



DEPARTMENT OF VETERANS AFFAIRS

8320-01

38 CFR Part 17

RIN 2900-AQ46

Veterans Community Care Program

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its medical regulations to implement its authority for covered veterans to receive necessary hospital care, medical services, and extended care services from non-VA entities or providers in the community. Section 101 of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Network Act of 2018 directs VA to implement a program to furnish such care and services to covered veterans through eligible entities and providers. This proposed rule would establish the criteria for determining when covered veterans may elect to receive such care and services through community health care entities or providers, as well as other parameters of this program.

DATES: Comments must be received on or before [insert date 30 days after the date of publication in the FEDERAL REGISTER].

ADDRESSES: Written comments may be submitted by email through <http://www.regulations.gov>; by mail or hand-delivery to Director, Office of Regulation

Policy and Management (00REG), Department of Veterans Affairs, 810 Vermont Avenue, NW., Room 1063B, Washington, DC 20420; or by fax to (202) 273-9026. (This is not a toll-free number.) Comments should indicate that they are submitted in response to “RIN 2900-AQ46, Veterans Community Care Program.” Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8:00 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: Joseph Duran, Office of Community Care (10D), Veterans Health Administration, Department of Veterans Affairs, Ptarmigan at Cherry Creek, Denver, CO, 80209; Joseph.Duran2@va.gov, (303) 370-1637. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION:

Summary:

Purpose of This Regulatory Action: We propose to create new regulations to define and implement the Veterans Community Care Program authorized by section 1703 of title 38, United States Code (U.S.C.), as that statute will be amended by section 101 of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of

2018, effective upon VA's issuance of implementing regulations. The Veterans Community Care Program will permit eligible veterans to elect to receive hospital care, medical services, and extended care services from eligible entities and providers. The Veterans Community Care Program would replace the Veterans Choice Program and would be used as the exclusive authority that determines eligibility under which VA would authorize covered veterans (as defined later in this rulemaking) to receive community care through eligible entities or providers.

Summary of the Major Provisions of this Regulatory Action: This proposed rule—

- Would establish the exclusive authority under which VA would authorize covered veterans to receive care in the community from eligible entities or providers at VA expense when such veterans meet established eligibility criteria.
 - Would define key terms used throughout the regulation. Many of these terms would be substantively similar to those defined in the Veterans Choice Program.
 - Would define eligibility criteria, including conditions under which covered veterans could elect to have VA authorize non-VA care through eligible entities or providers, subject to the availability of appropriations. In general, covered veterans would have to be enrolled in the VA health care system (or be eligible for care and services without enrolling) and would have to require care or services from an eligible entity or provider, as proposed to be defined in sections 17.4005 and 17.4030 of title 38, Code of Federal Regulations (CFR), because VA determined at least one of the following six conditions was met:
 - VA does not offer the required care or services;

- VA does not operate a full-service medical facility in the State in which the veteran resides;
 - the veteran was eligible to receive care under the Veterans Choice Program and is eligible to receive care under certain grandfathering provisions;
 - VA is not able to furnish care or services to a veteran in a manner that complies with VA's designated access standards;
 - the veteran and the referring clinician determine it is in the best medical interest of the veteran to receive care or services from an eligible entity or provider based on consideration of certain criteria VA proposes to establish;
- or
- the veteran is seeking care or services from a VA medical service line that VA has determined is not providing care that complies with VA's standards for quality.
- Would describe the process VA would use to identify medical service lines that are underperforming and that could be the basis for eligibility to receive non-VA care.
 - Would describe how non-VA care could be authorized through the election of a covered veteran who is eligible to receive non-VA care. Eligible veterans could also identify a specific entity or provider to furnish such care. VA would be able to authorize emergency care under certain conditions within 72 hours of such care being furnished.
 - Would describe the effect of the Veterans Community Care Program on other benefits and services available to covered veterans. In general, no provision in this section would 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. VA would continue to pay for and fill prescriptions written by non-VA health care providers to the extent such prescriptions were immediately required and were covered by the VA medical benefits package. VA would continue to calculate veterans' VA copayments under applicable regulations.

- Would establish those non-VA health care entities and providers that would be permitted to furnish care under the Veterans Community Care Program. The types of eligible entities or providers would be substantively identical to those presently permitted to participate under the Veterans Choice Program or in VA's other existing community care program.
- Would clarify payment rates and methodologies for care and services furnished by non-VA health care entities and providers through the Veterans Community Care Program, to include rates for Critical Access Hospitals as allowable under 42 U.S.C. 1395m, and other types of providers, including Federally Qualified Health Centers.
- Would designate access standards that would be a basis for eligibility for non-VA care.

Costs and Benefits: As further detailed in the Regulatory Impact Analysis, which can be found as a supporting document at <http://www.regulations.gov> and is available on VA's Web site at <http://www.va.gov/orpm/>, by following the link for "VA Regulations Published From FY 2004 Through Fiscal Year to Date," this proposed rule would affect covered veterans and eligible health care entities and providers. Covered veterans who meet at least one of the eligibility criteria may elect to receive, at VA expense and upon VA's authorization, care and services from an eligible entity or provider of their choice. Participating eligible entities and providers would be paid for furnishing authorized

hospital care, medical services, and extended care services to covered veterans under the Veterans Community Care Program in accordance with payment rates as described in this rulemaking.

General Discussion: On June 6, 2018, the President signed into law the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (hereafter referred to as the “MISSION Act,” Public Law 115-182, 132 Stat. 1395). This proposed rule would implement section 101 of the MISSION Act, which requires VA to implement a Veterans Community Care Program to furnish required care and services to covered veterans through eligible entities and providers. Section 101, which amends 38 U.S.C. 1703 upon the effective date of final regulations implementing this provision, further establishes the conditions under which VA would determine if covered veterans are eligible to elect to receive such care and services through eligible entities or providers, as well as other parameters of the Veterans Community Care Program. For the sake of convenience and understanding, we will refer to provisions of section 1703, as section 101 of the MISSION Act will amend it, although we recognize that section 1703 as so amended is not legally effective until VA has published a final rule implementing the Veterans Community Care Program. (Where we are referring to a provision in current section 1703, we will state “current section 1703.”).

We additionally clarify that throughout this rulemaking, the abbreviation “U.S.C.” or the term “section” will be used to indicate discussion of or reference to a statutory provision in the United States Code (e.g., “section 1703”) or in another statute, while the abbreviation “CFR” or the section symbol “§” will be used to indicate discussion of or

reference to an existing or proposed regulatory provision in the Code of Federal Regulations (e.g., “proposed § 17.4005”). There may be instances where the term “section” rather than the section symbol must be used at the beginning of a sentence to discuss or reference a regulatory provision, but it should be clear in the sentence that a regulatory provision is at issue. In general, any reference to a section that uses a period in it (e.g., § 17.55) is a reference to the CFR, while any reference without such a period (e.g., section 1703) is a reference to the U.S.C.

This proposed rule would implement in a regulatory framework the requirements in section 1703, consistent with the mandate that VA promulgate regulations to carry out the Veterans Community Care Program. Although VA is required to promulgate regulations, some of the provisions established in section 1703 are either self-executing and would not be more specifically interpreted by VA in regulation, or would be most appropriately established in the contracts, agreements, or other arrangements VA would use to purchase care under the Veterans Community Care Program. For instance, section 1703(h)(3)(A) establishes certain grounds for termination of a contract. There is no need to regulate this requirement, as section 1703 does not alter or amend VA’s existing authority to enter into, modify, or terminate a contract. This rulemaking generally will not promulgate regulations that merely restate the substantive provisions in section 1703 that are clear and unambiguous, although such provisions would apply to the Veterans Community Care Program regardless. VA proposes to codify the new Veterans Community Care Program regulations at 38 CFR 17.4000 through 17.4040.

Conforming revisions to regulations that reference the Veterans Choice Program

Subsection (p) of section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C.1701 note), as amended by section 143 of the MISSION Act, does not permit VA to furnish care and services through the Veterans Choice Program after June 6, 2019. However, this does not mean that all of the regulatory provisions under which the Veterans Choice Program is implemented (generally, 38 CFR 17.1500 - 17.1540) would be legally inoperative after June 6, 2019. There are some provisions in the Veterans Choice Program regulations (such as those provisions related to payment rates and limits on authorized care) that would need to continue to be in effect for resolution of claims arising from the Veterans Choice Program that would be in process after June 6, 2019 (for episodes of care performed under the Veterans Choice Program prior to June 6, 2019). We therefore do not propose to rescind the Veterans Choice Program regulations at this time, as VA will continue paying claims under such regulations for a period of time after the authority for the Veterans Choice Program expires, and we do not want to create any confusion as to how those claims should be processed or adjudicated. We anticipate further amendments to our regulations in the future to repeal the regulations governing the Veterans Choice Program and to remove references to the Veterans Choice Program in other regulations.

We similarly do not propose to remove references to the Veterans Choice Program in other applicable VA regulations at this time, but would add references to the Veterans Community Care Program in such regulations. Specifically, we would amend §§ 17.108(b)(4), 17.108(c)(4), and 17.110(b)(4) to include references to the Veterans Community Care Program under § 17.4000 through 17.4040 to ensure that copayments

for inpatient hospital care, outpatient medical care, and for medications reference the new Veterans Community Care Program in the same way these regulations currently reference the Veterans Choice Program. We also would amend § 17.111(b)(3) to include a reference to extended care services furnished through the Veterans Community Care Program under §§ 17.4000 through 17.4040 to ensure that copayments for extended care services (both institutional (i.e., continuous care occurring in a professional long-term care setting such as a nursing home) and non-institutional (i.e., non-continuous care occurring in non-professional settings such as a patient's home) under the new Veterans Community Care Program are treated the same way as copayments for non-institutional extended care services under the Veterans Choice Program.

Finally, we would delete the list of authorities for §§ 17.108, 17.110, and 17.111 to comply with the guidelines of the Office of the Federal Register and would add the complete list of authorities for these regulations, including 38 U.S.C. 1703, among the authority citations listed for part 17.

Conforming Amendments for Revisions to 38 U.S.C. 1703

We propose to make a number of conforming amendments to several existing regulations to reflect the consolidation of care and the initiation of the new Veterans Community Care Program. In general, for each of the regulations referenced below, we would also revise these regulations to remove specific authority citations in each section and instead to refer generally to these sections under the authority citation for part 17 to conform with publishing guidelines established by the Office of the Federal Register. We would generally impose sunset provisions on these regulations to ensure that they

do not continue to apply to VA's decisions regarding community care after the new Veterans Community Care Program begins on June 6, 2019. We do not propose to rescind these regulations at this time to allow VA to close out any bills or claims for care or services furnished prior to June 6, 2019, and to continue to refer to the existing regulations while processing these claims. VA will rescind any elements of these regulations at a later point in time when we are confident that such rescissions will not affect operations or create confusion for veterans or providers.

First, we propose to amend § 17.46. Section 17.46 governs how VA furnishes hospital care under 38 U.S.C. 1710(a)(1), which generally requires VA to furnish hospital care and medical services the Secretary determines to be needed to any veteran for a service-connected disability and to any veteran who has a service-connected disability rated at 50 percent or more. Section 17.46 specifically requires VA to furnish care in a VA facility, or if that facility is incapable of furnishing care, arrange to admit the veteran to another VA facility, a DoD facility with which VA has a sharing agreement, or arrange for care on a contract basis if authorized by 38 U.S.C. 1703 and 38 CFR 17.52, if the veteran is in immediate need of hospitalization. If the veteran does not need immediate hospitalization, § 17.46 further provides that VA will schedule the veteran for admission at a VA facility or refer the veteran to a DoD facility with which VA has a sharing agreement. We propose to amend § 17.46 to clarify that paragraph (a) of this provision would no longer apply after June 6, 2019. We do not propose to make any changes to paragraph (b) of § 17.46, which deals with eligibility for domiciliary care. While we do not generally believe that § 17.46(a) is used or relied upon to authorize care in the community for eligible veterans, we believe it is important to avoid creating

any confusion by establishing a sunset for this provision to ensure that any decisions regarding eligibility for a covered veteran to receive care in the community are made under the regulations proposed in this rulemaking.

Second, we propose to amend § 17.52 to add a new paragraph (c) that would similarly establish a sunset provision for this regulation. Section 17.52 generally establishes eligibility for community care under the existing 38 U.S.C. 1703. Upon the effective date of a final rule for this rulemaking, the current section 1703 will no longer exist. As a result, § 17.52 would no longer apply to care furnished after June 6, 2019, as it would be implementing a statute that no longer exists.

