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Medical

Book I

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

Supplement No. 97

Covering period of *Federal Register* issues
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GENERAL INSTRUCTIONS

Custom Federal Regulations Service™

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. 97

5 December 2015

Covering the period of Federal Register issues
through December 1, 2015

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FILING INSTRUCTIONS

**Book I, Supplement No. 97
December 5, 2015**

<i>Remove these old pages</i>	<i>Add these new pages</i>	<i>Section(s) Affected</i>
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17.INDEX-3 to 17.INDEX-4	17.INDEX-3 to 17.INDEX-4	Part 17 Index
17.1500-1 to 17.1535-1	17.1500-1 to 17.1535-1	§§17.1505, 17.1510, 17.1525 & 17.1530

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HIGHLIGHTS

Book I, Supplement No. 97 December 5, 2015

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 1 December 2015, the VA published an interim final rule effective that same day, to revise its medical regulations that implement section 101 of the Veterans Access, Choice, and Accountability Act of 2014, which requires VA to establish a program to furnish hospital care and medical services through eligible non-VA health care providers to eligible veterans who either cannot be seen within the wait-time goals of the Veterans Health Administration (VHA) or who qualify based on their place of residence. Changes:

- In §17.1505, revised definitions for *Episode of Care* and *VA Medical Facility*, and added definition for *Full-Time Primary Care Physician*,
- In §17.1510, revised paragraphs (a), (b)(1), and (b)(4)(ii),
- Removed and Reserved §17.1525, and
- In §17.1530, revised paragraphs (a) and (d), and added paragraph (e).



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Expanded Access to Non-VA Care Through the Veterans Choice Program**§17.1500 Purpose and scope.**

(a) *Purpose.* Sections 17.1500 through 17.1540 implement the Veterans Choice Program, authorized by section 101 of the Veterans Access, Choice, and Accountability Act of 2014.

(b) *Scope.* The Veterans Choice Program authorizes VA to furnish hospital care and medical services to eligible veterans, as defined in § 17.1510, through agreements with eligible entities or providers, as defined in § 17.1530.

(Authority: Sec. 101, Pub. L. 113-146, 128 Stat. 1754)

[79 FR 65585, Nov. 5, 2014]

Supplement *Highlights* references: 88(2).

§ 17.1505 Definitions.

For purposes of the Veterans Choice Program under §§ 17.1500 through 17.1540:

Appointment means an authorized and scheduled encounter with a health care provider for the delivery of hospital care or medical services. A visit to an emergency room or an unscheduled visit to a clinic is not an appointment.

Attempt to schedule means contact with a VA scheduler or VA health care provider in which a stated request by the veteran for an appointment is made.

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 from the date of the first appointment with a non-VA health care provider.

Full-time primary care physician means a single VA physician whose workload, or multiple VA physicians whose combined workload, equates to 0.9 full time equivalent employee working at least 36 clinical hours a week at the VA medical facility and who provides primary care as defined by their privileges or scope of practice and licensure.

Health-care plan 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 person may maintain more than one residence but may only have one residence at a time. If a veteran lives in more than one location during a year, the veteran's residence is the residence or domicile where the person is staying at the time the veteran wants to receive hospital care or medical services through the 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.

VA medical facility means a VA hospital, a VA community-based outpatient clinic, or a VA health care center, any of which must have at least one full-time primary care physician. A Vet Center, or Readjustment Counseling Service Center, is not a VA medical facility.

Wait-time goals of the Veterans Health Administration means, unless changed by further notice in the *Federal Register*, a date not more than 30 days from either:

(1) The date that an appointment is deemed clinically appropriate by a VA health care provider. In the event a VA health care provider identifies a time range when care must be provided (e.g., within the next 2 months), VA will use the last clinically appropriate date for determining whether or not such care is timely.

(2) Or, if no such clinical determination has been made, the date that a veteran prefers to be seen for hospital care or medical services.

(Authority: Sec. 101, Pub. L. 113-146, 128 Stat. 1754; Sec. 4005, Pub. L. 114-41, 129 Stat. 443)

[79 FR 65585, Nov. 5, 2014; as amended at 80 FR 74996, Dec. 1, 2015]

Supplement *Highlights* references: 88(2), 97(1).

§ 17.1510 Eligible veterans.

A veteran must meet the eligibility criteria under both paragraphs (a) and (b) of this section to be eligible for care through the Veterans Choice Program. A veteran must also provide the information required by paragraphs (c) and (d) of this section.

(a) A veteran must be enrolled in the VA health care system under §17.36.

(b) A veteran must also meet at least one of the following criteria:

(1) The veteran attempts, or has attempted, to schedule an appointment with a VA health care provider, but VA is unable to schedule an appointment for the veteran within:

(i) The wait-time goals of the Veterans Health Administration; or

(ii) With respect to such care or services that are clinically necessary, the period VA determines necessary for such care or services if such period is shorter than the wait-time goals of the Veterans Health Administration.

