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DEPARTMENT OF VETERANS AFFAIRS

8320-01

38 CFR Part 17

RIN 2900-AN86

Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Department of Veterans Affairs (VA) "Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities" regulations to conform with a statutory change that expanded veterans' eligibility for reimbursement. Some of the revisions in this final rule are purely technical, matching the language of our regulations to the language of the revised statute, while others set out VA's policies regarding the implementation of statutory requirements. This final rule expands the qualifications for payment or reimbursement to veterans who receive emergency services in non-VA facilities, and establishes accompanying standards for the method and amount of payment or reimbursement.

DATES: This final rule is effective [insert date 30 days after date of publication in the FEDERAL REGISTER].

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SUPPLEMENTARY INFORMATION:

On February 1, 2010, Congress enacted Public Law 111-137 (2010 Act), which amended 38 U.S.C. 1725 by expanding veteran eligibility for reimbursement for emergency treatment furnished in a non-VA facility. Current VA regulations implement section 1725 in 38 CFR 17.1000 through 17.1008 under the undesignated heading “Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities.” This final rule revises §§ 17.1001, 17.1002, 17.1004, and 17.1005. These revisions eliminate certain exclusions from emergency care payment or reimbursement, and define the payment limitations for those qualifying for payment or reimbursement under the law as amended by the 2010 Act.

The 2010 Act amended 38 U.S.C. 1725(f)(2) by removing a provision that included automobile insurance in the definition of “health-plan contract.” Under 38 U.S.C. 1725(b)(3)(B), veterans who are covered by a health-plan contract are ineligible for VA payment or reimbursement. Thus, we are removing current 38 CFR 17.1001(a)(5), which includes automobile insurance in the definition of “health-plan contract.” This amendment will implement VA’s authority to pay or reimburse claimants for providing emergency services to a veteran if the veteran received, or is legally eligible to receive, partial payment towards emergency services from an automobile insurer.

The 2010 Act also amended 38 U.S.C. 1725 by revising a provision that precluded certain claimants from payment or reimbursement by VA for emergency care at non-VA facilities. Parties who qualified as claimants under section 1725 prior to the 2010 Act (as implemented by VA in current 38 CFR 17.1004(a)) included veterans, the provider of the emergency treatment, or the person or organization that paid for such treatment on behalf of the veteran. Under the 2010 Act, claimants who are entitled to partial payment from a third party for providing non-VA emergency services to a veteran are no longer barred from also receiving VA payment or reimbursement for such care. Prior to the 2010 Act, section 1725(b)(3)(C) required that VA deny any claim in which a veteran has “other contractual or legal recourse against a third party that would, in whole or in part, extinguish such liability to the provider.” The 2010 Act removed “or in part” from this exclusion. In order to remove this partial payment exclusion from VA regulations, we are removing the clause “or in part” from § 17.1002(g) to parallel the language in current 38 U.S.C. 1725.

In addition, the 2010 Act authorized, but did not require, VA to provide repayment under section 1725 “for emergency treatment furnished to a veteran before the date of the enactment of the [2010] Act, if the Secretary determines that, under the circumstances applicable with respect to the veteran, it is appropriate to do so.” We interpret this provision to allow VA, through regulation, to provide retroactive reimbursement, and we are implementing this authority in new § 17.1004(f).

In a document published in the Federal Register on May 26, 2011 (76 FR 30598), VA proposed to amend the regulations that govern the payment or reimbursement for emergency services for nonservice-connected conditions in non-VA

facilities. We provided a 60 day comment period, which ended on July 25, 2011. We received three comments from the general public.

In the proposed rule, we stated that § 17.1005 would be amended by adding new paragraphs (c) and (d). However, on December 21, 2011 (76 FR 79071), VA published an entirely separate final rule that added new paragraphs (c) and (d) to § 17.1005. Accordingly, in this final rule we are renumbering proposed § 17.1005(c) as new § 17.1005(e), and we are also renumbering proposed § 17.1005(d) as new § 17.1005(f). None of the comments received on the proposed rulemaking for this final rule addressed these paragraphs, so the discussion below is not affected by this change.

One commenter applauded VA for “taking steps to change the reimbursement policies.” The commenter further believes that “it is only fair that the VA reimburse” veterans for the emergency care they receive in non-VA hospitals, especially when the non-VA hospitals are “better equipped to handle the injury.” We appreciate the supportive comment on this rulemaking, and thank the commenter.

A second commenter commended VA for the proposed regulation stating that the regulation is “in the best interest of the local health care provider, the veteran, and possibly the veteran’s administration.” We thank the commenter for taking the time to comment and for the commenter’s support of this rulemaking.

