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DEPARTMENT OF VETERANS AFFAIRS

8320-01

38 CFR Part 17

RIN 2900-AP09

Health Care for Certain Children of Vietnam Veterans and Certain Korea Veterans –
Covered Birth Defects and Spina Bifida

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its regulations concerning the provisions of health care to birth children of Vietnam veterans and veterans of covered service in Korea diagnosed with spina bifida, except for spina bifida occulta, and certain other birth defects. The proposed changes would more clearly define the types of health care VA provides, including day health care and health-related services, which VA would define as homemaker or home health aide services that provide assistance with Activities of Daily Living or Instrumental Activities of Daily Living that have therapeutic value. We would also make changes to the list of health care services that require preauthorization by VA.

DATES: Comments must be received by VA on or before [INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

ADDRESSES: Written comments may be submitted through www.regulations.gov; by mail or hand-delivery to the Director, Regulation Policy and Management (02REG), Department of Veterans Affairs, 810 Vermont Ave., NW., Room 1068, Washington, DC 20420; or by fax to (202) 273-9026. Comments should indicate that they are submitted in response to “RIN 2900-AP09 - Health Care for Certain Children of Vietnam Veterans and Certain Korea Veterans – Covered Birth Defects and Spina Bifida.” Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1068, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461-4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket -Management System (FDMS) at <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT: Karyn Barrett, Director, Program Administration Directorate, Chief Business Office Purchased Care (10NB3), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420, (303) 331-7500. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: Chapter 18 of title 38, United States Code, provides for benefits for certain birth children of Vietnam veterans and veterans of covered service in Korea who have been diagnosed with spina bifida, except spina bifida occulta, and certain other birth defects. These benefits include: (1) monthly monetary allowances for various disability levels; (2) health care; and (3) vocational

training and rehabilitation. VA has published regulations at 38 CFR 17.900 through 17.905 concerning health care for children authorized by 38 U.S.C. 1803 as well as 1813. Section 1803(a) authorizes VA to provide a child of a Vietnam veteran who is suffering from spina bifida, except spina bifida occulta, with health care. Section 1813(a) authorizes VA to provide a child of a woman Vietnam veteran who has been diagnosed with certain other birth defects needed health care for that child's covered birth defects or any disability that is associated with those birth defects. The definitions in section 1803(c) apply to both programs, with two narrow exceptions that are not relevant to this rulemaking.

The term "health care" under 38 U.S.C. 1803(c)(1) is defined as home care, hospital care, nursing home care, outpatient care, preventive care, habilitative and rehabilitative care, case management, and respite care. In addition, health care includes the training of appropriate members of a child's family or household in the care of the child; the provision of pharmaceuticals; supplies (including continence-related supplies such as catheters, pads, and diapers); equipment (including durable medical equipment); devices; appliances; assistive technology; and direct transportation costs to and from approved health care providers (including any necessary costs for meals and lodging en route and accompaniment by an attendant or attendants). Certain of these benefits and services require preauthorization by VA under § 17.902.

Health care that is not provided directly by VA must be provided by contract with an approved health care provider or by other arrangement with an approved health care provider. Under current § 17.900, "approved health care provider" means a health care provider currently approved by the Center for Medicare and Medicaid Services (CMS),

Department of Defense TRICARE Program, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Joint Commission on Accreditation of Health Care Organizations (JCAHO), or currently approved for providing health care under a license or certificate issued by a governmental entity with jurisdiction. An entity or individual will be deemed to be an approved health care provider only when acting within the scope of the approval, license, or certificate. We do not propose any substantive changes to the definition of approved health care provider, but the definition is relevant here because we use the term in this rulemaking.

VA has identified a need for certain types of care for these individuals and intends to clarify in regulation which services are authorized by 38 U.S.C. 1803 and 1813 and will be provided under this authority. We propose to amend our regulations to clarify what services constitute health care under § 17.900 and to revise the list of health care services that would require preauthorization by VA under § 17.902. These proposed changes are based on an advisory opinion from VA's Office of the General Counsel (OGC). VAOPGCADV 5-2013 (June 13, 2013). OGC issued this advisory opinion in response to a VA request for clarification as to whether VA is authorized by 38 U.S.C. 1803 to provide various types of health care services.

One of those services is day health care. Day health care services are a non-institutional alternative to nursing home care, and we believe that VA may reimburse these services under its authority in 38 U.S.C. 1803 to provide outpatient care and respite care.

