amount of time, and is determined by VA to be substitutable for another medication that has been and remains approved by the FDA pursuant to FDCA section 505(b)(1) or PHSA section 351(a). This may include but is not limited to insulin and levothyroxine.

(4) A listed drug, as defined in 21 CFR 314.3, that has been approved under FDCA section 505(c) and is marketed, sold, or distributed directly or indirectly to retail class of trade with either labeling, packaging (other than repackaging as the listed drug in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trademark that differs from that of the listed drug.

(B) *Tier 1 medication* means a multi-source medication that has been identified using the process described in paragraph (b)(2) of this section.

(C) *Tier 2 medication* means a multi-source medication that is not identified using the process described in paragraph (b)(2) of this section.

(D) *Tier 3 medication* means a medication approved by the FDA under a New Drug Application (NDA) or a biological product approved by the FDA pursuant to a biologics license agreement (BLA) that retains its patent protection and exclusivity and is not a multi-source medication identified in paragraph (b)(1)(iv)(A)(3) or (4) of this section.

(2) *Determining Tier 1 medications.* Not less than once per year, VA will identify a subset of multi-source medications as Tier 1 medications using the criteria below. Only medications that meet all of the criteria in paragraphs (b)(2)(i), (ii), and (iii) will be eligible to be considered Tier 1 medications, and only those medications that meet all of the criteria in paragraph (b)(2)(i) of this section will be assessed using the criteria in paragraphs (b)(2)(ii) and (iii).

(i) A medication must meet all of the following criteria:

(A) The VA acquisition cost for the medication is less than or equal to \$10 for a 30-day supply of medication;

(B) The medication is not a topical cream, a product used to treat musculoskeletal conditions, an antihistamine, or a steroid-containing medication;

(C) The medication is available on the VA National Formulary;

(D) The medication is not an antibiotic that is primarily used for short periods of time to treat infections; and

(E) The medication primarily is used to either treat or manage a chronic condition, or to reduce the risk of adverse health outcomes secondary to the chronic condition, for example, medications used to treat high blood pressure to reduce the risks of heart attack, stroke, and kidney failure. For purposes of this section, conditions that typically are known to persist for 3 months or more will be considered chronic.

(ii) The medication must be among the top 75 most commonly prescribed multi-source medications that meet the criteria in paragraph (b)(2)(i) of this section, based on the number of prescriptions issued for a 30-day or less supply on an outpatient basis during a fixed period of time.

(iii) VA must determine that the medication identified provides maximum clinical value consistent with budgetary resources.

(3) Information on Tier 1 medications. Not less than once per year, VA will publish a list of Tier 1 medications in the *Federal Register* and on VA's Web site at www.va.gov/health.

(4) *Veterans Choice Program*. For medications furnished through the Veterans Choice Program under §§17.1500 through 17.1540, or the Veterans Community Care Program under §§17.4000 through 17.4040, the copayment amount at the time the veteran fills the prescription is \$0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraphs (b)(1)(i) through (iii) of this section

(5) *Copayment cap*. The total amount of copayments for medications in a calendar year for an enrolled veteran will not exceed \$700.

(c) *Medication not subject to the copayment requirements*. The following are exempt from the copayment requirements of this section:

(1) Medication for a veteran who has a service-connected disability rated 50% or more based on a service-connected disability or unemployability.

(2) Medication for a veteran's service-connected disability.

(3) Medication for a veteran whose annual income (as determined under 38 U.S.C. 1503) does not exceed the maximum annual rate of VA pension which would be payable to such veteran if such veteran were eligible for pension under 38 U.S.C. 1521.

- (4) Medication authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Persian Gulf War veterans, post-Persian Gulf War combat-exposed veterans, or Camp Lejeune veterans pursuant to §17.400.
- (5) Medication for treatment of sexual trauma as authorized under 38 U.S.C. 1720D.
- (6) Medication for treatment of cancer of the head or neck authorized under 38 U.S.C. 1720E.
- (7) Medications provided as part of a VA approved research project authorized by 38 U.S.C. 7303.
- (8) Medication for a veteran who is a former prisoner of war.
- (9) A veteran who VA determines to be catastrophically disabled, as defined in 38 CFR 17.36(e).
- (10) A veteran receiving care for psychosis or a mental illness other than psychosis pursuant to §17.109.
- (11) Medication for a veteran who was awarded the Medal of Honor.

[66 FR 63451, Dec. 6, 2001, as amended at 74 FR 69285, Dec. 31, 2009; 75 FR 32670, June 9, 2010; 75 FR 32672, June 9, 2010; 75 FR 54030, Sept. 3, 2010; 76 FR 9646, Feb. 22, 2011; 76 FR 52274, Aug. 22, 2011; 76 FR 78826, Dec. 20, 2011; 77 FR 76867, Dec. 31, 2012; 78 FR 28143, May 14, 2013; 78 FR 30768, May 23, 2013; 78 FR 79317, Dec. 30, 2013; 79 FR 57414, Sep. 24, 2014; 79 FR 63821, Oct. 27, 2014; 79 FR 65585, Nov. 5, 2014; 81 FR 88120, Dec. 7, 2016; 81 FR 88120, Dec. 7, 2016; 81 FR 89390, Dec. 12, 2016; 84 FR 7815, March 5, 2019; 84 FR 26306, June 5, 2019]

Supplement *Highlights* references: 53(1), 55(1), 57(1), 64(1), 66(2), 74(4), 77(1), 83(3), 86(2), 87(1), 88(2), 103(1), 104(1), 102(1), 122(2).

§17.111 Copayments for Extended care services.

(a) *General.* This section sets forth requirements regarding copayments for extended care services provided to veterans by VA (either directly by VA or paid for by VA).