Third, we propose to amend § 17.55 to clarify the scope of its applicability. Section 17.55 currently establishes payment rates and standards for hospital care furnished by non-VA entities or providers. Proposed § 17.4035 as presented in this rulemaking would establish general parameters for payment, and thus would eliminate the need for this rule in part. However, it would not do so entirely. Current § 17.55 establishes payment rates for care that VA pays on a reimbursement basis, most notably emergency care under 38 U.S.C. 1728 and 38 CFR 17.120 and 17.128, as well as payment for care for eligible family members of veterans stationed at Camp Lejeune under 38 U.S.C. 1787 and 38 CFR 17.410. Because these programs will continue to operate independently from the new Veterans Community Care Program, VA is proposing to add language that would sunset the applicability of § 17.55 only for care and services furnished to covered veterans. Payments for care and services furnished under the Veterans Community Care Program would be subject to § 17.4035 as proposed in this rule. We would also make a technical change to § 17.55 to remove the

reference to the Health Care Financing Administration and instead refer to the Centers for Medicare & Medicaid Services (CMS) given the change in this agency's name. We would make a similar revision to § 17.1004(b) where an HCFA form is referenced to instead refer to a CMS form.

Finally, we propose to modify § 17.56 to include a new paragraph (e). Similar to the changes above regarding § 17.55, VA proposes to amend the current regulation to clarify that payments for care furnished under 38 U.S.C. 1725 and 38 CFR 17.1005, which govern VA's other authority to reimburse for emergency treatment, payments under 38 U.S.C. 1728 and 38 CFR 17.120 and 17.128, and payments under 38 U.S.C. 1787 and 38 CFR 17.410 would continue under this regulation, while this section would no longer generally establish payment rates for care in the community after June 6, 2019.

§ 17.4000, Purpose and Scope.

Proposed § 17.4000(a) would establish that the purpose of proposed regulations §§ 17.4000-17.4040 would be to implement the Veterans Community Care Program authorized by section 1703. As previously stated, we will refer to section 1703 as amended by section 101 of the MISSION Act for clarity and convenience, even though those amendments technically will not come into effect until final regulations are effective to implement the Veterans Community Care Program.

Section 17.4000(b) would state that the Veterans Community Care Program establishes when a covered veteran could elect to have VA authorize an episode of care for hospital care, medical services, or extended care services with eligible entities

or providers. Section 17.4000(b) would further state that §§ 17.4000-.4040 do not affect eligibility for non-VA care under sections 1724, 1725, 1725A, or 1728 of title 38, United States Code. Sections 1724, 1725, 1725A, and 1728 establish other methods for accessing community care without requiring express authorization from VA prior to the receipt of such care. Because sections 1724, 1725, 1725A, and 1728 establish distinct eligibility criteria that determine when VA can reimburse for care and services in the community as specified under those statutes, such criteria would not be affected by this proposed rule. This would relieve an individual that does meet the eligibility criteria under section 1725A, for instance, from also having to meet the eligibility criteria under section 1703 in order to receive care under section 1725A. As another example, this clarification would not amend VA's authority to furnish care to veterans participating in VA's Foreign Medical Program under section 1724. Similarly, some veterans receive care from the Indian Health Service (IHS) and Tribal Health Programs (THP) under a sharing agreement with VA. VA has existing reimbursement agreements with IHS and THPs under which VA reimburses IHS and THPs for certain care provided to eligible American Indian/Alaskan Native veterans. Care provided under these agreements (generally referred to as "other arrangements" in statute) would not be affected by this proposed rule. This proposal also would not modify VA's existing statutory authorities to furnish care in the community at VA expense to anyone who is not a covered veteran (generally, non-veteran beneficiaries) who may be eligible for such care pursuant to other authorities, such as sections 1786 or 1787, because such individual would not meet the definition of covered veteran (as would be defined in proposed § 17.4005). The requirements of those statutes and their implementing regulations would continue

to apply, and VA would use those specific authorities when appropriate to furnish community care for non-veteran beneficiaries of care under chapter 17 of title 38, U.S.C.

§ 17.4005, Definitions.

Proposed § 17.4005 would define terms for purposes of §§ 17.4000 through 17.4040. In general, these would be defined in the same way, or very similar ways, to terms used in VA's Veterans Choice Program regulation at § 17.1505, where such definitions would support the same or similar concepts in the Veterans Community Care Program. Certain terms defined in § 17.1505 would no longer be applicable in the Veterans Community Care Program and so would be excluded here. Other terms would be new to this section. The explanation that follows of the proposed definitions in § 17.4005 is presented by comparison to what is in current § 17.1505, to provide a clearer understanding of whether or to what extent definitions or concepts are proposed to change from the Veterans Choice Program to the future Veterans Community Care Program. We do not propose to explain the omission of certain terms from § 17.1505, but will instead explain the definitions we propose to adopt in § 17.4005 by reference to § 17.1505.

The term appointment is currently defined in § 17.1505 to mean an authorized and scheduled encounter with a health care provider for the delivery of hospital care or medical services. Under § 17.1505, a visit to an emergency room or an unscheduled visit to a clinic is not an appointment. The proposed definition of appointment in § 17.4005 would be slightly revised, to include the term extended care services, as all types of extended care services would be available for covered veterans who otherwise

qualify for such care under the Veterans Community Care Program in accordance with sections 1703, 1710, and 1710A. Also, the proposed definition of appointment would not include the sentence in current § 17.1505 excluding emergency room visits and unscheduled visits, as certain forms of emergency care would be otherwise addressed in proposed § 17.4020(c). We would further recognize that ad hoc telehealth encounters or same day care would be considered an appointment, even though these are not always scheduled in advance. The term appointment would be used primarily in proposed § 17.4010, related to veteran eligibility to receive care or services through the Veterans Community Care Program.

The term covered veteran would be newly defined in proposed § 17.4005 to mean 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 under 38 U.S.C. 1705(c)(2). This definition would be consistent with how the term covered veteran is defined in section 1703(b) and would be relevant for determinations of veteran eligibility for community care under proposed § 17.4010. We note that certain veterans are not required to enroll to receive care and services, although many would only qualify for a narrow range of services without enrolling. Section 1705(c)(2) directs VA to provide hospital care and medical services for the 12 month period following the veteran's discharge or release from service to any veteran referred to in sections 1710(a)(1) (which refers to furnishing hospital care and medical services determined to be needed for a service-connected disability and to any veteran with a service-connected disability rated at 50 percent or more) and (a)(2)(B) (which refers to furnishing hospital care, medical services, and nursing home care determined

to be necessary to a veteran whose discharge or release from active military, naval, or air services was for a disability that was incurred or aggravated in the line of duty) for a disability specified in those provisions of law, notwithstanding the failure of the veteran to enroll in the VA health care system. Any veteran meeting these conditions would be considered a covered veteran under this definition. Moreover, there are a number of special treatment authorities, such as sections 1702, 1710(a)(2)(F) and (e), 1720D, and 1720E, that direct VA to provide certain care and services to certain veterans. Although the conditions that can be treated under these special treatment authorities are not technically service-connected, as VA explained in a prior rulemaking titled “Third Party Billing for Medical Care Provided under Special Treatment Authorities” (RIN 2900-AP20), veterans eligible under these special treatment authorities are eligible for treatment of specific conditions, which although not adjudicated as service-connected, are treated as the practical equivalent for medical care purposes. 83 FR 31452, 31453 (July 6, 2018). As a result, we believe it would be consistent with our interpretation of these special treatment authorities under other laws and regulations to regard these as the practical equivalent of service-connected conditions as described in 1705(c)(2). Similarly, section 2 of Public Law 95-126, as amended (38 U.S.C. 5303 note), directs VA to provide the type of health care and related benefits authorized to be provided under chapter 17 for any disability incurred or aggravated during active military, naval, or air service in the line of duty by a person other than one statutorily barred from receiving benefits under section 5303(a), but prohibits VA from providing such health care and related benefits pursuant to this section for any disability incurred or aggravated during a period of service from which such person was discharged by

reason of a bad conduct discharge. We would, similar to the special treatment authorities, regard persons eligible under section 2 of Public Law 95-126 as satisfying the condition of not needing to enroll. Consequently, veterans who are not enrolled but who qualify for services under section 1705(c)(2), section 2 of Public Law 95-126, or any of the special treatment authorities would be considered covered veterans for purposes of this definition and would be subject to the eligibility criteria in proposed § 17.4010.

The term eligible entity or provider would be newly defined in proposed § 17.4005 to mean a health care entity or provider that meets the requirements of § 17.4030. The section of this rule that discusses proposed § 17.4030 will describe those requirements, but we note here that the potentially eligible entities and providers under the Veterans Community Care Program would be substantively identical to those expressly identified as eligible to participate in the Veterans Choice Program under current § 17.1510. This proposed definition is not intended to make any substantive changes from the Veterans Choice Program in terms of the entities or providers that would participate in the Veterans Community Care Program, and any entities or providers furnishing care and services through VA's existing community care program would similarly be eligible if they enter into a contract, agreement, or other arrangement to furnish such care and services. This would include private providers that are typically thought of in relation to furnishing VA community care, as well as non-VA Federal or other health care providers such as the Department of Defense or the Indian Health Service. As described in further detail in proposed § 17.4030, the critical elements that must be met for an entity or provider to be an eligible entity or provider are (1) that the

entity or provider must have entered into a contract, agreement, or other arrangement to furnish care and services under the Veterans Community Care Program; (2) the entity or provider not be a part of, or an employee of, VA; and (3) the entity or provider must be accessible to the covered veteran.

The term episode of care is currently defined in § 17.1505 to mean 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. The proposed definition of episode of care in § 17.4005 would vary from the definition under current § 17.1505 by removing the reference to the date of the first appointment with a non-VA health care provider. The phrase seems unnecessary, as the episode of care would necessarily begin with the first such appointment. This change would not, however, create a broader standard than presently exists in the Veterans Choice Program in terms of the possible duration of an episode of care, because the definition of episode of care in proposed § 17.4005 still means a necessary course of treatment, including follow-up appointments and ancillary and specialty services for identified health care needs. VA would therefore retain the responsibility for care coordination with eligible entity or providers in this proposed revised definition to determine whether ancillary and specialty care of any duration up to 1 year would be needed in the course of a veteran's care. For care or services that would need to extend beyond one year, additional care would need to be authorized by VA. In addition, it is possible that any one episode of care may not capture all care or treatment fully necessary to improve, restore, or promote a veteran's health, as a veteran may have multiple conditions that could require VA to authorize

several episodes of care at the same time. While some episodes of care require only a single visit, and others may require multiple visits, in all cases VA would continue to authorize, as part of care coordination, only care that is clinically necessary over the course of treatment. If an eligible entity or provider believed that a veteran needed additional care beyond the authorized episode of care, the eligible entity or provider would be required to contact VA prior to administering or referring such care to ensure that this care was authorized and therefore would be paid for by VA. In short, under the revised definition of episode of care in proposed § 17.4005, whether additional care constituted a new episode of care would continue to be a clinical determination based on generally acceptable clinical practices and protocols, whenever possible, as part of care coordination conducted by VA in close consultation with eligible entities or providers.

The term extended care services would be newly defined in proposed § 17.4005 to include the same services as described in 38 U.S.C. 1710B(a). This definition would be required as section 1703(a)(1) makes extended care services available under the Veterans Community Care Program, whereas only certain non-institutional extended care services are available as medical services under the Veterans Choice Program. This proposed definition to include those services described in section 1710B(a) would be sufficiently broad to capture all extended care services offered by VA.

The term full-service VA medical facility would be newly defined in proposed § 17.4505 to mean a VA medical facility that provides hospital care, emergency medical services, and surgical care and having a surgical complexity designation of at least standard. This proposed definition would also include a note that would state that VA

maintains a Web site 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. This proposed definition would be relevant for determinations of certain veteran eligibility under proposed § 17.4010 and is consistent with how a VA facility is characterized for purposes of similar veteran eligibility under current § 17.1510(b)(3). The current location for information regarding the surgical complexity levels of VA facilities is on VA’s website: www.va.gov/health/surgery. We do not propose to identify a specific URL in our regulations in the event that this information is ultimately moved to another page on VA’s website.

