DEPAR **320-01**

38 CFR Part 17

RIN 2900- AQ08

Reimbursement for Emergency Treatment

AGENCY: Department of Veterans Affairs.

ACTION: Final rule with comments.

SUMMARY: The Department of Veterans Affairs (VA) is finalizing, with some changes, an interim final rule that amended its medical regulations concerning payment or reimbursement for emergency treatment for non-service-connected conditions at non-VA (community) facilities. This final rule responds to public comments received on the interim final rule and amends VA's emergency treatment regulations to authorize payment or reimbursement for coinsurance, temporarily waive the timely filing requirements for veterans affected by the interim final rule, and authorize payment or reimbursement for emergency transportation associated with emergency treatment when VA has paid for the emergency treatment using a separate authority. Because the change to § 17.1004 was not addressed in the Supplementary Information section of the interim final rule, VA believes the public should have an opportunity to comment on the change. Therefore, a 60-day comment period to address this single topic will be provided.

DATES: *Effective date:* This final rule is effective [INSERT DATE 60 DAYS AFTER THE DATE OF PUBLICATION IN THE FEDERAL REGISTER].

Comment Date: Comments on VA temporarily waiving the timely filing requirement must be received on or before [INSERT DATE 60 DAYS AFTER THE DATE OF PUBLICATION IN THE FEDERAL REGISTER].

ADDRESSES: Comments must be submitted through www.regulations.gov. Except as provided below, comments received before the close of the comment period will be

available at www.regulations.gov for public viewing, inspection, or copying, including any personally identifiable or confidential business information that is included in a comment. We post the comments received before the close of the comment period on the following website as soon as possible after they have been received: http://www.regulations.gov. VA will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm the individual. VA encourages individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments. Any public comment received after the comment period's closing date is considered late and will not be considered in the final rulemaking.

FOR FURTHER INFORMATION CONTACT: Joseph Duran, Director, Policy and Planning VHA Office of Integrated Veteran Care (16IVC), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420, (303-370-1637). (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: In an interim final rule published in the Federal Register (FR) on January 9, 2018, 83 FR 974, VA amended its medical regulations pursuant to a decision from the Court of Appeals for Veterans Claims (Veterans Court), *Staab v. McDonald,* 28 Vet. App. 50 (2016), to authorize reimbursement for the costs of emergency treatment furnished in the community for a veteran's non-service-connected condition when the veteran is eligible for partial payment of these costs under a health-plan contract.

Among other changes made, the interim final rule clarified that VA would not pay or reimburse for a copayment, deductible, coinsurance, or similar payment owed by the veteran. 38 CFR 17.1005(a). In issuing the interim final rule, VA explained that VA is statutorily prohibited under section 1725(c)(4)(D) of title 38, United States Code (U.S.C.)

from paying for or reimbursing a copayment or similar payment and VA interpreted "similar payment" to include both deductibles and coinsurance. 38 CFR 17.1005(a)(5); 83 FR 974 (January 9, 2018).

VA provided a 60-day comment period, which ended on March 12, 2018. Twelve comments were received, which are described in detail in the following section of this discussion.

Following the comment period, on March 17, 2022, the United States Court of Appeals for the Federal Circuit (Federal Circuit) issued a decision, *Wolfe v. McDonough*, No. 2020-1958, on issues relating to a Writ of Mandamus granted by the Veterans Court. This case involved a challenge to VA's interpretation of 38 U.S.C. 1725(c)(4)(D) (that is, VA's prohibition on paying for copayments, coinsurance, and deductibles under 38 CFR 17.1005(a)(5)). In its opinion, the Federal Circuit interpreted 38 U.S.C. 1725(c)(4)(D) to exclude payment by VA of deductibles, but not coinsurance, as it found that a deductible is a similar payment to a copayment, but coinsurance is not.

However, the decision on the *Wolfe* appeal did not specifically invalidate or otherwise amend VA's regulations as they relate to the payment of coinsurance. Subsequent to the *Wolfe* decision, a petition for review was filed at the Federal Circuit on May 4, 2022. The petitioners in this case asked for the court to invalidate the portion of VA's regulation that prohibited payment of coinsurance. On October 25, 2022, the Federal Circuit issued an order directing VA to amend its regulations within 120 days to allow for the payment of coinsurance. Kimmel v. Sec'y of Veterans Affs, No. 2022-1754, 2022 U.S. App. LEXIS 29615 (Fed. Cir. Oct. 25, 2022).

For the reasons below and consistent with the *Wolfe* decision and subsequent order related to the *Kimmel* petition, this rulemaking will make final the interim final rule

(83 FR 974) with changes and will permit an additional comment period on the limited issue of the timely filing requirement.