Outpatient care is defined at 38 U.S.C. 1803(c)(6) to mean care and treatment of a disability, and preventive health services, furnished to an individual other than hospital

care or nursing home care. The phrase “care and treatment” is also found in the definitions of hospital care, nursing home care, and preventive care at 38 U.S.C. 1803(c)(4) through (7). The inclusion of the phrase “care and treatment” in the definitions of the categories of authorized health care services indicates legislative intent that a therapeutic component must be part of the service provided. Accordingly, we would define day health care to also include a therapeutic component. So defined, we believe that day health care services constitute care and treatment furnished outside of hospital care or nursing home care, and, therefore, that VA may provide day health care services as part of outpatient care authorized by 38 U.S.C. 1803. We would also amend the definition of outpatient care to include day health care as an authorized health care service.

We would define “day health care” to mean a therapeutic program prescribed by an approved health care provider that provides necessary medical services, rehabilitation, therapeutic activities, socialization, nutrition, and transportation services in a congregate setting. Day health care services contemplated under this proposal are equivalent to adult day health care provided to disabled veterans under 38 CFR 17.111(c)(1), except that such services would be provided to individuals who are not veterans. The essential features are the therapeutic focus of the day health care services and provision of these services in a congregate setting.

Current § 17.900 defines outpatient care as care and treatment, including preventive health services, furnished to a child other than hospital care or nursing home care. We would amend this definition to include day health care to clarify that day health care is a component of outpatient care.

Day health care services are also a component of respite care. Respite care is currently defined at § 17.900 as care furnished by an approved health care provider on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence. Respite care is a service that pays for a person to come to an individual beneficiary's home or for the beneficiary to go to a program, including a day health care program, so the family caregiver can have a period during which the caregiver is not responsible to provide care to the beneficiary. Respite care allows the family caregiver to run errands without worrying about leaving the beneficiary alone at home. Respite care can help reduce the stress a family caregiver may feel when managing a beneficiary's long-term care needs at home, and therefore can improve the quality of care and assistance provided to the beneficiary. VA currently provides day health care to eligible beneficiaries as an element of respite care, and we would amend the definition of respite care to clarify that it is an included service.

Home care is defined at § 17.900 as medical care, habilitative and rehabilitative care, preventive health services, and health-related services furnished to a child in the child's home or other place of residence. The regulation also defines habilitative and rehabilitative care and preventive health care but does not define "health-related services." We propose to define "health-related services" for purposes of §§ 17.900 through 17.905 as homemaker or home health aide services furnished in the individual's home or other place of residence to the extent that those services involve assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

that have therapeutic value. This is consistent with VA's interpretation of the term "health-related services" as it is used relative to care provided to veterans.

We would define homemaker services to mean certain activities that help to maintain a safe, healthy environment for an individual in the home or other place of residence. Such services contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care. Homemaker services would include assistance with personal care; home management; completion of simple household tasks; nutrition, including menu planning and meal preparation; consumer education; and hygiene education. Homemaker services may include assistance with IADLs, such as: light housekeeping; laundering; meal preparation; necessary services to maintain a safe and sanitary environment in the areas of the home used by the individual; and services essential to the comfort and cleanliness of the individual and ensuring individual safety. We would require that homemaker services must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

Home health aide services would mean personal care and related support services to an individual in the home or other place of residence. Home health aide services may include assistance with ADLs such as: bathing; toileting; eating; dressing; aid in ambulating or transfers; active and passive exercises; assistance with medical equipment; and routine health monitoring. We would also provide that home health aide services must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

Homemaker and home health aide services that are provided outside the beneficiary's residence, such as services related to grocery shopping, would not be covered, because the definition of home care is limited to those services provided in the child's home or other place of residence. Activities that have no therapeutic value or are not medical in nature also would not be covered. These activities include assisting an individual with personal correspondence or paying bills. For this reason, we define "health-related services" to include only those ADLs and IADLs with therapeutic value.

As with all services under section 1803, however, only those health-related services that are medical in nature and provided by an approved health care provider are covered by VA. Health-related services generally are delivered by different types of providers including personal attendants, custodial care providers, or companion services providers, and there may be instances in which these service providers are not "approved health care providers" as that term is defined by statute and regulation. As discussed in further detail below, we propose to require preauthorization for homemaker services, which is a subset of health-related services, and would be a newly defined service provided under existing statutory authority. VA already has an established review and payment process in place for home health aide services. Preauthorization for certain health care services is covered in § 17.902 and is discussed below. We believe that these requirements appropriately balance the needs of the beneficiaries served through this program and the statutory and regulatory requirements that any services provided through the program must be medical in nature and provided by an approved health care provider.