(b) *Copayments.*

(1) Unless exempted under paragraph (f) of this section, as a condition of receiving extended care services from VA, a veteran must agree to pay VA and is obligated to pay VA a copayment as specified by this section. A veteran has no obligation to pay a copayment for the first 21 days of extended care services that VA provided the veteran in any 12-month period (the 12-month period begins on the date that VA first provided extended care services to the veteran). However, for each day that extended care services are provided beyond the first 21 days, a veteran is obligated to pay VA the copayment amount set forth below to the extent the veteran has available resources. Available resources are based on monthly calculations, as determined under paragraph (d) of this section. The following sets forth the extended care services provided by VA and the corresponding copayment amount per day:

- (i) Adult day health care—\$15.
- (ii) Domiciliary care—\$5.
- (iii) Institutional respite care—\$97.
- (iv) Institutional geriatric evaluation—\$97.
- (v) Non-institutional geriatric evaluation—\$15.
- (vi) Non-institutional respite care—\$15.
- (vii) Nursing home care—\$97.

(2) For purposes of counting the number of days for which a veteran is obligated to make a copayment under this section, VA will count each day that adult day health care, non-institutional geriatric evaluation, and non-institutional respite care are provided and will count each full day and partial day for each inpatient stay except for the day of discharge.

(3) For hospital care and medical services considered non-institutional care furnished through the Veterans Choice Program under §§17.1500 through 17.1540, as well as extended care services furnished through the Veterans Community Care Program under §§17.4000 through 17.4040, the copayment amount at the time of furnishing such care or services by a non-VA entity or provider is \$0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraphs (b)(1) or (2) of this section.

(c) *Definitions.* For purposes of this section:

(1) *Adult day health care* is a therapeutic outpatient care program that provides medical services, rehabilitation, therapeutic activities, socialization, nutrition and transportation services to disabled veterans in a congregate setting.

(2) *Domiciliary care* is defined in §17.30(b).

(3) *Extended care services* means adult day health care, domiciliary care, institutional geriatric evaluation, noninstitutional geriatric evaluation, nursing home care, institutional respite care, and noninstitutional respite care.

(4) *Geriatric evaluation* is a specialized, diagnostic/consultative service provided by an interdisciplinary team that is for the purpose of providing a comprehensive assessment, care plan, and extended care service recommendations.

(5) *Institutional* means a setting in a hospital, domiciliary, or nursing home of overnight stays of one or more days.

(6) *Noninstitutional* means a service that does not include an overnight stay.

(7) *Nursing home care* means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care (nursing services must be provided 24 hours a day). Such term includes services furnished in skilled nursing care facilities. Such term excludes hospice care.

(8) *Respite care* means care which is of limited duration, is furnished on an intermittent basis to a veteran who is suffering from a chronic illness and who resides primarily at home, and is furnished for the purpose of helping the veteran to continue residing primarily at home. (Respite providers temporarily replace the caregivers to provide services ranging from supervision to skilled care needs.)

(d) *Effect of the veteran's financial resources on obligation to pay copayment.*

(1) A veteran is obligated to pay the copayment to the extent the veteran and the veteran's spouse have available resources. For veterans who have been receiving extended care services for 180 days or less, their available resources are the sum of the income of the veteran and the veteran's spouse, minus the sum of the veterans allowance, the spousal allowance, and expenses. For veterans who have been receiving extended care services for 181 days or more, their available resources are the sum of the value of the liquid assets, the fixed assets, and the income of the veteran and the veteran's spouse, minus the sum of the veterans allowance, the spousal allowance, the spousal resource protection amount, and (but only if the veteran—has a spouse or dependents residing in the community who is not institutionalized) expenses. When a

veteran is legally separated from a spouse, available resources do not include spousal income, expenses, and assets or a spousal allowance.

(2) For purposes of determining available resources under this section:

(i) *Income* means current income (including, but not limited to, wages and income from a business (minus business expenses), bonuses, tips, severance pay, accrued benefits, cash gifts, inheritance amounts, interest income, standard dividend income from non tax deferred annuities, retirement income, pension income, unemployment payments, worker's compensation payments, black lung payments, tort settlement payments, social security payments, court mandated payments, payments from VA or any other Federal programs, and any other income). The amount of current income will be stated in frequency of receipt, *e.g.*, per week, per month.

(ii) *Expenses* means basic subsistence expenses, including current expenses for the following: rent/mortgage for primary residence; vehicle payment for one vehicle; food for veteran, veteran's spouse, and veteran's dependents; education for veteran, veteran's spouse, and veteran's dependents; court-ordered payments of veteran or veteran's spouse (*e.g.*, alimony, child-support); and including the average monthly expenses during the past year for the following: utilities and insurance for the primary residence; out-of-pocket medical care costs not otherwise covered by health insurance; health insurance premiums for the veteran, veteran's spouse, and veteran's dependents; and taxes paid on income and personal property.

(iii) *Fixed Assets* means:

(A) Real property and other non-liquid assets; except that this does not include:

(1) Burial plots;

(2) A residence if the residence is:

(i) The primary residence of the veteran and the veteran is receiving only noninstitutional extended care service; or

(ii) The primary residence of the veteran's spouse or the veteran's dependents (if the veteran does not have a spouse) if the veteran is receiving institutional extended care service.

(3) A vehicle if the vehicle is:

(i) The vehicle of the veteran and the veteran is receiving only noninstitutional extended care service; or

(ii) The vehicle of the veteran's spouse or the veteran's dependents (if the veteran does not have a spouse) if the veteran is receiving institutional extended care service.

(B) [Reserved]

(iv) *Liquid assets* means cash, stocks, dividends received from IRA, 401K's and other tax deferred annuities, bonds, mutual funds, retirement accounts (*e.g.*, IRA, 401Ks, annuities), art, rare coins, stamp collections, and collectibles of the veteran, spouse, and dependents. This includes household and personal items (*e.g.*, furniture, clothing, and jewelry) except when the veteran's spouse or dependents are living in the community.

(v) *Spousal allowance* is an allowance of \$20 per day that is included only if the spouse resides in the community (not institutionalized).

(vi) *Spousal resource protection* amount means the value of liquid assets but not to exceed \$89,280 if the spouse is residing in the community (not institutionalized).

(vii) *Veterans allowance* is an allowance of \$20 per day.