Public Comments

Twelve comments were received in response to the interim final rule. Several commenters expressed support for the rule. The remaining substantive comments are discussed in detail below.

Retroactivity

In the interim final rule, we stated that judicial decisions invalidating a statute or regulation, or VA's interpretation of a statute or regulation, cannot affect prior final VA decisions, meaning decisions that were not timely appealed and have thus become final. As such, VA stated it will not retroactively pay benefits for claims filed under § 17.1002(f) that were finally decided before April 8, 2016, the date of the Veterans Court's *Staab* decision. We received multiple comments stating that VA should apply the amendments made in the interim final rule retroactively to February 1, 2010, the date of enactment of the Expansion of Veteran Eligibility for Reimbursement Act, Public Law 111-137 (hereinafter referred to as the "2010 Act").

One commenter stated that VA has the authority to consider these claims because section 1725 provides VA with broad authority to establish the claim and payment process. Another commenter stated that the *Staab* decision requires VA to provide reimbursement to veterans with claims pending on or after February 1, 2010, because the court stated that VA must re-adjudicate the appellant's claim, which was for reimbursement for treatment in December 2010. The commenter also stated that a judicial interpretation of a statute defines the meaning of the statute as of the date of enactment, not the date of the judicial decision. The commenter cited to the Federal Circuit's decision in *Patrick v. Shinseki*, 668 F.3d 1325, 1329 (Fed. Cir. 2011), to support that proposition.

We also received three comments concerning the need for retroactive application of the *Staab* decision from members of the United States Congress. Two of the comments were nearly identical. One was from the United States House of Representatives Committee on Veterans' Affairs and one was from members of the United States Senate. The comments requested that the interim final rule include those veterans whose claims were decided between the date of enactment of the 2010 Act, February 1, 2010, and the date of the *Staab* decision, April 8, 2016, so that veterans can take full advantage of a benefit Congress intended for them to receive. The Secretary of Veterans Affairs responded to these two comments in letters sent to each member of Congress who signed the two comments. The letter stated that the Secretary shared the concern of the members of Congress about veterans who, prior to the *Staab* decision, had their claims for reimbursement denied on the sole grounds that their health-plan contracts had made partial payments for their emergency treatment, thereby leaving them with personal liability for the remaining costs of that treatment.

Under 38 U.S.C. 7105(c), a decision of a VA agency of original jurisdiction (AOJ) that is not appealed in a timely manner is considered final and the claim may not thereafter be reopened or allowed "except as provided by regulations not inconsistent with this title." Under 38 U.S.C. 7104(b), when a claim is disallowed by the Board of Veterans' Appeals (Board), it may not thereafter be reopened and allowed "[e]xcept as provided in section 5108 of this title." To the extent these statutes may be construed to permit VA by regulation to create additional exceptions to the finality of AOJ decisions, but not Board decisions, we decline to exercise that authority here. Such a rule would depart significantly from the well-established principle, discussed below, that new judicial interpretations of a statute do not provide a basis for reopening final decisions, and it would create an unfair distinction among claimants based upon whether their last final decision was issued by an AOJ or the Board. Moreover, as explained below, other

authorities provide a basis for addressing claims involving expenses incurred on or after February 1, 2010, in a manner we believe to be more equitable and consistent with established precedents.

There are only two statutory exceptions to the rule of finality, new and material evidence and clear and unmistakable error, 38 USC 5108, neither of which authorizes VA to proactively re-open and re-adjudicate finally decided claims as a result of the *Staab* decision as suggested by the commenters. See 38 U.S.C. 5108, 5109A, and 7111; *Cook v. Principi*, 318 F.3d 1334, 1339 (Fed. Cir 2002). As these two exceptions relate to the lines of reasoning raised by the commenters above, we do not believe that the authority provided in section 1725 authorizes VA to re-adjudicate the claims in a manner that is inconsistent with 38 U.S.C. 5108, 5109A, and 7111. In addition, we do not believe that the *Staab* decision requires VA to re-adjudicate all finally decided claims retroactive to the effective date of the law. Significantly, the court did not order VA to re-adjudicate all finally decided claims from the date of enactment; instead, the court vacated the Board's decision that denied Mr. Staab's individual claim and ordered VA to re-adjudicate Mr. Staab's individual claim, which was not finally decided because he filed a timely appeal. In order to adjudicate the claim and address the court's invalidation of § 17.1002(f), VA amended its payment regulations to establish a payment methodology for claims, like Mr. Staab's, that involve partial payment by a health-plan contract. The *Staab* decision did not address and does not govern VA's authority to apply the new methodology to claims that were finally decided prior to the decision.