As noted above, home care is furnished to a child in the child's home or other place of residence. The term "other place of residence" is not further defined. In general, we believe this term applies to those instances in which the child may need a level of assistance that is not available in the home, but a higher level of care such as admission to a nursing home is not needed. We propose to define "other place of residence" to include assisted living facilities or residential group homes, both of which provide an intermediate level of assistance. We note that, while VA would provide home care services in an assisted living facility or residential group home, VA is not authorized to pay for a child to stay in either an assisted living facility or residential group home. The types of alternatives to home care that VA may provide under section 1803 are nursing home care, hospital care, and respite care.

We would also add a definition of "long-term care" to clarify the types of long-term care VA is authorized to provide under these programs. The term "long-term care" is not currently defined, and VA is frequently asked what types of long-term care VA is authorized to provide. Generally, "long-term care" encompasses a variety of services that include medical and non-medical care to people who have a chronic illness or disability. However, VA is authorized to provide only those types of long-term care that constitute "health care" as defined in 38 U.S.C. 1803(c)(1)(A). The three categories of health care VA has determined would be considered long-term care are home care, nursing home care, and respite care. We propose to define the term "long-term care" consistent with that determination. We would also amend the definition of "health care" to include long-term care.

In addition to the definitional clarifications proposed above, we propose to amend § 17.902, which sets forth the list of services and benefits for which preauthorization by VA is required. Preauthorization allows VA to ensure that health care services are provided by approved health care providers, prescribed and medically necessary, and provided at a reasonable cost. Requiring prior approval also limits the likelihood that beneficiaries will incur liability for non-reimbursable expenses. In selecting those services that require preauthorization, we focused on those services where there is likely to be a high cost and some question regarding whether a particular health care service meets the requirements of §§ 17.900 and 17.901.

Preauthorization is currently required for all mental health services. We would amend § 17.902(a) to provide that preauthorization is required only for outpatient mental health services in excess of 23 visits in a calendar year. We believe this change would assist beneficiaries by providing them with greater flexibility in obtaining needed mental health services. The proposed change would also align the preauthorization requirements for these programs with CHAMPVA, which does not require preauthorization for inpatient mental health services and requires preauthorization for outpatient mental health services only after the 23rd visit in a calendar year. CHAMPVA likewise covers non-veteran beneficiaries, and following the CHAMPVA standard here would ensure consistency. In addition, this proposed change would decrease the administrative burden for beneficiaries and would ensure that there is no delay in initiating necessary outpatient mental health services.

We also propose to add homemaker services to the list of services that require preauthorization. Both homemaker services and home health aide services are defined

as health-related services. We would not require preauthorization for home health aide services, because VA has an existing payment schedule and an established review process for these services. However, we would require preauthorization for homemaker services, because VA's authority to provide homemaker services is limited by type and scope. VA believes that requiring preauthorization for homemaker services would mitigate the possibility of beneficiaries receiving certain homemaker services that would not be covered by VA because the service was provided outside the individual's home or other place of residence, or the service had no therapeutic value.

As we noted above, day health care is an element of both outpatient care and respite care. VA already provides day health care to eligible beneficiaries as part of respite care, but it would now also be included as an element of outpatient care. Respite care, as a distinct class of services, does not require preauthorization. However, we would require preauthorization for day health care as part of outpatient care only to ensure that the day health care being claimed is a therapeutic program prescribed by an approved health care provider that provides necessary medical services, rehabilitation, therapeutic activities, socialization, and nutrition, and that the service is obtained at a reasonable cost. Preauthorization would still be required for dental services; substance abuse treatment; training; transplantation services; and travel (other than mileage at the General Services Administration rate for privately owned automobiles).

Current § 17.902(a) states that authorization will only be given in spina bifida cases where there is a demonstrated medical need. "Medically necessary" is a more

easily understood and more commonly used term than is “demonstrated medical need” and we propose to amend this paragraph to reflect the more commonly used term.

Payment for health care services is addressed in § 17.903(a)(1). The current rule states that payment for health care services will be determined using the same payment methodologies as provided for under CHAMPVA regulations. VA recognizes that services covered by CHAMPVA change periodically, and there may be instances in which CHAMPVA does not have a payment methodology for all health care services available under §§ 17.900 through 17.905 . For instance, homemaker services are excluded from CHAMPVA coverage at 38 CFR 17.272(a)(55) but may be covered as health-related services under § 17.900. To address this, we propose to amend this paragraph to state that payment for services or benefits covered by §§ 17.900 through 17.905 but not covered by CHAMPVA regulations will be determined using the same or similar payment methodologies applied by VA for the equivalent services or benefits provided to veterans. This may include negotiating a rate with the provider or using a national average or the Medicare rate.