Another commenter identified perceived inconsistencies between 38 U.S.C. 1725(c)(2) and 1725(d). The commenter stated that section 1725(c)(2) contains “a prerequisite to VA payments that the veteran or the provider of emergency treatment exhaust without success all reasonably available claims and remedies available against a third party for payment.” The commenter then noted that, in section 1725(d), VA is

given “[a]n independent right to recover amounts paid for such treatment when a third party subsequently makes payment for the same treatment ([paragraph] (1)), a lien against any amounts recovered when a third party subsequently makes payment for the same treatment ([paragraph] (3)), and the right to notice of any subsequent payment by a third party for the same treatment ([paragraph] (4)).” The commenter explained that the apparent inconsistencies between subsection (c) “requiring exhaustion of remedies prior to reimbursement” and subsection (d) “talking about [the] right to recover subsequent third party payment, liens on subsequent third part[y] payments and [the] right to notice of third party payments” can be resolved by “understanding the condition precedent to VA payment being that the veteran make a demand for payment from the third party for the cost of the emergency medical treatment.” The commenter concluded that subsection (d) should come into play after a “rejection of the demand or an offer to pay some but not all of the reasonable and necessary emergency medical treatment.” In order to effectively address these perceived inconsistencies, the commenter suggested changes to the regulation text that were not addressed in the proposed rulemaking.

The stated intent of one of the suggested changes would be to allow “a demand for payment [to] satisf[y] the exhaustion of remedies requirement.” The commenter suggested adding a new paragraph (d)(3) to § 17.1004 as a condition to receive payment or reimbursement for emergency services to state: “The date the veteran filed a demand for payment without complete success, against a third party, for payment of such treatment.” Current § 17.1004(d)(4) states: “The date the veteran finally exhausted, without success, action to obtain payment or reimbursement for the

treatment from a third party.” By requiring merely that the veteran “file[] a demand for payment without complete success” without requiring resolution of that demand, the text suggested by the commenter would, in some circumstances, require VA to make payment or reimbursement before the third party has finally decided not to make the demanded payment. The current language in § 17.1004(d)(4) requires the exhaustion of all attempts for reimbursement or payment from the third party before the claimant files a claim with VA. This ensures that duplicative payments are not made to the claimant for the care rendered. If VA were to pay before the claimant fully exhausted his or her claim with the third party, and the third party ultimately made payment, VA would be required to seek reimbursement of its premature payment, resulting in a collection action against the claimant and unnecessary administrative costs and resource utilization. We will not amend § 17.1004 based on the commenter’s suggestion because the suggested amendment could result in duplicative payments, increased costs and, ultimately, no additional benefit to the veteran. Thus, as proposed, we have retained the current language in paragraph (d)(4), renumbered as paragraph (d)(3) by this rulemaking.

Sections 1725(c)(2) and 1725(d) are not inconsistent because, even after “the veteran or the provider of emergency treatment has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such treatment” and VA has provided reimbursement, a third party may subsequently, under certain circumstances, make payment for the same treatment.

The commenter also suggested that we make changes to current § 17.1002, which permits payment or reimbursement under 38 U.S.C. 1725 for emergency

treatment only under certain conditions, which are specified in the regulation. One such condition bars payment if a veteran has coverage under a health-plan contract, such that the health-plan contract is responsible to pay for, or reimburse the veteran for payment of, the emergency treatment. This condition applies whether the health-plan contract's responsibility is for all or part of the cost of the emergency treatment.

The statutory authority for this paragraph is 38 U.S.C. 1725(b)(3)(B), which states that a veteran is liable for emergency treatment if he or she “has no entitlement to care or services under a health-plan contract.” The commenter suggested that we remove the term “or in part” from current § 17.1002(f). (We note that, although the commenter referred to § 17.1002(g), the December 21, 2011, rulemaking redesignated paragraph (g) as paragraph (f).) As previously stated in this rulemaking, the 2010 Act removed the term “or in part” from 38 U.S.C. 1725(b)(3)(C). Section 1725(b)(3)(B) had no such revision. In other words, section 1725(b)(3)(B) requires that the veteran have “no entitlement to care or services under a health-plan contract,” which means that any entitlement, even a partial one, bars eligibility under section 1725(b). In comparison, section 1725(b)(3)(C), as amended, requires veterans to have “no other contractual or legal recourse against a third party that would, in whole, extinguish such liability to the provider” to be eligible for reimbursement under section 1725(b). (Emphasis added.) If a veteran has a contractual or legal recourse against a third party that would, in part, extinguish liability to the provider, the veteran would not be barred from eligibility under section 1725(b). The current language of § 17.1002(f) clarifies the language of section 1725(b)(3)(B) by reiterating the veteran's liability for emergency treatment if such

veteran has no health-plan contract “in whole or in part.” If we were to remove “or in part,” the provision would treat a veteran with some coverage under a health-plan contract in the same manner as one without coverage. We respectfully decline to make any changes to the regulation text based on this comment.