The terms hospital care and medical services would be newly defined in proposed § 17.4005 by cross referencing to the applicable statutory definitions for these terms at 38 U.S.C. 1701(5) and (6), respectively, to sufficiently capture those types of care furnished by VA. These terms would be used throughout these proposed regulations, as section 1703(a)(1) requires the furnishing of hospital care, medical services, and extended care services through the Veterans Community Care Program. We have interpreted these terms through VA’s medical benefits package in § 17.38, and this benefits package would be available to covered veterans under the Veterans Community Care Program when clinically necessary, as required by section 1703(n)(1) and § 17.38(b). Section 1703(n)(1) prohibits VA from limiting the types of care or services covered veterans may receive under this section if it is in the best medical interest of the veteran to receive such care or services as determined by the veteran and the veteran’s health care provider. We interpret section 1703(n)(1) to reinforce the requirement currently in regulation at § 17.38(b) that 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.

The term health-care plan is currently defined in § 17.1505 to mean 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. We would propose minor changes in proposed § 17.4005 to rename this term as other health-care plan contract because other health-care plan contract is the term that appears in section 1703(j). This term would be relevant for purposes of proposed § 17.4010(c) related to when covered veterans participating in the Veterans Community Care Program would have to report on their third-party health care insurance, similar to how the term health-care plan is used in current § 17.1510(d).

The term residence is currently defined in § 17.1505 to mean a legal residence or personal domicile, even if such residence is seasonal. Section 17.1505 further provides that a person may maintain more than one residence but may only have one residence at a time. It also states that 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. Finally, it states that a post office box or other non-residential point of delivery does not constitute a residence. We would propose minor edits to this definition in proposed § 17.4005 to refer consistently to covered veterans instead of person or veteran, as this is the term used in these regulations. We also would include extended care services for the reasons described above. This term would be used in proposed § 17.4010, and the section of this rulemaking that explains proposed § 17.4010 would explain VA's proposed revisions to certain geographic conditions that can establish eligibility for community care.

The term schedule is currently defined in § 17.1505 to mean identifying and confirming a date, time, location, and entity or health care provider for an appointment. We would clarify in proposed § 17.4005 that schedule requires identifying and confirming a date, time, and location for an appointment in advance of such appointment. We would further add a note explaining that a VA telehealth encounter would be considered to be scheduled even if such encounter is conducted on an ad hoc basis. In the years since the Veterans Choice Program was established, VA's telehealth program has grown, and its authority to furnish care has been buttressed through regulation (see § 17.417) and statute (see section 1730C, as added by section 151 of the MISSION Act). Some telehealth encounters are scheduled well in advance of the appointment, while others are made available to eligible and interested veterans on an ad hoc basis (for example, if a veteran cancelled an appointment or did not show up to an appointment, VA schedulers may follow up with the veteran and ask the veteran if he or she would like to participate in a telehealth encounter at that moment). This note would clarify that in either scenario, a telehealth encounter would be

considered scheduled and would thus qualify as an appointment under the definition of appointment described above. As described in further detail later in this regulation, if VA is able to furnish a covered veteran with care or services through telehealth, whether through a telehealth encounter that was scheduled well-in advance or one conducted on an ad hoc basis, and the veteran accepts the use of this modality for care, VA would determine that it was able to furnish such care or services in a manner that complies with designated access standards. We would similarly consider same-day services provided to a veteran who did not schedule an appointment in advance as scheduled. This is also a new service that VA has only begun routinely offering in the past several years and is distinct from the unscheduled visits we referred to in the Veterans Choice Program regulations at § 17.1505, as those were primarily concerned with open clinics (such as general group counseling or services, like access to a gymnasium, that do not have or require an appointment). Just as with telehealth, if VA were able to offer the care or services a veteran required on a same-day basis, we would determine that VA was able to furnish the care or services in a manner that complies with designated access standards. The term schedule would be used throughout the proposed regulations, primarily in proposed § 17.4010 related to veteran eligibility for care under the Veterans Community Care Program.

The term VA facility would be newly defined in proposed § 17.4005 to mean a VA facility that offers hospital care, medical services, or extended care services, although the similar term VA medical facility was defined in § 17.1505. This definition would be required in relation to certain veteran eligibility under the Veterans Community Care Program in proposed § 17.4010. We note that we propose different definitions for full-

service VA medical facility and VA facility, as these terms would be applied to discrete proposed eligibility criteria to furnish care under the Veterans Community Care Program. We propose to refer in this definition of VA facility to the types of care and services that a facility provides, rather than the designations of the facilities (e.g., VA medical center, community-based outpatient clinic (CBOC), etc.) to ensure that any future descriptions of VA facilities would not result in a gap in our regulations for this Program. VA has multiple types of facilities from which VA care and services are furnished, including but not limited to medical centers, CBOCs, outreach clinics, and mobile clinics, among others. By defining VA facility broadly in terms of the types of care or services that could be provided, we would avoid the need to revise a specific list of facility types in the event that VA develops new types of facilities or renames existing types of facilities. We note that the term VA facility intends to capture a single site of care, and not for instance a grouping of multiple facilities that are under the direction of one administrative VA parent facility. We further note that Vet Centers, which were expressly excluded from the definition of a VA medical facility under § 17.1505, would still be excluded, as Vet Centers do not furnish hospital care, medical services, or extended care services.

The term VA medical service line would be newly defined in proposed § 17.4005 to mean a specific medical service or set of services delivered in a VA facility. We believe this is consistent with but also more appropriately descriptive than the definition of the term in section 1703(o)(2). We propose to refer to VA facilities, rather than only VA medical centers, because this definition is relevant for purposes of establishing eligibility under section 1703(e), and paragraph (1)(B) of that subsection specifically

refers to comparisons of timeliness and quality at a facility of the Department, rather than just a medical center. Moreover, reports from the Veterans' Affairs Committees of the Senate and the House of Representatives both consistently refer to this provision affecting VA facilities, rather than only VA medical centers. See S. Rpt. 115-212, p. 10; see also H. Rpt. 115-671, Part 1, pp. 5, 51. In this context, we believe using the term facility is appropriate. This definition would apply for purposes of proposed §§ 17.4010(a)(6) and 17.4015.

§ 17.4010, Veteran eligibility.

Section 1703(d) 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. Section 1703(d)(3) requires VA to make determinations regarding whether these conditions are met for sections 1703(d)(1)(A)-(D). Section 1703(e) authorizes VA to furnish care in the community through eligible entities and providers. VA proposes to establish a single section of regulations, § 17.4010, that would cover these three provisions of law under the general mantle of eligibility for ease of understanding and review and to align with dozens of other VA health care regulations. We emphasize that while we describe this as eligibility, covered veterans do not need to do anything other than contact VA to request care and provide the information required in paragraphs (b) and (c), as they typically would. It is VA's responsibility to determine whether the veteran has met any of the conditions described here and would be eligible to make an election to have VA authorize the care in the community.

Similar to the definitions section above, portions of the following explanation of veteran eligibility in proposed § 17.4010 will be presented by comparison to current veteran eligibility under the Veterans Choice Program at § 17.1510, to provide a clearer understanding of whether eligibility is proposed to change under the future Veterans Community Care Program. We will also note where the proposed eligibility criteria align with informal criteria used in VA's existing community care program. We additionally reiterate that, for the sake of convenience and understanding, we will refer to provisions of section 1703, as section 101 of the MISSION Act will amend it, although we recognize that section 1703 as so amended is not legally effective until VA has published a final rule implementing the Veterans Community Care Program. When we do refer to the current section 1703 to describe current eligibility criteria, we will refer to it as such.

Consistent with the structure of veteran eligibility determinations under the Veterans Choice Program at 38 CFR § 17.1510, as well as the structure of veteran eligibility under 38 USC section 1703(b), (d), and (e), proposed § 17.4010 would establish that determinations of veteran access to care or services through the Veterans Community Care Program would be based on a two-part assessment. First, the introductory text of proposed § 17.4010 would establish that a veteran must meet the definition of covered veteran, which as previously explained in the definitions section would mean that the veteran is enrolled under the system of patient enrollment in § 17.36, or the veteran must otherwise meet the criteria to receive care and services notwithstanding his or her failure to enroll under 38 U.S.C. 1705(c)(2). This requirement to establish a threshold eligibility related to a veteran's enrollment status would be

consistent with definition of a covered veteran in section 1703(b), and would be consistent generally with the Veterans Choice Program (which was only available to enrolled veterans). The proposed definition of covered veteran would clarify that the Veterans Community Care Program would include veterans under section 1705(c)(2) not subject to the requirement to enroll. Veterans meeting either of these requirements would be considered a covered veteran. The second part of the assessment is for VA to determine whether any of the six conditions described in proposed § 17.4010(a) are met. Moreover, such eligible veterans would have to provide VA with the information that would be required by proposed § 17.4010(b) and (c) as a condition for receiving care and services through this Program.

Proposed § 17.4010(a) would state that the covered veteran would have to require hospital care, medical services, or extended care services. This is a core requirement for VA to furnish any care under the medical benefits package at 38 CFR 17.38(b), as such care must be necessary to promote, preserve, or restore the health of the veteran. In addition, one of the six conditions identified in sub-paragraphs (1) through (6) would have to be met. These conditions in proposed § 17.4010(a)(1)-(a)(6) would reflect the specific six conditions under sections 1703(d) and (e) for covered veterans to receive care through the Veterans Community Care Program, which generally are:

- VA does not offer the care or services the veteran requires;
- VA does not operate a full-service medical facility in the State in which the veteran resides;

- The veteran was eligible to receive care under the Veterans Choice Program and is eligible to receive care under certain grandfathering provisions;
- VA is not able to furnish care or services to a veteran in a manner that complies with VA's designated access standards;
- The veteran and the veteran's referring clinician determine it is in the best medical interest of the veteran to receive care or services from an eligible entity or provider based on consideration of certain criteria that VA would establish; or
- The veteran is seeking care or services from a VA medical service line that VA has determined is not providing care that complies with VA's standards for quality.

The explanation that follows will provide more specific interpretations of these general conditions from sections 1703(d) and (e), and we note that each condition would be an independent means by which a covered veteran could access care or services through the Veterans Community Care Program. For instance, if a covered veteran did not qualify for community care under proposed § 17.4010(a)(1), such veteran might still qualify under proposed § 17.4010(a)(2)-(a)(6). The conditions in proposed §17.4010(a)(1)-(a)(6) would also not be mutually exclusive in an absolute sense. While VA proposes to distinguish each condition meaningfully, it may be the case that veterans could be considered eligible under more than one proposed criterion. For example, a veteran who resides in a State without a full-service VA medical facility might also require care or services that VA does not offer. Some of the conditions, such as residing in a State without a full-service VA medical facility, or qualifying under the grandfathering provision related to 40-mile eligibility and residence in one of the five States with the lowest population density in the 2010 census, would qualify a veteran to

receive any clinically necessary hospital care, medical services, or extended care services that is in accord with generally accepted standards of medical practice and that is needed to promote, preserve, or restore the veteran's health. Other conditions, such as VA not offering the care or service a covered veteran requires, would only qualify the veteran to receive a particular episode of care in the community for that care or service. We will describe these general parameters of eligibility as we explain each specific criterion.