We would make a technical edit to the definition of “approved health care provider” found in § 17.900. The current definition of “approved health care provider” includes health care providers currently approved by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). In 2007, JCAHO changed its name to The Joint Commission and we would amend this definition to reflect that change.

Finally, we address the Office of Management and Budget (OMB) control number referenced in §§ 17.902 through 17.904. OMB had approved information collection for

purposes of the Paperwork Reduction Act under OMB control number 2900-0578 for provision of health care, preauthorization, payment, review, and appeals. In 2010, OMB determined that information collection for the Spina Bifida Health Care Benefits program should be combined with a parallel information collection approved for CHAMPVA. This combined information collection was approved under OMB control number 2900-0219. We would make a technical edit to reflect the correct OMB control number.

Effect of Rulemaking

The Code of Federal Regulations, as proposed to be revised by this proposed rulemaking, would represent the exclusive legal authority on this subject. No contrary rules or procedures would be authorized. All VA guidance would be read to conform with this proposed rulemaking if possible or, if not possible, such guidance would be superseded by this rulemaking.

Paperwork Reduction Act

This proposed rule includes provisions constituting a modification to a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521) that requires approval by OMB. Accordingly, under 44 U.S.C. 3507(d), VA has submitted a copy of this rulemaking to OMB for review.

OMB assigns control numbers to collections of information it approves. 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. Proposed § 17.902 contains a collection of information under the Paperwork Reduction Act of 1995. If OMB

does not approve the modification as requested, VA will immediately remove the provisions containing a collection of information or take such other action as is directed by OMB.

Comments on the modification to the collection[s] of information contained in this proposed rule should be submitted to the Office of Management and Budget, Attention: Desk Officer for the Department of Veterans Affairs, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies sent by mail or hand delivery to the Director, Regulation Policy and Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue, NW., Room 1068, Washington, DC 20420; fax to (202) 273-9026; or through www.Regulations.gov. Comments should indicate that they are submitted in response to “RIN 2900-AP09-Health Care for Certain Children of Vietnam Veterans and Certain Korea Veterans – Covered Birth Defects and Spina Bifida.”

OMB is required to make a decision concerning the modification to the collection of information contained in this proposed rule between 30 and 60 days after publication of this document in the Federal Register. Therefore, a comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment on the proposed rule.

VA considers comments by the public on proposed collections of information in—

- Evaluating whether the proposed collections of information are necessary for the proper performance of the functions of VA, including whether the information will have practical utility;
- Evaluating the accuracy of VA’s estimate of the burden of the proposed collections of information, including the validity of the methodology and assumptions used;

- Enhancing the quality, usefulness, and clarity of the information to be collected;
- and
- Minimizing the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

The modifications to the collection of information contained in 38 CFR 17.902 are described immediately following this paragraph, under their respective titles.

Title: Health Care for Certain Children of Vietnam Veterans and Certain Korea Veterans – Covered Birth Defects and Spina Bifida.

Summary of collection of information: Section 17.902(a) states that preauthorization from VA is required for certain services or benefits under §§ 17.900 through 17.905. VA is modifying the preauthorization requirement for mental health services to only require preauthorization for outpatient mental health services in excess of 23 visits in a calendar year. VA also adds day health care provided as outpatient care and homemaker services to the list of services or benefits that must receive preauthorization.

Description of the need for information and proposed use of information: The information collected is needed to carry out the health care programs for certain children of Korea and/or Vietnam veterans authorized under 38 U.S.C. chapter 18, as amended by section 401, Public Law 106-419 and section 102, Public Law 108-183. VA's medical regulations 38 CFR part 17 (17.900 through 17.905) establish regulations regarding provisions of health care for certain children of Korea and Vietnam veterans

and women Vietnam veterans' children born with spina bifida and certain other covered birth defects. These regulations specify this information to be included in requests for preauthorization and claims from approved health care providers and eligible Veterans.

Description of likely respondents: Veterans and eligible family members seeking reimbursement for claims associated with spina bifida and certain other covered birth defects.

Estimated number of respondents per year: 12

Estimated frequency of responses: 1 time per year

Estimated average burden per response: 10 minutes

Estimated total annual reporting and recordkeeping burden: 2 hours

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would 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 proposed rule would directly affect only individuals and would not directly affect small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

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,” requiring review by the Office of Management and Budget (OMB), unless OMB waives such review, 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. VA’s impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA’s Web site at <http://www.va.gov/orpm/>, by following the link for VA Regulations Published From FY 2004 to FYTD.

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 the 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 1 year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

There are no Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document.