Further, in *George v. McDonough*, 142 S. Ct. 1953, the Court held that invalidation of a VA regulation after a veteran's benefits decision becomes final cannot support a claim for collateral relief based on clear and unmistakable error. Therefore, neither the Staab decision, nor later decisions in the Wolfe or Kimmel matters create a

clear and unmistakable error that would allow for readjudication of already denied claims.

However, when an intervening and substantive change in law occurs and creates a new basis for entitlement to a benefit (e.g., judicial interpretation and invalidation of a regulation results in expansion of entitlement to a benefit), VA may review a new claim based on the same facts as the finally decided claim. *Spencer v. Brown*, 17 F.3d 368, 372 (Fed. Cir.) (1994). In this situation, individuals whose claims were finally decided prior to the change in law may submit new claims to be adjudicated under the revised standard. We therefore explained to the members of Congress that VA can reach claims that were finally decided prior to the *Staab* decision (on the sole grounds that partial payment would be, or had been, made under the veterans' health-plan contract), if the veterans or providers file new claims for the same benefits that were previously denied. VA further explained that we will adjudicate claims from providers or veterans who, due to their awareness of the former interpretation of the law (former § 17.1002(f)), chose not to file claims because partial payment had been made or would be made under the veterans' health-plan contracts. The Secretary also informed the members of Congress that we would create a solution, through amendatory rulemaking, to avoid denial of these claims as untimely under the current filing deadlines specified in regulation. It was further explained that all providers or veterans seeking reimbursement under the revised regulation would be required to submit evidence showing the amount paid by their health insurance plan and the amount of the veteran's remaining liability. The reason for this requirement is explained below.

The third Congressional comment (from the Senate Committee on Veterans' Affairs) stated that the timely filing requirement for these claims should be waived completely. The comment further stated that VA should proactively reach out to veterans whose claims were denied under the previous regulations because making

veterans refile their claims would be unduly burdensome and create a barrier to filing that will disproportionately impact veterans whom the comment described as already being vulnerable.

VA agrees that it is necessary to provide the two groups of claimants described above with an opportunity to file new claims for payment or reimbursement of emergency treatment costs incurred in the community on or after February 1, 2010, up to April 8, 2016 (the date of the Staab decision), and to adjudicate these claims under the new legal standard, subject to the one-year filing deadline established in § 17.1004(f), as revised by this final rule. To simply waive the timely filing requirement for these claims would be problematic, however, as it would prevent VA from being able to reliably forecast budgetary and other claims processing needs relative to these claims. Moreover, health insurance claims are generally processed in accordance with firm time limits established by the governing contracts, including those applicable to the carriers' appeals processes. Thus, the amounts paid under veterans' health-plan contracts have already been identified. Unless these records are no longer retained by the carriers, this historical information exists and can be requested. In the alternative, the veteran may have personal possession of these historical records. In either event, VA believes that a one-year filing deadline is reasonable and gives these claimants an adequate opportunity to seek payment or reimbursement for costs incurred during the covered time-period. VA will therefore not waive the timely filing requirement for claimants affected by the *Staab* decision.

In order to address the concerns raised, and in response to comments that VA received on the IFR, VA will amend § 17.1004 to afford veterans affected by the *Staab* decision an opportunity to file a new claim based on the change in law. Specifically, VA is amending § 17.1004(f), which currently provides an exception to the timely filing requirements in § 17.1004(d) for dates of service between July 19, 2001, and 90 days

before May 21, 2012, if the claimant files a claim for reimbursement no later than one year after May 21, 2012. Because the time frame for the waiver in current § 17.1004(f) has passed, we will amend this paragraph by removing the previous time frame for the waiver and, in its place, allow claimants to file a claim, notwithstanding paragraph (d) of this section, for reimbursement of costs of non-VA emergency treatment rendered on or after February 1, 2010 and more than 90 days before [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER] for which partial payment was paid or payable under the veterans' health-plan contracts, provided the claimants file their claims for reimbursement no later than one year after [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]. This amendment will thus provide all claimants affected by the *Staab* decision, regardless of whether they previously filed claims for reimbursement, an opportunity to submit a claim for payment or reimbursement of the costs of non-VA emergency treatment they received on or after the effective date of the 2010 Act.

VA has additionally determined that anyone who had been potentially adversely affected by the issues raised in the *Wolfe* litigation, or the subsequent *Kimmel* petition, would fall within this waiver period. Therefore, they would also be able to seek adjudication of their claims under the new standard. To the extent the issues here are distinct from those raised by the *Staab* case, the inclusion within these timeframes will still allow for those issues to be addressed.