Proposed §17.4010(a)(1) would establish eligibility for a covered veteran to access care and services through the Veterans Community Care Program if VA determined that no VA facility offered the hospital care, medical services, or extended care services the veteran requires. Proposed § 17.4010(a)(1) would implement the eligibility criterion under section 1703(d)(1)(A) related to when the Department does not offer the care or services. VA proposes to interpret this criterion to capture certain care and services that VA does not offer at any of its facilities, (such as full obstetrics care, the limited provision of certain in vitro fertility services, and certain non-institutional extended care services such as homemaker/home health aide services) and that VA exclusively relies on non-VA health care entities or providers to furnish. Covered veterans requiring such care and services would be considered eligible for the Veterans Community Care Program under proposed § 17.4010(a)(1) for the specific care or service they require. Although this criterion would be an assessment of VA facilities at large, VA would capture whether a VA facility does not offer the specific care and service that a covered veteran requires in relation to the residence of the covered veteran, for instance, during the consultation with the VA clinician or member of the VA

care coordination team at the time when access to care in the community is determined. We intend that proposed § 17.4010(a)(1) would be a simple qualifier for covered veterans that need certain types of care that VA simply does not provide in any of its facilities. Any covered veteran requiring such care or services would not have to be assessed any further under other proposed eligibility criteria for community care. This would provide clarity for veterans and would be administratively simpler for VA. We note that proposed §17.4010(a)(1) would not be used to limit access to community care generally in instances where a single VA facility offers the care or services required; covered veterans would simply be assessed under one of the other five eligibility criteria in proposed §17.4010(a)(2)-(a)(6). We reiterate that each of the eligibility criteria in proposed §17.4010(a)(1)-(a)(6) would be an independent means by which a covered veteran could be considered eligible to receive required care or services through the Veterans Community Care Program. Because proposed § 17.4010(a)(4) would separately assess eligibility for community care in a manner that considered whether individual VA facilities offered the required care or services in relation to individual covered veterans, the interpretation in proposed § 17.4010(a)(1) to consider the availability of care or services anywhere in the VA system would allow VA to give meaning to every community care eligibility criterion under section 1703(d), and would prevent any one criterion from subsuming others. Proposed § 17.4010(a)(1) does not have an analogous or substantively similar eligibility criterion under current § 17.1510, but would reflect current practice through both the Veterans Choice Program and VA's traditional community care program. Under the Veterans Choice Program, eligible veterans requiring services that VA does not provide in any location would qualify under

the wait-time criteria, as the wait-time to receive that care in a VA facility would be infinite. Under the current section 1703(a), VA may contract with non-VA facilities to furnish care and services when VA facilities are not capable of furnishing the care or services required. Covered veterans would only be eligible under proposed § 17.4010(a)(1) for the specific care or service they require that VA does not furnish.

Proposed § 17.4010(a)(2) would establish eligibility for a covered veteran to receive care and services through the Veterans Community Care Program if VA has determined that it does not operate a full-service VA medical facility in the State in which such covered veteran resides. Proposed § 17.4010(a)(2) would implement the eligibility criterion in section 1703(d)(1)(B). Proposed § 17.4010(a)(2) would be analogous to current § 17.1510(b)(3)(i), although proposed § 17.4010(a)(2) would not retain the 20-mile qualifying criterion in current 38 CFR § 17.1510(b)(3)(ii), to be consistent with section 1703(d)(1)(B). VA has determined that this change would only affect a small portion of veterans residing in New Hampshire along the border with Vermont, and the effect would be to establish their eligibility to elect to receive community care under this new Program. We reiterate from the definitions section that VA would interpret a full-service VA medical facility to mean a VA medical facility that provides hospital care, emergency medical services, and surgical care and having a surgical complexity designation of at least “standard,” which is how a VA facility is characterized in current § 17.1510(b)(3)(i) for purposes of assessing the capabilities of a VA facility within a State to provide care and services. Currently, Alaska, Hawaii, New Hampshire, and most of the U.S. territories (American Samoa, the Northern Mariana Islands, Guam, and the U.S. Virgin Islands) qualify as States without a full-service VA

medical facility. Eligibility under this criterion would qualify a covered veteran to elect to receive in the community any hospital care, medical services, or extended care services that is needed to promote, preserve, or restore the health of the veteran and that is in accord with generally accepted standards of medical practice.

Proposed § 17.4010(a)(3) would establish eligibility for a covered veteran to receive care and services through the Veterans Community Care Program if VA has determined that the covered 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 (Public Law 113–146; 38 U.S.C.1701 note) as of June 5, 2018, and continues to reside in a location that would have qualified the veteran under section 101(b)(2)(B), and one of two additional conditions is met: the veteran (i) resides in one of the five States with the lowest population density as determined by data from the 2010 decennial census (Alaska, Montana, North Dakota, South Dakota, or Wyoming); or (ii) does not reside in one of these States, but received care or services under title 38 U.S.C. in the year preceding June 6, 2018, and is seeking care before June 6, 2020. For purposes of this latter category, we note that receipt of care or services under title 38, U.S.C., would include literally any hospital care, medical service, or extended care service VA furnished to the veteran, whether in a VA facility or not. Proposed § 17.4010(a)(3) would implement the eligibility criterion in section 1703(d)(1)(C), to effectively grandfather eligibility for those veterans who qualify for care under the Veterans Choice Program under current § 17.1510(b)(2) based on the 40-mile distance criterion. We note that, consistent with section 1703(d)(1)(C), the grandfathering of eligibility in proposed § 17.4010(a)(3) would be carried forward

indefinitely for only those covered veterans that reside in Alaska, Montana, North Dakota, South Dakota, or Wyoming. Any covered veterans that did not reside in one of these States would only be considered to have this grandfathered eligibility related to the 40-mile criterion in current § 17.1510(b)(2) for the first two years after the date of enactment of the MISSION Act, until June 6, 2020. Eligibility under this proposed criterion would qualify a covered veteran to elect to receive in the community any hospital care, medical service, or extended care service that is needed to promote, preserve, or restore the health of the veteran and that is in accord with generally accepted standards of medical practice.

Proposed § 17.4010(a)(4) would establish conditions for a covered veteran to access care and services through the Veterans Community Care Program if the covered veteran 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 VA access standards that would be established in proposed § 17.4040. Proposed § 17.4010(a)(4) would implement the eligibility criterion in section 1703(d)(1)(D). The proposed access standards themselves are explained in the section of this rule that discusses proposed § 17.4040, which would implement both section 1703(d)(1)(D) and portions of section 1703B. Access to care in the community based upon this criterion generally would only qualify a covered veteran to receive a specific care or service within an episode of care, but in practice could amount to general eligibility for any care or service within multiple episodes of care. While described in greater detail in our discussion of proposed § 17.4040, VA's designated access standards consider both wait-times to receive care or services, as

well as the average driving time from the covered veteran's residence to such care and services. Because both the wait-time and the average driving time standards are specific to the type of care required, these would generally only qualify a veteran for a specific type of care or service. However, if a covered veteran resided in a location that was beyond the average driving time standard for any service, that covered veteran would effectively qualify for any clinically necessary hospital care, medical service, or extended care service (except for nursing home care, as described below). This criterion is essentially a permutation of the existing distance and wait-time criteria in the Veterans Choice Program under current § 17.1510(b)(1) and (b)(2), as well as the general standards under current section 1703(a).

Proposed § 17.4010(a)(5) would establish eligibility for a covered veteran to receive care and services through the Veterans Community Care Program if the veteran and the veteran's referring clinician (either a VA or non-VA clinician) determine it is in the best medical interest of the veteran—for the purpose of achieving improved clinical outcomes—to receive the care or services the veteran requires from an eligible entity or provider, based on factors that could be considered under proposed § 17.4010(a)(5)(i)-(vii). We note that we propose to qualify a determination of best medical interest in proposed § 17.4010(a)(5) by expressly stating that such a determination would be for the purpose of the veteran achieving improved clinical outcomes by receiving the care or services in the community, versus from a VA health care provider. VA intends this distinction to clarify that the factors proposed in § 17.4010(a)(5)(i)-(vii) would be considered in the context of clinical decision making. This is well-supported by the reference in section 1703(d)(1)(E) to the determination being based on the best medical

interest of the covered veteran based on criteria developed by the Secretary. The inclusion of language referencing improved clinical outcomes would clarify that other factors (such as mere convenience), when unconnected to any clinical outcome, would not be a basis for determining that receipt of care in the community is in the covered veteran's best medical interest.

Sections 1703(d)(1)(E) and (d)(2) require VA to develop criteria to be used in determining the best medical interest of the veteran. Proposed § 17.4010(a)(5) would implement the eligibility criterion in section 1703(d)(1)(E), and proposed §17.4010(a)(5)(i)-(vii) would describe the criteria that VA proposes to guide determinations of whether it is in the best medical interest that a veteran be furnished care or services by an eligible entity or provider. Section 1703(d)(2) identifies specific criteria that VA must consider in developing these factors; this list is not exhaustive, as demonstrated by the statute's direction to ensure that the criteria developed under paragraph (1)(E) include consideration of the criteria that follow. This language makes the most sense when subsection (d)(2) is understood as a minimum description of the criteria that must be considered by VA. Thus, the additional factors VA is proposing to adopt in proposed § 17.4010(a)(5)(v)-(vii), discussed further below, would be an exercise of discretion authorized by Congress.

The specific factors that a veteran and a veteran's referring clinician could consider in proposed § 17.4010(a)(5)(i)-(iv) would mirror those expressly listed in section 1703(d)(2)(A)-(D), and we note that two of these proposed factors (related to the nature of the care and services, and frequency that the care and services would be needed) are presently assessed in the Veterans Choice Program under §

17.1510(b)(4)(ii)(A)-(B). We would make a minor clarification to the statutory criteria in proposed paragraph (a)(5)(i) to refer to a facility or facilities where care could be provided, in case there is more than one location that could furnish the care. The language concerning a facility or facilities is intended to include both VA and non-VA facilities.

Proposed § 17.4010(a)(5)(v) would not mirror a statutory criteria, but is proposed in the Secretary's discretion to permit the additional consideration of whether there would be the potential for improved continuity of care if a non-VA health care provider furnished the care, such as instances where the veteran might have an existing relationship with a non-VA health care provider that would make adherence to a clinical regimen more likely than if a VA health care provider were to start newly furnishing care or services. Proposed § 17.4010(a)(5)(vi) would similarly not mirror a statutory factor in section 1703(d)(2), but would permit the additional consideration of whether the quality of care provided by an eligible entity or provider might be considered more clinically appropriate for a veteran, such as when an eligible entity or provider might have more expertise in furnishing a specialized procedure than a VA health care provider.

Proposed § 17.4010(a)(5)(vii) would implement the factor in section 1703(d)(2)(E) to consider it in the best medical interest of the covered veteran to receive care or services from an eligible entity or provider if the veteran faces an unusual or excessive burden in accessing a VA facility. Proposed § 17.4010(a)(5)(vii)(A)-(D) would implement the express considerations in section 1703(d)(2)(E)(i)-(iv), many of which mimic the unusual or excessive travel burden criteria in current § 17.1510(b)(4)(ii). The unusual and excessive travel burden would apply to travel to a VA facility for any type or

category of care and services under VA's medical benefits package. Proposed § 17.4010(a)(5)(vii)(E) would implement the substantively similar consideration in current § 17.1510(b)(4)(ii)(C), that a covered veteran's need for an attendant to travel to a VA medical facility to receive care and services could be assessed as a factor in the best medical interest determination.

Proposed § 17.4010(a)(6) would establish eligibility for a covered veteran to receive care and services through the Veterans Community Care Program if, in accordance with proposed § 17.4015, explained later in this rule, 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. Proposed § 17.4010(a)(6) would implement the eligibility criterion for community care in section 1703(e), which permits but does not compel VA to furnish hospital care, medical services, or extended care services through the Veterans Community Care Program. We note this difference between the discretionary eligibility in section 1703(e) and the eligibility in section 1703(d), which is required subject to the availability of appropriations, at the outset here, and will explain more fully in the discussion below that addresses proposed § 17.4015 how VA would designate medical service lines based on data related to VA's standards for quality, and how this would be applied to eligibility decisions under this section.

Proposed § 17.4010(b) and (c) would incorporate without substantive change two requirements from the Veterans Choice Program at current § 17.1510(c) and (d), respectively, related to veterans alerting VA of a change of residence, and veterans providing VA with information about any other health-care plan contract under which the

veteran is covered. This information would continue to be needed in the Veterans Community Care Program so that VA could make accurate eligibility determinations under proposed § 17.4010(a)(2)-(6) that would rely on a veteran's place of residence, and so that VA could continue to recover or collect reasonable charges for care and services furnished in the community for a non-service connected disability from a health plan contract, consistent with section 1703(j). The only changes from current § 17.1510(c) and (d) would be referring to covered veterans instead of only veterans in both provisions and, proposed § 17.4010(c), referring to care and services the veteran requires instead of care under the Veterans Choice Program, as well as referring to other health-care plan contracts instead of health-care plans, as previously explained in the definitions section of this rulemaking.

Proposed §17.4010(d) would implement the requirements in section 1703(f) that any decisions concerning eligibility for community care under sections 1703(d) and (e) be subject to VA's clinical appeals process, and not be appealable to the Board of Veterans' Appeals. Proposed § 17.4010(d) would refer to all eligibility determinations under proposed §17.4010(a) as being subject to VA's clinical appeals process. We note that VA's current clinical appeals process is established in VHA Directive 1041, titled "Appeal of VHA Clinical Decisions," and any successor VHA policy would equally apply. The current Directive and any future policies are and will be made available on VA's website <https://www.va.gov/vhapublications/publications.cfm?pub=1>.