(3) The maximum amount of a copayment for any month equals the copayment amount specified in paragraph (b)(1) of this section multiplied by the number of days in the month. The copayment for any month may be less than the amount specified in paragraph (b)(1) of this section if the veteran provides information in accordance with this section to establish that the copayment should be reduced or eliminated.

(e) *Requirement to submit information.*

(1) Unless exempted under paragraph (f) of this section, a veteran must submit to a VA medical facility a completed VA Form 10-10EC and documentation requested by the Form at the following times:

(i) At the time of initial request for an episode of extended care services;

(ii) At the time of request for extended care services after a break in provision of extended care services for more than 30 days; and

(iii) Each year at the time of submission to VA of VA Form 10-10EZ.

(2) When there are changes that might change the copayment obligation (*i.e.*, changes regarding marital status, fixed assets, liquid assets, expenses, income (when received), or whether the veteran has a spouse or dependents residing in the community), the veteran must report those changes to a VA medical facility within 10 days of the change.

(f) *Veterans and care that are not subject to the copayment requirements.* The following veterans and care are not subject to the copayment requirements of this section:

(1) A veteran with a compensable service-connected disability.

(2) A veteran whose annual income (determined under 38 U.S.C. 1503) is less than the amount in effect under 38 U.S.C. 1521(b).

(3) Care for a veteran's noncompensable zero percent service-connected disability.

(4) An episode of extended care services that began on or before November 30, 1999.

(5) Care authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Persian Gulf War veterans, post-Persian Gulf War combat-exposed veterans, or Camp Lejeune veterans pursuant to §17.400.

(6) Care for treatment of sexual trauma as authorized under 38 U.S.C. 1720D.

(7) Care or services authorized under 38 U.S.C. 1720E for certain veterans regarding cancer of the head or neck.

(8) A veteran who VA determines to be catastrophically disabled, as defined in 38 CFR 17.36(e), is exempt from copayments for adult day health care, non-institutional respite care, and non-institutional geriatric care.

(9) A veteran receiving care for psychosis or a mental illness other than psychosis pursuant to §17.109.

(10) A veteran who was awarded the Medal of Honor.

(g) VA Form 10-10EC.

[Note: Form 10-10EC will be found on the next three pages.]

[67 FR 35040, May 17, 2002, as amended at 69 FR 39846, July 1, 2004; 76 FR 52274, Aug. 22, 2011; 78 FR 28143, May 14, 2013; 79 FR 57414, Sep. 24, 2014; 79 FR 65585, Nov. 5, 2014; 84 FR 7815, March 5, 2019; 84 FR 26307, June 5, 2019]

Supplement *Highlights* references: 9(1), 24(1), 64(1), 77(1), 86(2), 88(2), 120(1), 122(2).

Application for Extended Services, VAF 10-10EC:

<http://www.va.gov/vaforms/medical/pdf/10-10EC.pdf>

§17.1003 Emergency transportation.

Notwithstanding the provisions of §17.1002, payment or reimbursement under 38 U.S.C. 1725 for ambulance services, including air ambulance services, may be made for transporting a veteran to a facility only if the following conditions are met:

(a) Payment or reimbursement is authorized under 38 U.S.C. 1725 for emergency treatment provided at a non-VA facility, or payment or reimbursement would have been authorized under 38 U.S.C. 1725 for emergency treatment had:

(1) The veteran's personal liability for the emergency treatment not been fully extinguished by payment by a third party, including under a health-plan contract; or

(2) Death had not occurred before emergency treatment could be provided;

(b) The veteran is financially liable to the provider of the emergency transportation;

(c) The veteran does not have coverage under a health-plan contract that would fully extinguish the medical liability for the emergency transportation (this condition is not met if the veteran has coverage under a health-plan contract but payment is barred because of a failure by the veteran or the provider to comply with the provisions of that health-plan contract);

(d) If the condition for which the emergency transportation was furnished was caused by an accident or work-related injury, the claimant has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such transportation; and the veteran has no contractual or legal recourse against a third party that could reasonably be pursued for the purpose of fully extinguishing the veteran's liability to the provider; and

(e) If the veteran is not eligible for reimbursement for any emergency treatment expenses under 38 U.S.C. 1728.

[66 FR 36470, July 12, 2001, as amended at 83 FR 979, Jan. 9, 2018]

Supplement *Highlights* reference: 113(1).

§17.1004 Filing claims.

(a) A claimant for payment or reimbursement under 38 U.S.C. 1725 must be the entity that furnished the treatment, the veteran who paid for the treatment, or the person or organization that paid for such treatment on behalf of the veteran.

(b) To obtain payment or reimbursement for emergency treatment under 38 U.S.C. 1725, a claimant must submit to the VA medical facility of jurisdiction a completed standard billing form (such as a UB92 or a CMS 1500). The completed form must also be accompanied by a signed, written statement declaring that “I hereby certify that this claim meets all of the conditions for payment by VA for emergency medical services under 38 CFR 17.1002 and 17.1003. I am aware that 38 U.S.C. 6102(b) provides that one who obtains payment without being entitled to it and with intent to defraud the United States shall be fined in accordance with title 18, United States Code, or imprisoned not more than one year, or both.”

Note to §17.1004(b): These regulations regarding payment or reimbursement for emergency services for nonservice-connected conditions in non-VA facilities also can be found on the internet at <http://www.va.gov/health/elig>.

(c) Notwithstanding the provisions of paragraph (b) of this section, no specific form is required for a claimant (or duly authorized representative) to claim payment or reimbursement for emergency transportation charges under 38 U.S.C. 1725. The claimant need only submit a signed and dated request for such payment or reimbursement to the VA medical facility of jurisdiction, together with a bill showing the services provided and charges for which the veteran is personally liable and a signed statement explaining who requested such transportation services and why they were necessary.