(2) The veteran's residence is more than 40 miles from the VA medical facility that is closest to the veteran's residence.

(3) The veteran's residence is both:

(i) In a state without a VA medical facility that provides hospital care, emergency medical services, and surgical care having a surgical complexity of standard (VA maintains a Web site with a list of the facilities that have been designated with at least a surgical complexity of standard. That Web site can be accessed here:www.va.gov/health/surgery); and

(ii) More than 20 miles from a medical facility described in paragraph (b)(3)(i) of this section.

(4) The veteran's residence is in a location, other than one in Guam, American Samoa, or the Republic of the Philippines, which is 40 miles or less from a VA medical facility and the veteran:

(i) Must travel by air, boat, or ferry to reach such a VA medical facility; or

(ii) Faces an unusual or excessive burden in traveling to such a VA medical facility based on 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; environmental factors, such as roads that are not accessible to the general public, traffic, or hazardous weather; a medical condition that affects the ability to travel; or other factors, as determined by VA, including but not limited to:

(A) The nature or simplicity of the hospital care or medical services the veteran requires;

(B) The frequency that such hospital care or medical services need to be furnished to the veteran; and

(C) 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.

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

(d) A veteran must provide to VA information on any health-care plan under which the veteran is covered prior to obtaining authorization for care under the Veterans Choice Program. If the veteran changes health-care plans, the veteran must update VA about the change within 60 days.

(e) For purposes of calculating the distance between a veteran's residence and the nearest VA medical facility under this section (except for purposes of calculating a driving route under paragraph (b)(4)(ii) of this section), VA will use the straight-line distance between the nearest VA medical facility and a veteran's residence.

(Authority: Sec. 101, Pub. L. 113-146, 128 Stat. 1754; Section 3(a)(2) of Pub. L. 114-19, 129 Stat. 215)

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

[79 FR 65585, Nov. 5, 2014; as amended at 80 FR 74996, Dec. 1, 2015]

Supplement *Highlights* references: 88(2), 97(1).

§ 17.1515 Authorizing non-VA care.

(a) *Electing non-VA care.* A veteran eligible for the Veterans Choice Program under § 17.1510 may choose to schedule an appointment with a VA health care provider, be placed on an electronic waiting list for VA care, or have VA authorize the veteran to receive an episode of care for hospital care or medical services under 38 CFR 17.38 from an eligible entity or provider.

(b) *Selecting a non-VA provider.* An eligible veteran may specify a particular non-VA entity or health care provider, if that entity or health care provider meets the requirements of § 17.1530. If an eligible veteran does not specify a particular eligible entity or provider, VA will refer the veteran to a specific eligible entity or provider.

(Authority: Sec. 101, Pub. L. 113-146, 128 Stat. 1754)

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

[79 FR 65586, Nov. 5, 2014]

Supplement *Highlights* references: 88(2).

§ 17.1520 Effect on other provisions.

(a) *General.* In general, eligibility under the Veterans Choice Program does not affect a veteran's eligibility for hospital care or medical services under the medical benefits package, as defined in § 17.38, or other benefits addressed in this part. Notwithstanding any other provision of this part, VA will pay for and fill prescriptions written by eligible providers under § 17.1530 for eligible veterans under § 17.1510, including prescriptions for drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.

(b) *Copayments.* VA will be liable for any deductibles, cost-shares, or copayments required by an eligible veteran's health-care plan for hospital care and medical services furnished under this Program, to the extent that such reimbursement does not result in expenditures by VA for the furnished care or services in excess of the rate established under § 17.1535. Veterans are also liable for a VA copayment for care furnished under this Program, as required by §§ 17.108(b)(4), 17.108(c)(4), 17.110(b)(4), and 17.111(b)(3).

(c) *Beneficiary travel.* For veterans who are eligible for beneficiary travel benefits under part 70 of this chapter, VA will provide beneficiary travel benefits for travel to and from the location of the eligible entity or provider who furnishes hospital care or medical services for an authorized appointment under the Veterans Choice Program without regard to the limitations in § 70.30(b)(2) of this chapter.

(Authority: 38 U.S.C. 111; Sec. 101, Pub. L. 113-146, 128 Stat. 1754)

[79 FR 65586, Nov. 5, 2014]

Supplement *Highlights* references: 88(2).

§ 17.1525 [Removed and Reserved]

[79 FR 65586, Nov. 5, 2014; as amended at 80 FR 74996, Dec. 1, 2015]

Supplement *Highlights* references: 88(2), 97(1).

§ 17.1530 Eligible entities and providers.