§ 17.4015, Designated VA medical service lines

Proposed § 17.4015 would establish the process by which VA would identify its medical service lines that were not able to furnish care or service in a manner that complied with VA's standards for quality, so that veterans who would receive care or services through such VA medical service lines could be considered eligible for the Veterans Community Care Program under proposed § 17.4010(a)(6).

Consistent with section 1703(e)(1)(A)-(B), proposed § 17.4015(a) would establish that VA's permissive authority to consider covered veterans as eligible for community care under proposed § 17.4010(a)(6) would be based on whether VA medical service lines were identified by VA as underperforming in accordance with timeliness standards when compared with the same VA medical service lines at other VA facilities and based on two or more distinct and appropriate quality measures of VA's standards for quality when compared with non-VA medical service lines. Proposed § 17.4015(b) would further clarify that VA's identification of its underperforming medical service lines would be based on the data that VA would analyze under proposed § 17.4015(a), VA's standards for quality themselves, as well as factors in proposed § 17.4015(e) that would guide how VA would assess the information it gathered related to VA and non-VA medical service lines.

Consistent with section 1703(e)(4), proposed § 17.4015(c) would establish that VA would announce any VA medical service lines identified under proposed § 17.4015(a) in a document in the Federal Register and would identify and describe the standards for quality VA used to inform its determination under proposed § 17.4015(a), as well as how the data described in proposed § 17.4015(a) and the factors identified in proposed § 17.4015(e) were used to make the determinations. The announcement of

this information through a document in the Federal Register would provide clear information to the public regarding how VA arrived at its choice of standards, while additionally allowing VA to remain nimble (subject to existing legal authorities, such as the Paperwork Reduction Act, as applicable) with its gathering and analysis of data related to its standards for quality, and possible identification of its medical service lines that are underperforming. Consistent with section 1703(e)(2), proposed § 17.4015(c) would also establish that this document in the Federal Register would identify limitations, if any, concerning when and where covered veterans can receive qualifying care and services at their election in the community, which could include defined timeframes in which such care and services could be available, defined geographic areas in which such care and services may be provided, and a defined scope of services that veterans may elect to receive. Finally, in accordance with section 1703(e)(4), VA would be required to take all reasonable steps to provide direct notice to covered veterans affected under this section. Such direct notice would generally include written correspondence and could include electronic messages or direct contact (in person or by phone).

Proposed § 17.4015(d) would restate the requirement from section 1703(e)(1)(C)(ii) that VA could not identify more than 3 of its medical service lines in any single VA facility, and not more than 36 such service lines throughout VA nationally, when determining those underperforming service lines that might create eligibility for community care. We believe these provisions to be clear in the statute, but in the interest of being comprehensive, we have included these requirements in regulation to avoid confusion. To provide some scope of the relative impact of designating up to 36

service lines, we note that 36 services lines would be a very small number of those that exist nationally. For instance, it is possible that a single VA medical center could have as many as 20 service lines itself, and VA operates more than 1,200 sites of care.

Proposed § 17.4015(e) would establish the factors that VA would consider when determining whether one of its medical service lines should be identified as underperforming; we clarify that the threshold requirements, in accordance with section 1703(e)(1)(B) are performance on timeliness standards when compared with medical services lines at other VA facilities and on quality standards when compared with non-VA medical service lines when external benchmarks are available. The data on performance for these timeliness and other quality standards will identify potential service lines that could be designated, and VA would apply the factors described in this paragraph to determine which service lines to designate. These same factors would also be used in the event that one of the limitations in proposed §17.4015(d) restricted VA's ability to designate all VA medical service lines that might be considered underperforming under proposed § 17.4015(a). Proposed § 17.4015(e)(1) would establish that VA would consider whether the differences between performance of individual VA medical service lines (concerning timeliness) and performance of VA medical service lines and non-VA medical service lines (concerning quality) are clinically significant. This factor would allow VA to appropriately discern small differences in performance metrics as not evidencing underperformance per se.

Proposed § 17.4015(e)(2) would establish that VA would consider the likelihood or ease of remediation of a medical service line within a short timeframe in identifying whether it is underperforming, to permit VA to be selective as remediation would require

further considerations of VA resource management or allocation. Section 1706A requires VA to develop plans and to remediate VA medical service lines that are identified as underperforming under section 1703(e). We therefore propose to consider the likelihood and ease of remediation in designating such service lines in the first place, as it would be illogical to designate a VA medical service line as underperforming and in need of the kind of intensive remediation envisioned by section 1706A when a simple action (such as the purchase of new equipment) would be sufficient and is likely to occur. This view is further reinforced by the limited number of VA medical service lines VA could designate under this authority; VA should not use a limited authority when other options are already available.

Proposed § 17.4015(e)(3) would establish that VA would consider any recent trends (as they were known) that might concern a VA or non-VA medical service line, as such trends could be more contemporary than the data or information upon which VA would be basing a determination of underperformance. Given the requirements to gather, analyze, and verify quality data, there may be a considerable period of time (sometimes up to 18-24 months) between when the data are first collected and when decisions can be made on that data. If VA had reason to believe, based on more contemporaneous information, that some of the factors that contributed to poor performance on quality metrics had already been corrected, VA would factor such evidence into its decision making.

Proposed § 17.4015(e)(4) would establish that VA would consider the number of veterans served by the medical service line or that could be affected by the designation. This could be considered in several ways. For example, this is likely to be a relevant

consideration to allow VA to properly assess data about its own medical service lines, and for comparing a particular medical service line to other VA or to non-VA medical service lines. For example, a VA medical service line that only treated a few patients may be more likely to be adversely affected by a single negative outcome than would be other VA or non-VA service lines with larger numbers of patients. It could also be relevant when deciding whether to designate a VA medical service line at all, or in a situation where VA had to choose which service line to designate because one of the limitations in paragraph (d) applied. For example, if VA could only choose one of two VA medical service lines to designate, and one of those service lines only treated one patient within the past year, while another treated 1,000 patients, it would likely make more sense to designate the VA medical service line with a greater patient volume to ensure the maximum number of covered veterans receive access to community care.

Proposed § 17.4015(e)(5) would establish that VA would consider the potential impact on patient outcomes when considering whether a VA medical service line was underperforming. Some medical service lines, by the nature of their clinical area of responsibility, deal with more significant health concerns than others.

Finally, proposed § 17.4015(e)(6) would allow VA to take into account the effect that designating one VA medical service line would have on other VA medical service lines. For example, if VA identified a surgical line as underperforming, that could have collateral effects on a range of other service lines, such as cardiology, orthopedics, or gastroenterology. For instance, a cardiology service line would be less likely to undertake complex interventional procedures if there is not appropriate surgical support in the event of a procedural complication. VA could consider these secondary effects

and weigh the relative costs and benefits associated with designating one VA medical service line as it would affect other service lines within the VA facility.

We reiterate that proposed § 17.4015 would establish a process by which VA would determine, announce, and explain the VA medical service lines it determines are underperforming based on an assessment of the timeliness of its care compared with other VA facilities and the quality of that service line's care when compared with two or more distinct and appropriate quality measures of VA's standards for quality. Proposed § 17.4015 would not itself list VA's standards for quality as these standards and measures are dynamic and will evolve based on new discoveries and innovations as well as wider adoption of standardized quality measures across the U.S. health care industry; VA is submitting a report to Congress detailing its standards for quality no later than March 4, 2019. It also would not announce any VA medical service lines that VA might identify as underperforming in accordance with such standards, as this would be done through a document in the Federal Register under proposed § 17.4015(c) and direct notice to affected veterans. The process in proposed § 17.4015 would be the means of identifying those VA medical service lines that would be the basis for the eligibility determination under proposed § 17.4010(a)(6).

§ 17.4020, Authorized non-VA care

Proposed § 17.4020 would describe the process and requirements for authorizing non-VA care under this Program, similar to current § 17.1515.

Proposed § 17.4020(a) and (b) would implement, without substantive change, two provisions from the Veterans Choice Program at § 17.1515 (a) and (b), respectively,

related to a covered veteran's election to receive care in the community, and related to a covered veteran's selection of an eligible entity or provider. These provisions would be carried over to the Veterans Community Care Program to confirm a veteran's ability to elect to receive community care under appropriate circumstances, consistent with section 1703(d)(3), and to ensure continuity of veteran experience from the Veterans Choice Program in being able to choose an eligible entity or provider, while also being consistent with section 1703(g)(2). Section 1703(g)(2) provides that VA may not prioritize providers in a manner that limits the choice of a covered veteran in selecting an eligible entity or provider. The only non-substantive changes from current §17.1515(a) would be referring to covered veterans in proposed § 17.4020(a) and removing language related to a veteran's election to be placed on an electronic waiting list for VA care because such a waiting list is not an express option in section 1703 related to a veteran's election to receive VA care versus VA community care. Proposed § 17.4020(a) would retain the premise in the Veterans Choice Program that the covered veteran who has been determined to be eligible for community care could elect to still receive such care through VA, or could elect to receive such care through an eligible entity or provider. We would clarify that any authorized care must be determined to be clinically necessary. This is a requirement both of existing § 17.38(b), as well as section 1703(n)(1), but adding this language would be particularly critical for determinations by a non-VA referring clinician that receiving care or services would be in the best medical interest of the covered veteran. VA must ultimately determine that such care is clinically necessary. Section 17.4020(b) would also refer now to covered veterans for the reasons previously explained.

In paragraph (c) of § 17.4020, we would clarify the timelines associated with the authorization of care and services. In general, care furnished under the Veterans Community Care Program must be furnished following an authorization by VA that such care and services are to be provided to a covered veteran. However, we recognize that emergency care will be needed in applicable situations. VA currently permits emergency care, in certain situations, to be considered as authorized for purpose of current section 1703 through regulation at § 17.54. We propose to rescind and reserve the existing § 17.54 and instead establish a comparable rule in paragraph (c) of § 17.4020. We believe this is authorized under the new section 1703 amendments. Section 1703(a)(3) states that covered veterans may only receive care or services under this section upon the authorization of such care or services by VA, but it does not state that such authorization must occur in advance. We presume Congress was aware of the existing provisions allowing for authorizations within 72 hours, and did not consider it necessary to require prior authorization to allow VA to continue this practice. This presumption is based on the principle of statutory interpretation that Congress does not make sweeping changes to existing practice without explicitly stating so. We would state clearly, though, that this paragraph would not affect eligibility for, or create any new rules or conditions affecting, reimbursement for emergency treatment under sections 1725 or 1728. These authorities permit VA to reimburse eligible veterans for the receipt of emergency treatment under certain conditions, and no aspect of the VA MISSION Act of 2018 affected eligibility for care under these authorities. Care that cannot be authorized under this paragraph would be considered for reimbursement under 1725 or 1728, as applicable.

Paragraph (c)(1) would state that VA could authorize emergency treatment after it has been furnished to a covered veteran. This is consistent with the description of the scope of this provision above. We would define the term emergency treatment to be consistent with the definition of section 1725(f)(1). We would not reproduce the definition in this regulation in the event that any future changes are made to the statute; by cross-referencing, this would ensure that our regulations and statutes remain consistent on this point. In general, emergency treatment under section 1725(f)(1) means medical care or services furnished that, in the judgment of VA, meet three conditions. First, that VA or other Federal facilities are not feasibly available and an attempt to use them beforehand would not be reasonable. Second, that the care or services are rendered in a medical emergency of such nature that a prudent layperson reasonably expects that delay in seeking immediate medical attention would be hazardous to life or health. Third, emergency treatment continues until such time that the veteran can be transferred safely to a VA facility or other Federal facility and such facility is capable of accepting such transfer, or such time as the VA facility or other Federal facility accepts such transfer if at the time the veteran could have been transferred safely to a VA or other Federal facility, no VA or other Federal facility agreed to accept such transfer and the non-VA facility in which such medical care or services were furnished made and documented reasonable attempts to transfer the veteran to a VA or other Federal facility.