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. Jose D. Riojas, Chief of Staff, Department of Veterans Affairs, approved this document on April 2, 2015, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, 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, Reporting and recordkeeping requirements, Travel and transportation expenses, Veterans.

Dated: May 11, 2015

William F. Russo
Acting Director
Office of Regulation Policy & Management,
Office of the General Counsel,
Department of Veterans Affairs.

For the reasons stated in the preamble, Department of Veterans Affairs proposes to amend 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.

2. Amend § 17.900 by:

a. In the definition of “Approved health care provider” removing “Joint Commission on Accreditation of Health Care Organizations (JCAHO)” from the first sentence and adding, in its place, “The Joint Commission”;

b. Adding in alphabetical order a definition of “Day health care”;

c. In the definition of “Health care” adding “long-term care,” to the first sentence immediately after “hospital care,”;

d. Adding in alphabetical order definitions of “Health-related services”, “Home health aide services”, “Homemaker services”, “Long-term care”, and “Other place of residence”;

e. In the definition of “Outpatient care” adding “day health care and” immediately after the word “including”; and

f. Revising the definition of “Respite care”.

The additions and revision read as follows:

§ 17.900 Definitions.

* * * * *

Day health care means a therapeutic program prescribed by an approved health care provider that provides necessary medical services, rehabilitation, therapeutic activities, socialization, nutrition, and transportation services in a congregate setting. Day health care may be provided as a component of outpatient care or respite care.

* * * * *

Health-related services means homemaker or home health aide services furnished in the individual's home or other place of residence to the extent that those services provide assistance with Activities of Daily Living and Instrumental Activities of Daily Living that have therapeutic value.

* * * * *

Home health aide services is a component of health-related services providing personal care and related support services to an individual in the home or other place of residence. Home health aide services may include assistance with Activities of Daily Living such as: bathing; toileting; eating; dressing; aid in ambulating or transfers; active and passive exercises; assistance with medical equipment; and routine health monitoring. Home health aide services must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

Homemaker services is a component of health-related services encompassing certain activities that help to maintain a safe, healthy environment for an individual in the home or other place of residence. Such services contribute to the prevention, delay, or

reduction of risk of harm or hospital, nursing home, or other institutional care. Homemaker services include assistance with personal care; home management; completion of simple household tasks; nutrition, including menu planning and meal preparation; consumer education; and hygiene education. Homemaker services may include assistance with Instrumental Activities of Daily Living, such as: light housekeeping; laundering; meal preparation; necessary services to maintain a safe and sanitary environment in the areas of the home used by the individual; and services essential to the comfort and cleanliness of the individual and ensuring individual safety. Homemaker services must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

* * * *

Long-term care means home care, nursing home care, and respite care.

* * * *

Other place of residence includes an assisted living facility or residential group home.

* * * * *

Respite care means care, including day health care, furnished by an approved health care provider on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence.

* * * * *

3. Amend § 17.902 by:
 - a. Revising the first three sentences of paragraph (a); and

b. At the end of the section, removing “2900-0578” from the notice of the Office of Management and Budget control number and adding, in its place, “2900-0219”.

The revisions read as follows:

§ 17.902 Preauthorization.

(a) Preauthorization from VA is required for the following services or benefits under §§ 17.900 through 17.905: rental or purchase of durable medical equipment with a total rental or purchase price in excess of \$300, respectively, day health care provided as outpatient care; dental services; homemaker services; outpatient mental health services in excess of 23 visits in a calendar year; substance abuse treatment; training; transplantation services; and travel (other than mileage at the General Services Administration rate for privately owned automobiles). Authorization will only be given in spina bifida cases where it is demonstrated that the care is medically necessary. In cases of other covered birth defects, authorization will only be given where it is demonstrated that the care is medically necessary and related to the covered birth defects. * * *

* * * * *

4. Amend § 17.903 by:

a. In paragraph (a)(1), adding a second sentence; and

b. At the end of the section, removing “2900-0578” from the notice of the Office of Management and Budget control number and adding, in its place, “2900-0219”.

The addition reads as follows:

§ 17.903 Payment.

(a)(1) * * * For those services or benefits covered by §§ 17.900 through 17.905 but not covered by CHAMPVA we will use payment methodologies the same or similar to those used for equivalent services or benefits provided to veterans.

* * * * *

§ 17.904 [Amended]

5. Amending § 17.904 by, at the end of the section, removing “2900-0578” from the notice of the Office of Management and Budget control number and adding, in its place, “2900-0219”.

[FR Doc. 2015-11718 Filed: 5/14/2015 08:45 am; Publication Date: 5/15/2015]