(a) *General.* An entity or provider is eligible to deliver care under the Veterans Choice Program if, in accordance with paragraph (c) of this section, it is accessible to the veteran and is an entity or provider identified in section 101(a)(1)(B)(i)-(iv) of the Veterans Access, Choice, and Accountability Act of 2014 or is an entity identified in paragraph (e) of this section, and is either:

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

(2) If the provider is an employee of VA, is not acting within the scope of such employment while providing hospital care or medical services through the Veterans Choice Program.

(b) *Agreement.* An entity or provider must enter into an agreement with VA to provide non-VA hospital care or medical services to eligible veterans through one of the following types of agreements: contracts, intergovernmental agreements, or provider agreements. Each form of agreement must be executed by a duly authorized Department official.

(c) *Accessibility.* An entity or provider may only furnish hospital care or medical services to an eligible veteran if the entity or provider is accessible to the eligible veteran. VA will determine accessibility by considering the following factors:

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

(2) The qualifications of the entity or provider to furnish the hospital care or medical services to the eligible veteran; and

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

(d) *Requirements for health care providers.*

(1) To be eligible to furnish care or services under the Veterans Choice Program, a health care provider must:

(i) Maintain at least the same or similar credentials and licenses as those required of VA's health care providers, as determined by the Secretary. The agreement reached under paragraph (b) of this section will clarify these requirements. Eligible health care providers must submit verification of such licenses and credentials maintained by the provider to VA at least once per 12-month period.

(ii) Not be excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f)) under section 1128 or 1128A of such Act (42 U.S.C. 1320a-7 and 1320a-7a)), not be identified as an excluded source on the list maintained in the System for Award Management or any successor system, and not be identified on the List of Excluded Individuals and Entities that is maintained by the Office of the Inspector General of the U.S. Department of Health and Human Services.

(2) Any entities that are eligible to provide care through the Program must ensure that any of their providers furnishing care and services through the Program meet the standards identified in paragraph (d)(1) of this section. An eligible entity may submit this information on behalf of its providers.

(e) *Other eligible entities and providers.* In accordance with sections 101(a)(1)(B)(v) and 101(d)(5) of the Veterans Access, Choice, and Accountability Act of 2014 (as amended), the following entities or providers are eligible to deliver care under the Veterans Choice Program, subject to the additional criteria established in this section.

(1) A health care provider that is participating in a State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), including any physician furnishing services under such program, if the health care provider has an agreement under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or a waiver of such a plan;

(2) An Aging and Disability Resource Center, an area agency on aging, or a State agency (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)), or a center for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)).

(3) A health care provider that is not identified in paragraph (e)(1) or (2) of this section, if that provider meets all requirements under paragraph (d) of this section.

(Authority: Sec. 101, Pub. L. 113-146, 128 Stat. 1754; Sec. 4005, Pub. L. 114-41, 129 Stat. 443)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0823.)

[79 FR 65586, Nov. 5, 2014; as amended at 80 FR 74996, Dec. 1, 2015]

Supplement *Highlights* references: 88(2), 97(1).

[Reserved]

§ 17.1535 Payment rates and methodologies.

(a) *Payment rates.* Payment rates will be negotiated and set forth in an agreement between the Secretary and an eligible entity or provider.

(1) Except as otherwise provided in this section, payment rates may not exceed the rates paid by the United States to a provider of services (as defined in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)) or a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d)) under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for the same care or services. These rates are known as the “Medicare Fee Schedule” for VA purposes.

(2) For eligible entities or providers in highly rural areas, the Secretary may enter into an agreement that includes a rate greater than the rate defined paragraph (a)(1) of this section for hospital care or medical services, so long as such rate is still determined by VA to be fair and reasonable. 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.

(3) When there are no available rates as described in paragraph (a)(1) of this section, the Secretary shall, to the extent consistent with the Veterans Access, Choice, and Accountability Act of 2014, follow the process and methodology outlined in §§17.55 and 17.56 and pay the resulting rate.

(b) *Payment responsibilities.* Responsibility for payments will be as follows.

(1) For a nonservice-connected disability, as that term is defined at §3.1(l) of this chapter, a health-care plan of an eligible veteran is primarily responsible, to the extent such care or services is covered by the health-care plan, for paying the eligible entity or provider for such hospital care or medical services as are authorized under §§17.1500 through 17.1540 and furnished to an eligible veteran. VA shall be responsible for promptly paying only for costs of the VA-authorized service not covered by such health-care plan, including a payment made by the veteran, except that such payment may not exceed the rate determined for such care or services pursuant to paragraph (a) of this section.

(2) For hospital care or medical services furnished for a service-connected disability, as that term is defined at §3.1(k) of this chapter, or pursuant to 38 U.S.C. 1710(e), 1720D, or 1720E, VA is solely responsible for paying the eligible entity or provider for such hospital care or medical services as are authorized under §§17.1500 through 17.1540 and furnished to an eligible veteran.