Proposed paragraph (c)(2) would state that VA could only authorize emergency treatment under this paragraph 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 under paragraph (c)(3). This would be consistent with existing § 17.54(a), with the specific inclusion of an eligible entity or provider being a possible entity that could notify VA; § 17.54(a) only refers to notification by the veteran or by others in his or her behalf, so our proposed language in paragraph (c)(2) would still provide flexibility while recognizing that an eligible entity or provider might be the most appropriate party to notify VA given their contractual relationship to furnish care on VA's behalf. This 72-hour requirement is consistent with the window for approval under existing § 17.54(a). We believe the 72-hour requirement continues to be a reasonable period of time as it would allow notification upon stabilization of the patient or upon the next business day in the overwhelming majority of cases. We would not retain the language from § 17.54(a)(2) concerning non-contiguous States because, as noted in proposed paragraph (c)(3)(i), this rule would only apply to emergency care furnished by eligible entities or providers who have a contract or agreement to furnish care on VA's behalf; this relationship would provide the means for notifying VA in a timely manner, while the prior rule in § 17.54 did not require such a relationship.

Notification, however, would not guarantee that care would be approved by VA as authorized; paragraph (c)(2) would note that paragraph (c)(3) would further describe the conditions under which VA would approve such care. Paragraph (c)(3) would explain that VA would approve care as authorized only if three conditions are met. First, the veteran must be receiving emergency treatment from an eligible entity or provider. This is a requirement for the care to be furnished under section 1703 and these proposed regulations. It would also ensure that all care furnished is subject to the

payment rates established in a contract or agreement. VA would further require the notification be submitted appropriately, as further described in paragraph (c)(4), and provided within 72 hours of the beginning of such treatment. This would ensure that VA is able to make an appropriate determination as soon as possible as to whether or not the emergency treatment is qualifying care under these authorities. Finally, VA would limit emergency treatment to services covered by VA's medical benefits package. This would ensure VA does not authorize any care or services it lacks the authority to furnish at all.

Paragraph (c)(4) would stipulate requirements that the notice must satisfy to be accepted as notice for purposes of this paragraph. The notice would need to contain three elements. First, it would have to be made to an appropriate VA official at the nearest VA medical facility. While we would not define how this official would be defined through the regulation, we believe that either through the contract or agreement the eligible entity or provider has with VA or through another means (like each VA medical facility's website), the eligible entity or provider would know the right official to contact. Veterans or other parties could simply contact their VA medical center to provide this information. This would ensure that the appropriate officials are notified and can make determinations under this authority. Second, the notice would have to identify the covered veteran. This would ensure VA could review and determine the veteran actually meets the definition of a covered veteran for purposes of these regulations. Finally, the notice would have to identify the eligible entity or provider furnishing the emergency treatment. This would ensure that the entity or provider is in

fact eligible to furnish care and services for VA pursuant to a contract or agreement authorizing such entity or provider to furnish care and services on our behalf.

We note that we have not included language in this proposed rule to address the provisions in section 1703(l) regarding organ and bone marrow transplants. VA will address this through a subsequent rulemaking. Section 1703(l) provides that the Secretary shall determine whether to authorize an organ or bone marrow transplant for a covered veteran at a non-VA facility. If the rulemaking focused on organ and bone marrow transplants is not effective by the time this rule for the Veterans Community Care Program is effective, the Secretary will effectively have exercised his discretion to determine that the election of a covered veteran eligible under § 17.4010(a) on where to receive organ or bone marrow transplant care controls.

We further note that section 153 of the MISSION Act added a new section 1788 to title 38, U.S.C., specifically authorizing VA to provide for an operation on a live donor to carry out a transplant procedure for an eligible veteran, notwithstanding that the live donor may not be eligible for VA health care. VA will issue separate regulations concerning this new authority. Any comments on care for living donors will be considered outside the scope of this rulemaking.

§ 17.4025, Effect on other provisions

Proposed § 17.4025 would address the effect of the Veterans Community Care Program on other provisions and programs administered by VA, similar to current § 17.1520.

Proposed § 17.4025(a) would provide that, consistent with section 1703(n)(2), no provision in these sections may be construed to alter or modify any other provision of law establishing specific eligibility criteria for hospital care, medical services, or extended care services. If particular services, such as dental benefits under §§ 17.160-17.169, have unique eligibility standards, only veterans who are eligible under proposed § 17.4010 and meet the eligibility standards for those services can elect to receive them through the Veterans Community Care Program. Nothing in section 1703 or these regulations would waive the eligibility requirements established in other applicable statutes or regulations. This is substantively similar to the first sentence of current § 17.1520(a).

Similar to the second sentence of current § 17.1520(a), proposed § 17.4025(b) would address VA's paying for and filling of prescriptions obtained by covered veterans from eligible entities and providers, but would clarify VA's current practice that distinguishes circumstances under which VA pays for (versus fills) such prescriptions. Proposed § 17.4025(b)(1) would retain the practice in the Veterans Choice Program that VA will pay for prescriptions, including prescription drugs, over the counter drugs, and medical and surgical supplies written by non-VA health care providers furnishing services through VA community care, but would clarify that such payment would be for a course of treatment that lasts no longer than 14 days. This current practice to limit payment for non-VA prescriptions is reasonable, as it would allow VA to ensure that any amount of medication in excess of 14 days would be filled through VA's Consolidated Mail Order Pharmacy system to ensure cost and quality controls. VA believes that the economies of scale related to bulk purchase of medications allow for the best

maximization of Federal resources. Proposed § 17.4025(b)(2) would establish the correlate rule from the Veterans Choice Program, that VA would fill longer-term prescriptions for courses of treatment that exceed 14 days if they are filled through VA's Consolidated Mail Order Pharmacy system.

Proposed § 17.4025(b)(3) and (b)(4) would further clarify current practice under the Veterans Choice Program regarding VA paying for or filling prescriptions written by non-VA health care providers for durable medical equipment (DME) and devices. Although not expressly stated in current § 17.1520, the Veterans Choice Program currently permits VA to pay for such prescriptions to be furnished by a community provider only when there is an urgent or emergent need for the durable medical equipment or medical device, meaning the veteran has a medical condition of acute onset or exacerbation manifesting itself by severity of symptoms including pain, soft tissues symptomatology, bone injuries, etc. Urgent or emergent DME or medical devices may include, but are not limited to: splints, crutches, canes, slings, soft collars, walkers, and manual wheelchairs. This current practice to limit payment for non-VA prescriptions of DME or medical devices to only what is immediately needed is reasonable, as VA must ensure administrative oversight as well as clinical appropriateness of all other DME and medical devices prescribed by non-VA health care providers. DME and medical devices are specific to a particular clinical need and in most cases are further specifically tailored to fit or serve an individual, and as such require direct provision by VA (except when urgently needed) to ensure clinical appropriateness and the best use of Federal resources. Proposed § 17.4025(b)(3) would establish that VA would pay for prescriptions written by eligible entities or

providers for covered veterans that have an immediate need for durable medical equipment and medical devices to address urgent or emergent conditions, and would parenthetically reference a non-exhaustive list of such devices to include splints, crutches, and manual wheelchairs. Proposed 38 CFR § 17.4025(b)(4) would then establish a correlate rule that VA would fill prescriptions written by eligible entities or providers for covered veterans for DME and medical devices without any limitation related to the equipment being required for an urgent or emergent need.

Proposed § 17.4025(c) would restate with slight revision the last sentence of current § 17.1520(b), as veterans would continue to be liable as applicable under §§ 17.108(b)(4) and (c)(4), 17.110(b)(4), and 17.111(b)(3) for copayments for community care that is furnished through the Veterans Community Care Program. The Veterans Community Care Program would not alter the current treatment of veteran copayments for community care as exists in the Veterans Choice Program. We are not including the language in the first sentence of 17.1520(b), concerning VA's liability for deductibles, cost-shares, or copayments required by an eligible veterans' health-care plan, because that language was originally included in the Veterans Choice Program regulations when VA was a secondary payer to an eligible veteran's other health insurance. That language was needed to ensure veterans faced no additional liability for using the Veterans Choice Program, as opposed to VA's traditional community care programs where VA was and is the primary payer. Under the Veterans Community Care Program, VA will be the primary payer, so this language is unnecessary.

§ 17.4030, Eligible entities and providers

Similar to current § 17.1530 under the Veterans Choice Program, proposed § 17.4030 would establish requirements for non-VA entities and providers to be eligible to furnish hospital care, medical services, and extended care services to covered veterans under the Veterans Community Care Program. We would not identify specific lists of health care entities or providers (e.g., Department of Defense, Medicare providers, etc.), as section 1703(c) already provides VA broad authority to include additional health care providers who enter into contracts or agreements to furnish care and services under this Program. Proposed § 17.4030(b) would establish conditions that non-VA entities and providers must meet to be considered eligible to furnish care or services under the Veterans Community Care Program. We note that the requirements in this paragraph are not exhaustive, as there are other provisions established in law (namely, in 1703(h)(3)(A)(IV) and section 108 of the MISSION Act) that must be met to be a participating eligible entity or provider.

Proposed § 17.4030(a) would require the non-VA entity or provider to enter into a contract, agreement, or other arrangement to furnish care and services under the Veterans Community Care Program established by these regulations. The terms of the contract, agreement, or other arrangement will impose additional requirements that must be met, particularly concerning additional qualifications, but it is not necessary to regulate these conditions because entities or providers will agree to be bound by them through the contract, agreement, or other arrangement.

Proposed § 17.4030(b) would be consistent with existing § 17.1530(a), which prohibits an entity or provider that is part of VA, or providers who are employed by VA from furnishing care or services while acting within the scope of their VA employment,

from being an eligible entity or provider. As we explained in the Veterans Choice Program regulations, the purpose of VA's use of community providers to furnish care is to ensure that veterans are able to access non-VA entities or providers, so it would be contrary to the purpose of the statute to include VA entities or providers within the definition of eligible entities or providers for community care. This same rationale applies to the Veterans Community Care program for covered veterans.

Proposed § 17.4030(c) would require that the non-VA entity or provider be accessible to an eligible veteran. VA would make determinations regarding accessibility by considering the length of time the veteran would have to wait to receive care or services from the entity or provider; the qualifications of the entity or provider; and the distance between the eligible veteran's residence and the entity or provider. This language would be substantively identical to § 17.1530(c), which requires that non-VA entities or providers in the Veterans Choice Program be accessible to veterans eligible under that Program. As the Veterans Community Care Program is intended, like the Veterans Choice Program, to expand access to care, we believe that imposing the same assurance of accessibility is appropriate. We would make minor edits to include references to extended care services for the reasons explained above.

§ 17.4035, Payment rates

Similar to current § 17.1535 for the Veterans Choice Program, proposed § 17.4035 would establish the rate structure for payment for hospital care, medical services, and extended care services furnished pursuant to a contract or an agreement authorized by section 1703A would be the rates set forth in the terms of such contract or

agreement. Such payment rates would comply with parameters defined in proposed § 17.4035(a)-(e), as described below, and would be analogous to the parameters established in section 1703(i).

Proposed § 17.4035(a) would establish that, except as otherwise provided in proposed § 17.4035, payment rates would 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 referred to as “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). This would be analogous to the general provision in section 1703(i)(1), that, with exceptions, the rates paid for care and services may not exceed the applicable Medicare rate. This would also be similar to current § 17.1535(a)(1). The parenthetical language in proposed § 17.4035(a), to indicate that VA’s rates would be based on Medicare rates without any changes based on the subsequent development of information under Medicare authorities is intended to limit VA’s rate adjustments to an annual basis in line with Medicare’s annual payment update, versus other adjustments that Medicare may make to its rates throughout any given year that is typically provider-specific and is based on provider and other reporting.

Proposed § 17.4035(b) would establish that, 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 rate under paragraph (a) would be calculated based on the payment rates under such agreement. This is consistent with section 1703(i)(4) and § 17.1535(a)(4).

Proposed § 17.4035(c) would establish, consistent with section 1703(i)(2)(A), that payment rates for services furnished in a highly rural area may exceed the limitations set forth in proposed § 17.4035(a)-(b). Proposed § 17.4035(c) would further establish that 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, consistent with the definition of highly rural area in section 1703(i)(2)(B). .

Proposed § 17.4035(c) would further interpret that the assessment of a highly rural area would be made in relation to the areas where the services are furnished, and not the areas where the individuals receiving the care or services may reside as provided under section 1703(i)(2)(A). We believe this interpretation is reasonable because the typical laws of supply and demand dictate that in highly rural areas, the scarcity of health care providers and other health care resources tends to create increased prices for delivery of health care services. Additionally, it may not be accurate that, in all cases, individuals who reside in highly rural areas are receiving care and services in those same areas, and VA would not want to adopt an interpretation that would permit payment of higher rates to health care providers in other than highly rural areas. Attempting to tie payment rates to particular patients, rather than setting general rates for particular health care providers, would be administratively cumbersome and could lead to selective acceptance of patients that would adversely affect other patients.