(d) To receive payment or reimbursement for emergency services, a claimant must file a claim within 90 days after the latest of the following:

- (1) The date that the veteran was discharged from the facility that furnished the emergency treatment;
- (2) The date of death, but only if the death occurred during transportation to a facility for emergency treatment or if the death occurred during the stay in the facility that included the provision of the emergency treatment; or
- (3) The date the veteran finally exhausted, without success, action to obtain payment or reimbursement for the treatment from a third party.

(e) If after reviewing a claim the decisionmaker determines that additional information is needed to make a determination regarding the claim, such official will contact the claimant in writing and request additional information. The additional information must be submitted to the decisionmaker within 30 days of receipt of the request or the claim will be treated as abandoned, except that if the claimant within the 30-day period requests in writing additional time, the time period for submission of the information may be extended as reasonably necessary for the requested information to be obtained.

(f) Notwithstanding paragraph (d) of this section, VA will provide retroactive payment or reimbursement for emergency treatment received by the veteran on or after July 19, 2001, but more than 90 days before May 21, 2012, if the claimant files a claim for reimbursement no later than 1 year after May 21, 2012.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0620.)

[66 FR 36470, July 12, 2001, as amended at 77 FR 23617, Apr. 20, 2012; 84 FR 26307, June 5, 2019]

Supplement *Highlights* references: 69(1), 122(2).

§17.1005 Payment limitations.

(a) Payment or reimbursement for emergency treatment (including emergency transportation) under 38 U.S.C. 1725 will be calculated as follows:

(1) If an eligible veteran has personal liability to a provider of emergency treatment and no contractual or legal recourse against a third party, including under a health-plan contract, VA will pay the lesser of the amount for which the veteran is personally liable or 70 percent of the applicable Medicare fee schedule amount for such treatment.

(2) If an eligible veteran has personal liability to a provider of emergency treatment after payment by a third party, including under a health-plan contract, VA will pay:

(i) The difference between the amount VA would have paid under paragraph (a)(1) of this section for the cost of the emergency treatment and the amount paid (or payable) by the third party, if that amount would be greater than zero, or;

(ii) If applying paragraph (a)(2)(i) of this section would result in no payment by VA, the lesser of the veteran's remaining personal liability after such third-party payment or 70 percent of the applicable Medicare fee schedule amount for such treatment.

(3) In the absence of a Medicare fee schedule rate for the emergency treatment, VA payment will be the lesser of the amount for which the veteran is personally liable or the amount calculated by the VA Fee Schedule in Sec. 17.56 (a)(2)(i)(B).

(4) Unless rejected and refunded by the provider within 30 days from the date of receipt, the provider will consider VA's payment made under paragraphs (a)(1), (a)(2), or (a)(3) of this section as payment in full and extinguish the veteran's liability to the provider. (Neither the absence of a contract or agreement between the Secretary and the provider nor any provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate the requirement in the preceding sentence.)

(5) VA will not reimburse a veteran under this section for any copayment, deductible, coinsurance, or similar payment that the veteran owes the third party or is obligated to pay under a health-plan contract.

(b) Except as provided in paragraph (c) of this section, VA will not approve claims for payment or reimbursement of the costs of emergency treatment not previously authorized for any period beyond the date on which the medical emergency ended. For this purpose, VA considers that an emergency ends when the designated VA clinician at the VA facility has determined that, based on sound medical judgment, a veteran who received emergency treatment:

(1) Could have been transferred from the non-VA facility to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment, or

(2) Could have reported to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment.

Veterans Community Care Program**§17.4000 Purpose and scope**

(a) *Purpose.* Sections 17.4000 through 17.4040 implement the Veterans Community Care Program, authorized by 38 U.S.C. 1703.

(b) *Scope.* The Veterans Community Care Program establishes when a covered veteran may elect to have VA authorize an episode of care for hospital care, medical services, or extended care services from an eligible entity or provider. Sections 17.4000 through 17.4040 do not affect eligibility for non-VA care under sections 1724, 1725, 1725A, or 1728 of title 38, United States Code.

[84 FR 26307, June 5, 2019]

Supplement *Highlights* references: 122(2).

§17.4005 Definitions

For purposes of the Veterans Community Care Program under §§17.4000 through 17.4040:

Appointment means an authorized and scheduled encounter, including telehealth and same-day encounters, with a health care provider for the delivery of hospital care, medical services, or extended care services.

Covered veteran means a veteran enrolled under the system of patient enrollment in §17.36, or a veteran who otherwise meets the criteria to receive care and services notwithstanding his or her failure to enroll in §17.37(a) through (c).

Eligible entity or provider means a health care entity or provider that meets the requirements of §17.4030.

Episode of care means a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than 1 calendar year.

Extended care services include the same services as described in 38 U.S.C. 1710B(a).

Full-service VA medical facility means a VA medical facility that provides hospital care, emergency medical services, and surgical care and having a surgical complexity designation of at least "standard."

Note 1 to the definition of "full-service VA medical facility": VA maintains a website with a list of the facilities that have been designated with at least a surgical complexity of "standard," which can be accessed on VA's website.

Hospital care has the same meaning as defined in 38 U.S.C. 1701(5).

Medical services have the same meaning as defined in 38 U.S.C. 1701(6).

Other health-care plan contract means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement not administered by the Secretary of Veterans Affairs, under which health services for individuals are provided or the expenses of such services are paid; and does not include any such policy, contract, agreement, or similar arrangement pursuant to title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.) or chapter 55 of title 10, United States Code.

Residence means a legal residence or personal domicile, even if such residence is seasonal. A covered veteran may maintain more than one residence but may only have one residence at a time. If a covered veteran lives in more than one location during a year, the covered veteran's residence is the residence or domicile where they are staying at the time they want to receive hospital care, medical services, or extended care services through the Veterans Community Care Program. A post office box or other non-residential point of delivery does not constitute a residence.

Schedule means identifying and confirming a date, time, location, and entity or health care provider for an appointment in advance of such appointment.

Note 1 to the definition of ``schedule": A VA telehealth encounter and a same-day care encounter are considered to be scheduled even if such an encounter is conducted on an ad hoc basis.

VA facility means a VA facility that offers hospital care, medical services, or extended care services.