Finally, this rule amends current paragraph (g) of § 17.1002 by removing the words “or in part” to parallel the language in 38 U.S.C. 1725(b)(3)(C), and removes the partial payment exclusion from VA regulations. A commenter suggested further amending current § 17.1002(g) by dividing the paragraph into two separate paragraphs. However, the commenter’s suggested revision does not contain the amendment established by the 2010 Act, which removed the term “or in part.” The suggested revision does not offer any substantive amendment to the language of the current paragraph (g), nor does it offer ease of readability. We, therefore, will not further amend current paragraph (g) of § 17.1002.

Based on the rationale set forth in the proposed rule and in this document, VA is adopting the proposed rule as a final rule, with the above stated renumbering change.

Effect of rulemaking

Title 38 of the Code of Federal Regulations, as revised by this final rule, represents the exclusive legal authority on this subject. No contrary rules or procedures are authorized. All VA guidance must be read to conform with this rulemaking if possible or, if not possible, such guidance is superseded by this rulemaking.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in an expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

The Office of Management and Budget (OMB) assigns a control number for each collection of information it approves. Except for emergency approvals under 44 U.S.C. 3507(j), VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Current § 17.1004 contains a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521). OMB previously approved the collection of information and assigned Control Number 2900–0620. Because this final rule does not alter the information collection approved by OMB under the existing control number, we are not seeking new approval.

We are inserting a citation to the OMB control number immediately after the authority citation for § 17.1004 to clarify that that section contains an approved collection of information.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a “significant regulatory action,” which requires review by OMB, as “any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in this Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined and it has been determined not to be a significant regulatory action under Executive Order 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. This final rule will not cause a significant economic impact on health care providers, suppliers, or entities since only a small portion of the business of such entities concerns VA beneficiaries. Further, under this final rule, affected small entities will be reimbursed for the expenses they incur for the emergency treatment of certain veterans. Therefore, pursuant to 5 U.S.C. 605(b), this final rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance program number and title for this final rule are as follows: 64.005, Grants to States for Construction of State Home Facilities; 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care; and 64.024, VA Homeless Providers Grant and Per Diem Program.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. John R. Gingrich, Chief of Staff, Department of Veterans Affairs, approved this document on April 11, 2012, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Grant programs-Veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Dated: April 12, 2012

Robert C. McFetridge,
Director of Regulation Policy and Management,
Office of the General Counsel,
Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs amends 38 CFR part 17 as follows:

PART 17—MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

§ 17.1001 [Amended]

2. Amend § 17.1001 by removing paragraph (a)(5).

§ 17.1002 [Amended]

3. Amend § 17.1002 by removing the words “or in part” in paragraph (g).

4. Amend § 17.1004 as follows:

a. Remove paragraph (d)(1).

b. Redesignate paragraphs (d)(2), (d)(3) and (d)(4) as new paragraphs (d)(1), (d)(2) and (d)(3), respectively.

c. Add paragraph (f).

d. Add an information collection approval parenthetical at the end of the section.

The additions read as follows:

§ 17.1004 Filing claims.

* * * * *

(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 [insert date 30 days after date of publication in the FEDERAL REGISTER], if the claimant files a claim for reimbursement no later than 1 year after [insert date 30 days after date of publication in the FEDERAL REGISTER].

* * * * *

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

5. Amend § 17.1005 by adding paragraphs (e) and (f), to read as follows:

§ 17.1005 Payment limitations.

* * * * *

(e) If an eligible veteran under § 17.1002 has contractual or legal recourse against a third party that would only partially extinguish the veteran's liability to the provider of emergency treatment, then:

(1) VA will be the secondary payer;

(2) Subject to the limitations of this section, VA will pay the difference between the amount VA would have paid under this section for the cost of the emergency treatment and the amount paid (or payable) by the third party; and

(3) The provider will consider the combined payment under paragraph (c)(2) of this section as payment in full and extinguish the veteran's liability to the provider.

(f) VA will not reimburse a claimant under this section for any deductible, copayment or similar payment that the veteran owes the third party.

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[FR Doc. 2012-9265 Filed 04/19/2012 at 8:45 am; Publication Date: 04/20/2012]