Proposed § 17.4035(d) would establish that VA may deviate from the parameters set forth in proposed § 17.4035(a)-(c) when VA determines that, based on patient needs, market analyses, health care provider qualifications, or other factors, it is not

practicable to limit payments as would be dictated by application of proposed § 17.4035(a)-(d). This general exception would be consistent with the provision in section 1703(i)(1) that authorizes VA to pay at rates not to exceed the Medicare rate to the extent practicable. Proposed § 17.4035(d) would afford VA the flexibility to ensure it can reach agreement with non-VA entities or providers to furnish necessary services when factors that drive costs may shift faster than established Medicare rates. This flexibility would not be a guarantee of payments above applicable Medicare rates because the introductory language in proposed § 17.4035 would establish that payment rates are ultimately set forth in the terms of the contract or agreement under which the care and services are furnished. Such contracts or agreements will provide for the relevant procedures and review process for any payments that might utilize the exception in proposed § 17.4035(d), to ensure a consistent level of VA oversight.

Finally, proposed § 17.4035(e) would establish, consistent with section 1703(i)(3), that payment rates for services furnished in Alaska would not be subject to paragraphs (a) through (d) and would be set forth in the terms of the procurement contract or agreement authorized by section 1703A, pursuant to which such services are furnished. Proposed § 17.4035(e) would further state that, if no payment rate is set forth in the terms of such a contract or agreement to which services are furnished, payment rates for services furnished in Alaska would follow the Alaska Fee Schedule of the Department of Veterans Affairs. Under the VA Alaska Fee Schedule, as described in § 17.56(b), 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' (CMS) rate for each code and multiply it times the average percentage paid by VA in Alaska for CMS-like codes. VA will increase the amounts on the VA Alaska Fee Schedule annually in accordance with the published national Medicare 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.

§ 17.4040, Designated access standards

Proposed § 17.4040 would establish the designated access standards by which VA would assess the availability of VA care and services in relation to individual covered veterans for purposes of eligibility determinations under proposed § 17.4010(a)(4). As we explained in the context of § 17.4015, this section would not establish all of VA's access standards, just as § 17.4015 would not establish VA's standards for quality. Proposed § 17.4040 would implement both section 1703(d)(1)(D) related to VA's eligibility determinations for community care, and portions of section 1703B related to VA's establishment of access standards. Section 1703(d)(1)(D) refers specifically to eligibility based on an inability to furnish care or services in a manner that complies with VA's designated access standards. This section would establish these designated access standards, which cover all care or services under VA's medical benefits package (with the exception of institutional extended care services, or nursing home care), to allow VA to determine whether the condition under proposed § 17.4010(a)(4) has been met. In publishing these standards through a final rule

implementing this section, we would also satisfy part of the requirement in section 1703B(g); VA will also publish the final designated access standards on its website when they are effective.

In developing these proposed designated access standards, VA researched access standards established by Federal- and State-level agencies, consulted with the Department of Defense (DoD), the Department of Health and Human Services (HHS), as well as several commercial entities to identify best practices and acceptable standards for consideration, as required by section 1703B(c). On June 29, 2018, VA published a Notice in the Federal Register requesting public comments, and on July 13, 2018, VA held a public meeting to provide an additional opportunity for public comment. Results of these consultations will be discussed in a report to Congress detailing the access standards, which is required by 38 U.S.C. 1703B(d)(1).

A prime consideration were the existing standards in the Veterans Choice Program; these standards measure timeliness of and distance to receive care. Other access standards that VA researched measured the distance from the patient's home to the service needed, whereas VA currently measures, under the Veterans Choice Program, the distance from the patient's home to the nearest VA medical facility with a full-time primary care physician. This difference means that veterans, particularly in rural areas, currently must often travel farther to receive specialty care than they would under the proposed rule, if finalized, because they do not qualify for community care under the Veterans Choice Program distance criterion. Changing VA's distance-related measurement for community care to be the distance from the patient's home to the care or service needed would assist VA in determining when covered veterans can be

served directly by VA and when covered veterans can choose community care, thereby helping to ensure adequate health care access for covered veterans.

Further changing the standard to refer to an average driving time would recognize that distance is often a poor indicator of actual conditions; veterans in large metropolitan areas may be physically closer to VA facilities than their counterparts in rural areas, but may actually face more significant challenges in accessing care based on traffic. Adopting access standards based on average driving time would result in more equitable access for all covered veterans. VA's proposal to use the average driving time is premised on the use of a personal vehicle, but we believe this applies to many of the veterans we serve, and that it would be too difficult to fairly and consistently implement and operationalize a system that considered the variety of transportation options potentially available to an individual veteran. We note that the proposed approach is similar to that taken by DoD.

Using the results of its access standards analysis, VA developed and modeled several options using VA's Enrollee Health Care Projection Model. After considering this information, VA determined that its access standards should reflect a driving time-based criterion that considers the care or services needed in relation to the veteran's residence and should reflect a wait-time criterion that would be considered in tandem with the driving time criterion. VA used the same rationale as TRICARE Prime in proposing its standards related to travel standards, opting to use time versus distance. To reiterate, distance-based criteria do not recognize the inherent variation of driving speeds in rural versus urban areas. Traffic levels and speed limits allow rural residents to travel farther and faster than urban residents. The switch to average drive-time

criteria versus distance provides a more consistent standard of access for urban and rural veterans. More specific analyses showed trends of 30-minute drive times for primary care and 60-minute drive times for specialty care in TRICARE, State Medicaid plans, State insurance departments, and commercial health plans. VA determined that it would be reasonable to fall in line with these other network expectations throughout the industry. The proposed wait-time standards would similarly fall within the range of appointment wait-time standards found in other government organizations, State programs, and commercial entities (e.g., 7-28 days for primary care and 15-30 days for specialty care). Further, the proposed wait-time standards are achievable in most VA facilities and are consistent with capabilities identified in the private sector. On average, VA national wait times (as of December 2018) for new appointments (e.g., the first appointment in a new episode of care versus a subsequent appointment in the continuation of an existing episode of care) are approximately 21.6 days for primary care, 11.2 days for mental health care, and 23.2 days for specialty care. We note that data presented in VA's report to Congress, and that VA has provided previously to Congress, includes different averages, but this variance is due simply to when the data were collected; the information in the report to Congress and what has previously been provided was from the fall of 2018. The proposed wait-time standard of 20 days for primary care and mental health, for example, is both in line with other similar industry standards and is a manageable goal for access to VA care.

The following access standards would therefore be designated in proposed § 17.4040(a) to apply for purposes of eligibility determinations under § 17.4010(a)(4). For primary care, mental health care, and non-institutional extended care services,

proposed § 17.4040(a)(1) would establish that the access standard would not be met if VA cannot schedule an appointment for a covered veteran with a VA health care provider that can furnish the required care or services within 30 minutes average driving time of the veteran's residence, and within 20 days of the date of request, unless a later date has been agreed to by the veteran in consultation with the VA provider. For specialty care, proposed § 17.4040(a)(2) would establish that the designated access standard would not be met if VA cannot schedule an appointment for the covered veteran with a VA health care provider that can furnish the required care or services within 60 minutes average driving time of the veteran's residence, and within 28 days of the date of request, unless a later date has been agreed to by the veteran in consultation with the VA provider

The later date that a veteran could agree to be scheduled for an appointment would be determined through the veteran's consultation with a VA health care provider. This consultation would ensure that the veteran's preferred date to be seen, as well as clinical considerations regarding the appropriate time for an appointment, were taken into account. For instance, veterans might agree to a later date because they prefer to be seen after the 20 or 28 days (as applicable) from the date they contact VA to request an appointment, such as if the veteran expects to be traveling. In such a case, the veteran might discuss this later date with a provider to ensure that it was clinically appropriate to delay the appointment.

A veteran might also agree to a later date because the provider has consulted with the veteran, and the provider has determined that an appointment would not be clinically useful until after the 20 or 28 days (as applicable) from the date the veteran

might contact VA to request an appointment. This scenario most often arises in the context of follow-up appointments, where a veteran might contact VA to schedule an appointment that is, for instance, no sooner than 30 days away to accommodate the completion of necessary diagnostic tests that were ordered by the provider as part of the veteran's prior appointment. This scenario can also arise outside of the context of typical follow-up care, such as for regularly scheduled, routine care or treatment that typically occurs perhaps only once or twice a year. For instance, a veteran could agree to a later date for a routine dental cleaning that the veteran typically schedules to receive every six months.

The option in proposed § 17.4040(a)(1)(ii) and (a)(2)(ii) for a veteran to agree to a later date is similar to the definition of the term wait-time goals of the Veterans Health Administration in current § 17.1505, because the veteran's preference as well as clinical appropriateness would continue to be considered in determining the later date. We believe that proposed § 17.4040(a)(1)(ii) and (a)(2)(ii) are more simply stated than current § 17.1505, and are framed in a more veteran-centric manner because these provisions propose to shift the decision for the later date entirely to the veteran. In practice, we do not believe that this proposed shift would create significant changes in veteran eligibility for VA community care based on the wait-time standard, because the veteran's agreement to a later date would still be informed by consultation with the VA health care provider. However, as proposed § 17.4040(a)(1)(ii) and (a)(2)(ii) would be a significant technical change from the way the wait-time goals of the Veterans Health Administration are written in current § 17.1505, we invite comment on this issue as with other changes as described in this rulemaking.

A full explanation of the estimated impact of these proposed access standards, when compared to the distance-based and wait-time based standards in current § 17.1510(b)(1) and (b)(2), can be found in the Regulatory Impact Analysis that accompanies this proposed rule, which can be found as a supporting document at <http://www.regulations.gov> and is available on VA's Web site at <http://www.va.gov/orpm/>, by following the link for "VA Regulations Published From FY 2004 Through Fiscal Year to Date." For purposes of this rulemaking, VA believes these proposed access standards are reasonable applications of VA's discretion to establish access standards in 38 USC section 1703B. Section 1703B confers broad authority on the Secretary to establish access standards, and sections 1703B and 1703(d)(1)(D) further authorize the Secretary to designate certain access standards as the basis for eligibility for community care.

Proposed § 17.4040(b) would establish, similar to current § 17.1510(e), that for purposes of calculating the distance from the veteran's residence to a VA facility for eligibility determinations, VA would use geographic information system software. As with current § 17.1510(e), proposed § 17.4040(b) cannot be more specific in naming the system software or describing its methodology because it is proprietary. The most substantive change from current § 17.1510(e) is that proposed § 17.4040(b) would use the phrase average driving time instead of driving distance, because the access standards under proposed § 17.4040(a) would be based on average driving time. The average driving time in proposed § 17.4040(a) and (b) would be calculated by using the geographic information system software to calculate the average drive time from the

veteran's residence to the applicable VA facility, based on predictive traffic patterns from historical data, as opposed to real-time traffic conditions.

We note that we do not propose to regulate the process described in section 1703B(h), which must be followed to review requests from veterans to determine whether or not VA can furnish care or services within the designated access standards. Because this is a procedural requirement relating to VA's operations and will not affect veteran eligibility, we are not proposing to include this process in this rulemaking, but will establish such a process through internal policy. However, we anticipate that veterans would contact VA to request such reviews in the same manner they would contact VA to seek care generally that then might be referred to the community under an access standard.

We further note that we have considered whether VA would want to ensure the continued utilization of VA care and services that VA has particular expertise in directly providing, such as VA's specialized care models for veterans with disabilities such as traumatic brain injury, posttraumatic stress disorder, and military sexual trauma. VA Centers of Excellence, such as the Polytrauma Rehabilitation Centers, deliver certain types of specialized care that may improve quality of care or reduce costs when compared with similar care that might be furnished in the community. However, there are far fewer Centers of Excellence than VA medical centers, and as there would be fewer locations in relation to the total number of veterans nationwide, travel distances for veterans to these Centers of Excellence could in many cases exceed the designated access standards in this rule. At this time, VA does not propose to designate (or not designate) particular access standards for these or other types of more specialized

care; the general specialty care access standards would apply. Moreover, veterans would be made aware if such care was available from VA outside of the designated access standards to be fully informed of their options prior to electing to receive care in the community or in VA. Similarly, VA does not propose at this time to designate particular access standards for care that it might consider to be its foundational services. VA will continue to sharpen its focus on directly providing those services that are most important to the coordination and management of a veteran's overall medical and health needs, while purchasing services that can be as effectively or more conveniently delivered by non-VA providers. VA will continue to examine whether its proposed designated access standards should be revised with future rulemakings to account for such specialized areas of expertise as the care provided by Centers of Excellence or other similar organizations within VA (such as the War Related Illness and Injury Study Center), as well as VA's foundational services, and we welcome public comment on whether any of these services, or others, should be further considered in terms of designated access standards for purposes of eligibility for community care.