VA medical service line means a specific medical service or set of services delivered in a VA facility.

[84 FR 26307, June 5, 2019]

Supplement *Highlights* references: 122(2).

§17.4010 Veteran eligibility

Section 1703(d) of title 38, U.S.C., establishes the conditions under which, at the election of the veteran and subject to the availability of appropriations, VA must furnish care in the community through eligible entities and providers. VA has regulated these conditions under paragraphs (a)(1) through (5) of this section. If VA determines that a covered veteran meets at least one or more of the conditions in paragraph (a) of this section and has provided information required by paragraphs (b) and (c) of this section, the covered veteran may elect to receive authorized non-VA care under §17.4020.

(a) The covered veteran requires hospital care, medical services, or extended care services and:

(1) No VA facility offers the hospital care, medical services, or extended care services the veteran requires.

(2) VA does not operate a full-service VA medical facility in the State in which the veteran resides.

(3) The veteran was eligible to receive care and services from an eligible entity or provider under section 101(b)(2)(B) of the Veterans Access, Choice, and Accountability Act of 2014 (Pub. L. 113-146, §101, as amended; 38 U.S.C. 1701 note) as of June 5, 2018, and continues to reside in a location that would qualify the veteran under that provision, and:

(i) Resides in Alaska, Montana, North Dakota, South Dakota, or Wyoming; or

(ii) Does not reside in one of the States described in paragraph (a)(3)(i) of this section, but received care or services under title 38 U.S.C. between June 6, 2017, and June 6, 2018, and is seeking care before June 6, 2020.

(4) Has contacted an authorized VA official to request the care or services the veteran requires, but VA has determined it is not able to furnish such care or services in a manner that complies with designated access standards established in §17.4040.

(5) The veteran and the veteran's referring clinician determine it is in the best medical interest of the veteran, for the purpose of achieving improved clinical outcomes, to access the care or services the veteran requires from an eligible entity or provider, based on one or more of the following factors, as applicable:

(i) The distance between the veteran and the facility or facilities that could provide the required care or services;

(ii) The nature of the care or services required by the veteran;

(iii) The frequency the veteran requires the care or services;

(iv) The timeliness of available appointments for the required care or services;

(v) The potential for improved continuity of care;

(vi) The quality of the care provided; or

(vii) Whether the veteran faces an unusual or excessive burden in accessing a VA facility based on consideration of the following:

(A) Excessive driving distance; geographical challenges, such as the presence of a body of water (including moving water and still water) or a geologic formation that cannot be crossed by road; or environmental factors, such as roads that are not accessible to the general public, traffic, or hazardous weather.

(B) Whether care and services are available from a VA facility that is reasonably accessible.

(C) Whether a medical condition of the veteran affects the ability to travel.

(D) Whether there is a compelling reason the veteran needs to receive care and services from a non-VA facility.

(E) The need for an attendant, which is defined as a person who provides required aid and/or physical assistance to the veteran, for a veteran to travel to a VA medical facility for hospital care or medical services.

(6) In accordance with §17.4015, VA has determined that a VA medical service line that would furnish the care or services the veteran requires is not providing such care or services in a manner that complies with VA's standards for quality.

(b) If the covered veteran changes his or her residence, the covered veteran must update VA about the change within 60 days.

(c) A covered veteran must provide to VA information on any other health-care plan contract under which the veteran is covered prior to obtaining authorization for care and services the veteran requires. If the veteran changes such other health-care plan contract, the veteran must update VA about the change within 60 days.

(d) Review of veteran eligibility determinations. The review of any decisions under paragraph (a) of this section are subject to VA's clinical appeals process, and such decisions may not be appealed to the Board of Veterans' Appeals.

(The information collection is pending Office of Management and Budget approval.)

[84 FR 26307, June 5, 2019]

Supplement *Highlights* references: 122(2).

§17.4015 Designated VA medical service lines

(a) VA may identify VA medical service lines that are underperforming based on the timeliness of care when compared with the same medical service line at other VA facilities and based on data related to two or more distinct and appropriate quality measures of VA's standards for quality when compared with non-VA medical service lines.

(b) VA will make determinations regarding VA medical service lines under this section using data described in paragraph (a) of this section, VA standards for quality, and based on factors identified in paragraph (e) of this section.

(c) VA will announce annually any VA medical service lines identified under paragraph (a) of this section by publishing a document in the *Federal Register*. Such document will identify and describe the standards for quality VA used to inform the determination under paragraph (a), as well as how the data described in paragraph (a) and factors identified in paragraph (e) of this section were used to make the determinations. Such document will also identify limitations, if any, concerning when and where covered veterans can receive qualifying care and services at their election in the community based on this section. Such limitations may include a defined timeframe, a defined geographic area, and a defined scope of services. VA will also take reasonable steps to provide direct notice to covered veterans affected under this section.

(d) VA will identify no more than 3 VA medical services lines in a single VA facility under this section, and no more than 36 VA medical service lines nationally under this section.

(e) In determining whether a VA medical service line should be identified under paragraph (a) of this section, and to comply with paragraph (c) of this section, VA will consider:

(1) Whether the differences between performance of individual VA medical service lines, and between performance of VA medical service lines and non-VA medical service lines, is clinically significant.

(2) Likelihood and ease of remediation of the VA medical service line within a short timeframe.

(3) Recent trends concerning the VA medical service line or non-VA medical service line.

(4) The number of covered veterans served by the medical service line or that could be affected by the designation.

(5) The potential impact on patient outcomes.

(6) The effect that designating one VA medical service line would have on other VA medical service lines.

[84 FR 26308, June 5, 2019]

Supplement *Highlights* references: 122(2).

§17.4020 Authorized non-VA care

(a) *Electing non-VA care.* Except as provided for in paragraph (d) of this section, a covered veteran eligible for the Veterans Community Care Program under §17.4010 may choose to schedule an appointment with a VA health care provider, or have VA authorize the veteran to receive an episode of care for hospital care, medical services, or extended care services from an eligible entity or provider when VA determines such care or services are clinically necessary.