We note that institutional extended care services (nursing home care) are not the subject of a designated access standard; the designated access standards in paragraphs (a) and (b) only cover primary care, mental health, non-institutional extended care, and specialty care, but nursing home care does not fit within any of these categories. Nursing home care is distinct from specialty care—it is a form of extended care services, and is subject to copayments related to extended care services under § 17.111 (as opposed to specialty care, which is subject to copayments under § 17.108). We have not included a designated access standard for nursing home care

because of the unique nature of this care, as it is VA's anecdotal experience in referring nursing home care to the community that the relative scarcity of such resources in the community, the variability in quality in community nursing homes, and the expense associated with such care are all variables that make the assignment of a standardized wait time, for instance, impracticable. Any covered veteran requiring nursing home care may still qualify to receive such care in the community, but the veteran would have to qualify for non-VA care under this section under a different eligibility criterion in § 17.1410(a).

Section 17.4040 would establish access standards that would be applicable until further rulemaking amended them. VA has preliminarily determined that its goal is to revise over time the access standards that would be designated in proposed § 17.4040, after designated access standards are made effective through final rulemaking, in order to reduce the maximum wait-times for primary and mental health care services from 20 days to 14 days no sooner than June 2020. This reduction from 20 days to 14 days is not proposed in this rulemaking, and VA would need to publish a future rulemaking should it proceed with this goal. Presently, implementing a 14-day wait-time standard would be difficult for VA due to the current availability of primary care providers and variability in primary care appointment wait-times across VA facilities. However, we share this goal with the public at this time, as it may influence the comments submitted by the public on the current proposed designated access standard of 20 days.

Improving VA

While this proposed rulemaking has focused on the new Veterans Community Care Program required by the MISSION Act, we believe it is important to note that the MISSION Act also improves care furnished directly in VA facilities in a number of ways. For example, section 1703C of title 38, U.S.C. as added by section 104 of the MISSION Act, requires VA to establish standards for quality. VA is proposing standards for quality in a report that will be submitted to Congress no later than March 4, 2019. If VA designated a medical service line under proposed § 17.4015, we would also be required to begin remediation efforts for that service line under section 1706A. However, VA's remediation efforts will not be limited to just those service lines designated under § 17.4015. In addition to establishing standards for quality, section 1703C requires VA to publish the quality rating of VA medical facilities in the Hospital Compare website for the purpose of providing Veterans with information that allows them to compare performance measure information among VA and non-VA health care providers. We take this charge seriously, and will be monitoring performance to ensure we direct resources appropriately. We will develop a consolidated and integrated network of community providers to ensure that all Veteran care furnished by VA, whether delivered in our facilities or purchased in the community, represents the best possible care, every time and everywhere.

As noted earlier, each year, VA will incorporate the collected data, assessments, and remediation plans under sections 1703C and 1706A to inform its resourcing requirements and prioritization of those resources. VA will also consider performance of its facilities against its access standards for appointment wait times when making resource allocation decisions.

There are numerous provisions within the MISSION Act that require the assessment, collection, and monitoring of data about VA performance and improvement, including information on remediation, on a regular annual basis. See, e.g., sections 401(d) and 505(b) of the MISSION Act; see also sections 1703(m)(1), (3); 1703B(d)(3); 1703B(e); and 1706A(d)(1). VA is also required, on a quadrennial basis, to conduct market assessments and develop a strategic plan that specifies a four-year forecast of demand for care and capacity to furnish care in VA and in the community. Through these requirements, VA will provide analyses and assessments on VA's performance in terms of timeliness, quality, and other elements of its health care system collected at the level of the medical service line, and no less than annually, VA will develop and publish a consolidated report detailing a description of care provided both internally and externally. This information will be used to detail resource allocations and the related budget requirements to address quality and access issues, as well as for efforts to improve the VA workforce and address the problem of underserved facilities.

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

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507) requires that VA consider the impact of paperwork and other information collection burdens imposed on the public. Under 44 U.S.C. 3507(a), an agency may not collect or sponsor the collection of information, nor may it impose an information collection requirement unless it displays a currently valid Office of Management and Budget (OMB) control number. See also 5 CFR 1320.8(b)(2)(vi).

This proposed rule would amend information collection requirements currently approved under control number 2900-0823 and would impose new collections of information requirements and burden. VA will separately notice and take comment on the information collection requirements associated with this proposed rulemaking in the Federal Register. As required by 44 U.S.C. 3507(d), VA will submit these information collection amendments to OMB for its review. Notice of OMB approval for this information collection will be published in a future Federal Register document.

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. Although some eligible entities or providers that would furnish care and services to veterans under this rule might be considered small entities, there would be no significant adverse economic impact. To the extent there is any impact on small entities, it would be a potential increase in business due to proposed expanded eligibility for non-VA care. While this rulemaking defines payment rates and eligible entities and providers, it does so in a way

that is consistent with VA's current authorities. We note that a separate and subsequent rulemaking, RIN 2900-AQ45, will authorize VA to enter into agreements with eligible providers, many of whom will likely be small businesses. We will further consider the effects on such entities through that rulemaking. We also do not believe there will be a significant economic impact on insurance companies, as claims would only be submitted for care that would otherwise have been received whether such care was authorized under this Program or not. 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, 13563 and 13771

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.”

VA has examined the economic, interagency, budgetary, legal, and policy implications of this regulatory action and determined that the action would be an economically significant regulatory action under Executive Order 12866. VA's regulatory 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 website at <http://www.va.gov/orpm> by following the link for VA Regulations Published from FY 2004 through FYTD. This proposed rule is expected to be an EO 13771 regulatory action. Details on the estimated costs of this proposed rule can be found in the rule's economic analysis. Preliminary estimates of the administrative costs that would be tallied for E.O. 13771 purposes appear in the rightmost column of the Regulatory Impact Analysis (RIA) Table 8.

Executive Order 12866 also directs agencies to “in most cases . . . include a comment period of not less than 60 days.” This regulation would replace the existing Veterans Choice Program and VA's traditional community care program to be the means for covered veterans to receive VA care in the community from eligible entities or providers. Providing a 30-day comment period would allow the Secretary to ensure a smooth transition from the current Veterans Choice Program that will expire on June 6,

2019, and prevent lapses in regulatory oversight for VA's national community care program. On June 6, 2019, if this rulemaking is not finalized, no one other VA authority would permit expressly the application of the time and geographic standards in determining eligibility for VA community care, which the public and veterans have come to expect. Delays in implementation of the Veterans Community Care Program arising because the regulatory standards and guidelines were not in place by June 6, 2019, would result in inconsistent decision making in VA facilities, which would increase the likelihood that veterans' care would be delayed. Having clear, consistent criteria is essential to ensuring that Veterans receive the right care in the right place at the right time. Moreover, we believe VA community care is now a familiar benefit to the public, and that 30 days would be a sufficient period of time for the public to comment on this rulemaking, which incorporates many of the provisions of the prior Veterans Choice Program. In sum, providing a 60-day public comment period instead of a 30-day public comment period would be against public interest and contrary to the health and safety of eligible veterans. For the above reasons, the Secretary issues this rule with a 30-day public comment period. VA will consider and address comments that are received within 30 days of the date this proposed rule is published in the Federal Register.

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

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are as follows: 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.016, Veterans State Hospital 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.

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 devices, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, Veterans.

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. Robert L. Wilkie, Secretary, Department of Veterans Affairs, approved this document on January 2, 2019, for publication.

Dated: January 15, 2019

Michael P. Shores
Director,
Office of Regulation Policy & Management
Office of the Secretary
Department of Veterans Affairs

For the reasons set forth in the preamble, we propose to amend 38 CFR part 17 as follows:

PART 17 – MEDICAL

1. The general authority citation and specific authority citations for part 17 continue to read as follows:

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

* * * * *

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 17.108 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 17.4000 et seq. is also issued under 38 U.S.C. 1703, 1703B, and 1703C.

* * * * *

§ 17.46 [Amended]

2. Amend § 17.46 in paragraph (a) introductory text by adding the phrase “prior to June 6, 2019,” after the phrase “In furnishing hospital care”.

b. Removing the authority citation at the end of paragraph (a) and paragraph (b).

3. Amend § 17.52 by removing the authority citations following paragraphs (a)(1) through (10) and by adding paragraph (c).

The addition reads as follows:

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

* * * * *

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

§ 17.54 [Removed and Reserved]

4. Remove and reserve § 17.54.

5. Amend § 17.55 by revising the introductory text and removing the authority citation at the end of the section.

The revision reads as follows:

§ 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 prior to June 6, 2019, under 38 U.S.C. 1703 and 38 CFR 17.52, or at any time under 38 U.S.C. 1728 and 38 CFR 17.120 and 17.128 of this part or under 38 U.S.C. 1787 and 38 CFR 17.410 of this part, 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.

* * * * *

6. Amend § 17.56 by adding paragraph (e) and removing the authority citation at the end of the section.

The addition reads as follows:

§ 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.

* * * * *

(e) Except for payments for care furnished under 38 U.S.C. 1725 and section 17.1005 of this part, under 38 U.S.C. 1728 and 38 CFR 17.120 and 17.128 of this part, or under 38 U.S.C. 1787 and 38 CFR 17.410 of this part, 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.

* * * * *

7. Amend § 17.108:

a. In paragraph (b)(4), by adding the phrase “, or the Veterans Community Care Program under § 17.4000 through 17.4040” after the phrase “Veterans Choice Program under § 17.1500 through 17.1540”;

b. In paragraph (c)(4), by adding the phrase “, or the Veterans Community Care Program under § 17.4000 through 17.4040” after the phrase “Veterans Choice Program under § 17.1500 through 17.1540”; and

c. Removing the authority citation at the end of the section.

§ 17.110 [Amended]

8. Amend § 17.110 in paragraph (b)(4) by adding the phrase “, or the Veterans Community Care Program under § 17.4000 through 17.4040” after the phrase “Veterans Choice Program under § 17.1500 through 17.1540” and by removing the authority citation at the end of the section.

§ 17.111 [Amended]

9. Amend § 17.111 by in paragraph (b)(3) by adding the phrase “, as well as extended care services furnished through the Veterans Community Care Program under § 17.4000 through 17.4040,” after the phrase “hospital care and medical services considered non-institutional care furnished through the Veterans Choice Program under § 17.1500 through 17.1540” and by removing the authority citation at the end of the section.

§ 17.1004 [Amended]

10. Amend § 17.1004 in paragraph (b) introductory text by removing the phrase “HCFA 1500” and adding in its place “CMS 1500” and by removing the authority citation at the end of the section.

11. Add an undesignated center heading and §§ 17.4000 through 17.4040 to read as follows:

Veterans Community Care Program

Sec.

- 17.4000 Purpose and scope.
- 17.4005 Definitions.
- 17.4010 Veteran eligibility.
- 17.4015 Designated VA medical service lines.
- 17.4020 Authorized non-VA care.
- 17.4025 Effect on other provisions.
- 17.4030 Eligible entities and providers.
- 17.4035 Payment rates.
- 17.4040 Designated access standards.

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.

§ 17.4005 Definitions.

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

Appointment means an authorized and scheduled encounter 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 under 38 U.S.C. 1705(c)(2).

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: VA maintains a Web site 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: 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.

§ 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 (Public Law 113–146, sec. 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, 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;
- (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.)

§ 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.

§ 17.4020 Authorized non-VA care.

(a) Electing non-VA care. 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 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 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, VA may authorize emergency treatment after it has been furnished to a covered veteran. For purposes of this paragraph, “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 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 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 of this part.

(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.

§ 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 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 no longer than 14 days.

(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), § 17.108(c)(4), § 17.110(b)(4), or § 17.111(b)(3).

§ 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 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, 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 eligible veteran's residence and the entity or provider.

§ 17.4035 Payment rates.

The rates paid by VA for hospital care, medical services, and extended care services (hereafter in this section referred to as “services”) furnished pursuant to a procurement contract or an agreement authorized by section 1703A of this title 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 section 1703A of this title, 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.

§ 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.

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