(b) *Selecting an eligible entity or provider.* A covered veteran may specify a particular eligible entity or provider. If a covered veteran does not specify a particular eligible entity or provider, VA will refer the veteran to a specific eligible entity or provider.

(c) *Authorizing emergency treatment.* This paragraph (c) applies only to emergency treatment furnished to a covered veteran by an eligible entity or provider when such treatment was not the subject of an election by a veteran under paragraph (a) of this section. This paragraph (c) does not affect eligibility for, or create any new rules or conditions affecting, reimbursement for emergency treatment under section 1725 or 1728 of title 38, United States Code.

(1) Under the conditions set forth in this paragraph (c), VA may authorize emergency treatment after it has been furnished to a covered veteran. For purposes of this paragraph (c), “emergency treatment” has the meaning defined in section 1725(f)(1) of title 38, United States Code.

(2) VA may only authorize emergency treatment under this paragraph (c) if the covered veteran, someone acting on the covered veteran's behalf, or the eligible entity or provider notifies VA within 72-hours of such care or services being furnished and VA approves the furnishing of such care or services under paragraph (c)(3) of this section.

(3) VA may approve emergency treatment of a covered veteran under this paragraph (c) only if:

(i) The veteran is receiving emergency treatment from an eligible entity or provider.

(ii) The notice to VA complies with the provisions of paragraph (c)(4) of this section and is submitted within 72 hours of the beginning of such treatment.

(iii) The emergency treatment only includes services covered by VA's medical benefits package in §17.38.

(4) Notice to VA must:

(i) Be made to the appropriate VA official at the nearest VA facility;

(ii) Identify the covered veteran; and

(iii) Identify the eligible entity or provider.

(d) *Organ and bone marrow transplant care.*

(1) In the case of a covered veteran described in paragraph (d)(3) of this section, the Secretary will determine whether to authorize an organ or bone marrow transplant for the covered veteran through an eligible entity or provider.

(2) The Secretary will make determinations under paragraph (d)(1) of this section, and the primary care provider of the veteran will make determinations concerning whether there is a medically compelling reason to travel outside the region of the Organ Procurement and Transplantation Network in which the veteran resides to receive a transplant, in consideration of, but not limited to, the following factors:

(i) Specific patient factors.

(ii) Which facilities meet VA's standards for quality, including quality metrics and outcomes, for the required transplant.

(iii) The travel burden on covered veterans based upon their medical conditions and the geographic location of eligible transplant centers.

(iv) The timeliness of transplant center evaluations and management.

(3) This paragraph (d) applies to covered veterans who meet one or more conditions of eligibility under §17.4010(a) and:

(i) Require an organ or bone marrow transplant as determined by VA based upon generally-accepted medical criteria; and

(ii) Have, in the opinion of the primary care provider of the veteran, a medically compelling reason, as determined in consideration of the factors described in paragraph (d)(2) of this section, to travel outside the region of the Organ Procurement and Transplantation Network in which the veteran resides, to receive such transplant.

[84 FR 26308, June 5, 2019]

Supplement *Highlights* references: 122(2).

§17.4025 Effect on other provisions

(a) *General.* No provision in this section may be construed to alter or modify any other provision of law establishing specific eligibility criteria for certain hospital care, medical services, or extended care services.

(b) *Prescriptions.* Notwithstanding any other provision of this part, VA will:

(1) Pay for prescriptions no longer than 14 days written by eligible entities or providers for covered veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system to cover a course of treatment for an urgent or emergent condition.

(2) Fill prescriptions written by eligible entities or providers for covered veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system.

(3) Pay for prescriptions written by eligible entities or providers for covered veterans that have an immediate need for durable medical equipment and medical devices that are required for urgent or emergent conditions (e.g., splints, crutches, manual wheelchairs).

(4) Fill prescriptions written by eligible entities or providers for covered veterans for durable medical equipment and medical devices that are not required for urgent or emergent conditions.

(c) *Copayments.* Covered veterans are liable for a VA copayment for care or services furnished under the Veterans Community Care Program, if required by §17.108(b)(4) or (c)(4), §17.110(b)(4), or §17.111(b)(3).

[84 FR 26309, June 5, 2019]

Supplement *Highlights* references: 122(2).

§17.4030 Eligible entities and providers

To be eligible to furnish care and services under the Veterans Community Care Program, entities or providers:

(a) Must enter into a contract, agreement, or other arrangement to furnish care and services under the Veterans Community Care Program under §§17.4000 through 17.4040.

(b) Must either:

(1) Not be a part of, or an employee of, VA; or

(2) If the provider is an employee of VA, not be acting within the scope of such employment while providing hospital care, medical services, or extended care services through the Veterans Community Care Program under §§17.4000 through 17.4040.

(c) Must be accessible to the covered veteran. VA will determine accessibility by considering the following factors:

(1) The length of time the covered veteran would have to wait to receive hospital care, medical services, or extended care services from the entity or provider;

(2) The qualifications of the entity or provider to furnish the hospital care, medical services, or extended care services from the entity or provider; and

(3) The distance between the covered veteran's residence and the entity or provider.

[84 FR 26309, June 5, 2019]

Supplement *Highlights* references: 122(2).

§17.4035 Payment rates

The rates paid by VA for hospital care, medical services, or extended care services (hereafter referred to as “services”) furnished pursuant to a procurement contract or an agreement authorized by §§17.4100 through 17.4135 will be the rates set forth in the terms of such contract or agreement. Such payment rates will comply with the following parameters:

(a) Except as otherwise provided in this section, payment rates will not exceed the applicable Medicare fee schedule (including but not limited to allowable rates under 42 U.S.C. 1395m) or prospective payment system amount (hereafter “Medicare rate”), if any, for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities).

(b) With respect to services furnished in a State with an All-Payer Model Agreement under section 1814(b)(3) of the Social Security Act (42 U.S.C. 1395f(b)(3)) that became effective on or after January 1, 2014, the Medicare payment rates under paragraph (a) of this section will be calculated based on the payment rates under such agreement.

(c) Payment rates for services furnished in a highly rural area may exceed the limitations set forth in paragraphs (a) and (b) of this section. The term “highly rural area” means an area located in a county that has fewer than seven individuals residing in that county per square mile.

(d) Payment rates may deviate from the parameters set forth in paragraphs (a) through (c) of this section when VA determines, based on patient needs, market analyses, health care provider qualifications, or other factors, that it is not practicable to limit payment for services to the rates available under paragraphs (a) through (c).

(e) Payment rates for services furnished in Alaska are not subject to paragraphs (a) through (d) of this section and will be set forth in the terms of the procurement contract or agreement authorized by §§17.4100 through 17.4135, pursuant to which such services are furnished. If no payment rate is set forth in the terms of such a contract or agreement pursuant to which such services are furnished, payment rates for services furnished in Alaska will follow the Alaska Fee Schedule of the Department of Veterans Affairs.

[84 FR 26309, June 5, 2019]

Supplement *Highlights* references: 122(2).

§17.4040 Designated access standards

(a) The following access standards have been designated to apply for purposes of eligibility determinations to access care in the community through the Veterans Community Care Program under §17.4010(a)(4).

(1) *Primary care, mental health care, and non-institutional extended care services.* VA cannot schedule an appointment for the covered veteran with a VA health care provider for the required care or service:

(i) Within 30 minutes average driving time of the veteran's residence; and

(ii) Within 20 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.

(2) *Specialty care.* VA cannot schedule an appointment for the covered veteran with a VA health care provider for the required care or service:

(i) Within 60 minutes average driving time of the veteran's residence; and

(ii) Within 28 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.

(b) For purposes of calculating average driving time from the veteran's residence in paragraph (a) of this section, VA will use geographic information system software.

[84 FR 26310, June 5, 2019]

Supplement *Highlights* references: 122(2).

Veterans Care Agreements

§17.4100 Definitions

For the purposes of §§17.4100 through 17.4135, the following definitions apply:

Contract is any of the following: Federal procurement agreements regulated by the Federal Acquisition Regulation; common law contracts; other transactions; or any other instrument. Veterans Care Agreements are excluded from this definition.

Covered individual is an individual who is eligible to receive hospital care, medical services, or extended care services from a non-VA provider under title 38 U.S.C. and title 38 CFR.

Extended care services are the services described in 38 U.S.C. 1710B(a).

Hospital care is defined in 38 U.S.C. 1701(5).

Medical services is defined in 38 U.S.C. 1701(6).

Sharing agreement is an agreement, under statutory authority other than 38 U.S.C. 1703A, by which VA can obtain hospital care, medical services, or extended care services for a covered individual.

VA facility is a point of VA care where covered individuals can receive hospital care, medical services, or extended care services, to include a VA medical center, a VA community-based outpatient clinic, a VA health care center, a VA community living center, a VA independent outpatient clinic, and other VA outpatient services sites.

Veterans Care Agreement is an agreement authorized under 38 U.S.C. 1703A for the furnishing of hospital care, medical services, or extended care services to covered individuals.

[84 FR 21678, May 14, 2019]

Supplement *Highlights* references: 121(1).

§17.4105 Purpose and Scope

(a) *Purpose.* Sections 17.4100 through 17.4135 implement 38 U.S.C. 1703A, as required under section 1703A(j). Section 1703A authorizes VA to enter into and utilize Veterans Care Agreements to furnish hospital care, medical services, and extended care services to a covered individual when such individual is eligible for and requires such care or services that are not feasibly available to the covered individual through a VA facility, a contract, or a sharing agreement.

(b) *Scope.* Sections 17.4100 through 17.4135 contain procedures, requirements, obligations, and limitations for: The process of certifying entities or providers under 38 U.S.C. 1703A; entering into, administering, furnishing care or services pursuant to, and discontinuing Veterans Care Agreements; and all disputes arising under or related to Veterans Care Agreements. Sections 17.4100 through 17.4135 apply to all entities and providers, where applicable, that are parties to a Veterans Care Agreement, participate in the certification process, or furnish hospital care, medical services, or extended care services pursuant to a Veterans Care Agreement.

[84 FR 21678, May 14, 2019]

Supplement *Highlights* references: 121(1).

(3) *Review of dispute and written decision.*

(i) Upon receipt of a notice of dispute, the responsible VA official will review the dispute and all facts pertinent to the dispute.

(ii) If the responsible VA official determines additional information or documentation is required for review and adjudication of the dispute, the official will, within 90 calendar days of VA's receipt of the notice of dispute, provide written notice to both parties, in accordance with the notice provisions of the Veterans Care Agreement, that additional information or documentation is required for review and adjudication of the dispute. Such notice will identify and request the additional information and documentation deemed necessary to review and adjudicate the dispute.

(iii) Upon VA receipt of a notice of dispute that conforms to the requirements of paragraph (c)(1) of this section (including containing all information and documentation necessary to review and adjudicate the dispute), the responsible VA official will take one of the following actions within 90 calendar days:

(A) Issue a written decision, in accordance with the notice provisions of the Veterans Care Agreement, to both parties. The written decision will include:

(1) A description of the dispute;

(2) A reference to the pertinent terms of the Veterans Care Agreement and any relevant authorizations;

(3) A statement of the factual areas of agreement and disagreement;

(4) A statement of the responsible official's decision, with supporting rationale; and

(5) A statement that the decision constitutes the final agency decision on the matter in dispute.

(B) Upon a determination that additional time is reasonably required to issue a decision, the responsible VA official will provide written notice to both parties, in accordance with the notice provisions of the Veterans Care Agreement, of such determination and the time within which a decision will be issued. The time within which a decision will be issued must be reasonable, taking into account the complexity of the dispute and any other relevant factors, and must not exceed 150 calendar days after receipt of a notice of dispute that conforms to the requirements of paragraph (c)(1) of this section and all information and documentation necessary to review and adjudicate the dispute. The responsible VA official will subsequently issue a written decision in accordance with paragraph (c)(3)(iii)(A) of this section.

(4) *Issuance of decision.* VA will furnish the decision to the entity or provider by any method that provides evidence of receipt.

(5) *Effect of decision.* A written decision issued by the responsible VA official constitutes the agency's final decision on the dispute.

(The information collection requirements have been submitted to the Office of Management and Budget (OMB) and are pending OMB approval.)

[84 FR 21678, May 14, 2019]

Supplement *Highlights* references: 121(1).

Next Section is §17.4600

§17.4600 Urgent care.

(a) *Purpose.* The purpose of this section is to establish procedures for accessing urgent care. Eligible veterans may obtain urgent care, in accordance with the requirements and processes set forth in this section, from qualifying non-VA entities or providers in VA's network that are identified by VA in accordance with paragraph (c)(2) of this section.

(b) *Definitions.* The following definitions apply to this section.

(1) *Eligible veteran* means a veteran described in 38 U.S.C. 1725A(b).

(2) *Episodic care* means care or services provided in a single visit to an eligible veteran for a particular health condition, or a limited set of particular health conditions, without an ongoing relationship being established between the eligible veteran and qualifying non-VA entities or providers.

(3) *Longitudinal management of conditions* means outpatient care that addresses important disease prevention and treatment goals and is dependent upon bidirectional communications that are ongoing over an extended period of time. For purposes of this section, the term "longitudinal management of conditions" and "longitudinal care" are synonymous.

(4) *Qualifying non-VA entity or provider* means a non-VA entity or provider, including Federally-qualified health centers as defined in 42 U.S.C. 1396d(1)(2)(B), that has entered into a contract, agreement, or other arrangement with the Secretary to furnish urgent care under this section, or has entered into an agreement with a third-party administrator with whom VA has a contract to furnish such care.

(5) *Urgent care* means services provided by a qualifying non-VA entity or provider, and as further defined in paragraphs (b)(5)(i) through (iv) of this section.

(i) Urgent care includes service available from entities or providers submitting claims for payment as a walk-in retail health clinic (Centers for Medicare and Medicaid Services (CMS) Place of Service code 17) or urgent care facility (CMS Place of Service code 20);

(ii)

(A) Except as provided in paragraph (b)(5)(ii)(B) or (b)(5)(iv) of this section, urgent care does not include preventive health services, as defined in section 1701(9) of title 38, United States Code, dental care, or chronic disease management.

(B) Urgent care includes immunization against influenza (flu shots), as well as therapeutic vaccines that are necessary in the course of treatment of an otherwise included service and screenings related to the treatment of symptoms associated with an immediate illness or exposure.

(iii) Urgent care may only be furnished as episodic care for eligible veterans needing immediate non-emergent medical attention, and it does not include longitudinal

care. Veterans requiring follow-up care as a result of an urgent care visit under this section must contact VA or their VA-authorized primary care provider to arrange such care.

(iv) If VA determines that the provision of additional services is in the interest of eligible veterans, based upon identified health needs, VA may offer such additional services under this section as VA determines appropriate. Such services may be limited in duration and location. VA will inform the public through a *Federal Register* document, published as soon as practicable, and other communications, as appropriate.

(c) *Procedures.*

(1)(i) (A) Eligible veterans may receive urgent care under this section without prior approval from VA.

(B) Eligible veterans must declare at each episode of care if they are using this benefit prior to receiving urgent care under this section.

(2) VA will publish a website providing information on urgent care, including the names, locations, and contact information for qualifying non-VA entities or providers from which urgent care is available under this section.

(3) In general, eligibility under this section does not affect eligibility for hospital care or medical services under the medical benefits package, as defined in §17.38, or other benefits addressed in this title. Nothing in this section waives the eligibility requirements established in other statutes or regulations.

(4) Urgent care furnished under this section must meet VA's standards for quality established under 38 U.S.C. 1703C, as applicable.

(d) *Copayment.*

(1) Except as provided in paragraphs (d)(2) and (3) of this section, an eligible veteran, as a condition for receiving urgent care provided by VA under this section, must agree to pay VA (and is obligated to pay VA) a copayment of \$30:

(i) After three visits in a calendar year if such eligible veteran is enrolled under §17.36(b)(1) through (6), except those veterans described in §17.36(d)(3)(iii) for all matters not covered by priority category 6.

(ii) If such eligible veteran is enrolled under §17.36(b)(7) or (8), including veterans described in §17.36(d)(3)(iii).

(2) An eligible veteran who receives urgent care under paragraph (b)(5)(iv) of this section or urgent care consisting solely of an immunization against influenza (flu shot) is not subject to a copayment under paragraph (d)(1) of this section and such a visit shall not count as a visit for purposes of paragraph (d)(1)(i) of this section.

(3) If an eligible veteran would be required to pay more than one copayment under this section, or a copayment under this section and a copayment under §17.108 or §17.111, on the same day, the eligible veteran will only be charged the higher copayment.

(e) *Prescriptions.* Notwithstanding any other provision of this part, VA will:

(1) Pay for prescriptions written by qualifying non-VA entities or providers for eligible veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system to cover a course of treatment for urgent care no longer than 14 days.

(2) Fill prescriptions for urgent care written by qualifying non-VA entities or providers for eligible veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system.

(3) Pay for prescriptions written by qualifying non-VA entities or providers for eligible veterans that have an immediate need for durable medical equipment and medical devices that are required for urgent conditions (e.g., splints, crutches, manual wheelchairs).

(f) *Payments.* Payments made for urgent care constitute payment in full and shall extinguish the veteran's liability to the qualifying non-VA entity or provider. The qualifying non-VA entity or provider may not impose any additional charge on a veteran or his or her health care insurer for any urgent care service for which payment is made by VA. This section does not abrogate VA's right, under 38 U.S.C. 1729, to recover or collect from a third party the reasonable charges of the care or services provided under this section.

[84 FR 26018, June 5, 2019]

Supplement *Highlights* references: 122(1).

End of Part 17

[Reserved]