As a matter of prudence, and because this precise change to § 17.1004 differs from the interim final rule, VA is inviting the public to comment on the change. Therefore, a 60-day comment period to address this single topic will be provided.

Copayments and Similar Payments

Section 1725(c)(4)(D) prohibits VA from reimbursing a veteran for a copayment or similar payment that the veteran owes a third party or is responsible to pay under a

health-plan contract. The interim final rule interpreted “similar payment” to include deductibles and coinsurance. We received multiple comments that coinsurance and deductibles are not “similar payments” to copayments and should be removed from the list of payments for which VA will not provide reimbursement. Following the public comment period, the Federal Circuit’s order regarding the *Kimmel* petition held that coinsurance was the type of payment envisioned by Congress that VA would pay or reimburse while deductibles were similar to copayments and therefore prohibited from payment or reimbursement pursuant to 38 U.S.C. 1725(c)(4)(D).

Consistent with this decision, we are removing coinsurance from the list of prohibited payments in § 17.1005(a)(5) but will not remove deductibles from that list.

The following discussion specifically addresses the related comments we received during the public comment period on this issue.

Commenters explained that a copayment, by definition, is distinguishable from other forms of cost-sharing, such as deductibles and coinsurance, and that copayments result in much lower liabilities than deductibles and coinsurance. The commenters stated that each term is a “term of art” with a specific, accepted, meaning and that the term copayment cannot be read to include these different obligations. One commenter defined copayment as the set dollar amount the patient pays for care after the deductible is paid, deductible as the amount an insured must pay each year before the insurance source pays its share, and coinsurance as the percent of costs the enrollee must pay. Another commenter similarly defined a copayment as a fixed, flat fee, amount paid by an insured for each particular covered health care service after paying any deductible, a deductible as a fixed amount an insured pays each year for eligible medical services or medicines before insurance will make any payment, and coinsurance as a portion of all the medical costs that an insured must pay of all costs subject to the coinsurance.

In *Wolfe v. McDonough*, No. 2020-1958, Fed. Cir. (Mar. 17, 2022), the Federal Circuit indicated that copayments and deductibles were similar payments, as they are both fixed quantities which become known once insurance is purchased, while coinsurance is a variable quantity that becomes known after medical expenses are incurred. The Federal Circuit also found that the legislative history supports that deductibles were intentionally excluded from reimbursement as a similar payment but coinsurance was not. Later, in the response to the *Kimmel* petition, the Federal Circuit determined that coinsurance was the type of payment envisioned by Congress that VA would pay or reimburse while deductibles were similar to copayments and therefore prohibited from payment or reimbursement pursuant to 38 U.S.C. 1725(c)(4)(D).

Several commenters stated that the rules of statutory construction require us to presume Congress meant what it said and that, in other statutory contexts, Congress has not used the specific term, copayment, to include other forms of cost-sharing. One commenter noted that they do not believe there is a Congressional reference to copayments that includes coinsurance and deductibles. The commenters provided the following examples: 38 U.S.C. 1729(a)(3) uses “deductible or copayment;” under the essential health benefit limitations on cost-sharing, Congress refers to “copayments and coinsurance;” in establishing premium and cost sharing subsidies for low-income individuals, Congress made reference to copayment separately from coinsurance; and in the statutory authority for VA to require copayments for medications, the law referred to copayments and did not include coinsurance or deductibles. The commenters stated that had Congress intended deductibles or coinsurance be excluded from reimbursement, it would have used such language.

To clarify, VA does not believe that Congress intended for the term “copayment” in section 1725(c)(4)(D) to, by itself, encompass deductibles. Instead, VA believes it is the phrase “or similar payment” that is intended to include other forms of cost sharing,

such as deductibles. VA agrees that we must presume Congress meant what it said, and in section 1725, Congress said "copayment or similar payment." A statute must be interpreted, "so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant." *Corley v. United States*, 556 U.S. 303, 304 (2009). To find meaning in the phrase "similar payment," VA must identify and consider other payments for which a veteran is responsible under a health plan contract. VA can find no payment more similar to a copayment than a deductible, which serves as a fixed-amount cost-sharing measure to which the insured freely agrees to pay as a condition of insurance coverage. As noted in *Wolfe*, similar payments necessarily means that some payments that are not copayments are similar payments. The Federal Circuit found that deductibles were envisioned by Congress to be similar to copayments and thus prohibited from payment or reimbursement. The Federal Circuit looked at the legislative history for 38 U.S.C. 1725 and determined that it supports that Congress intentionally excluded deductibles from reimbursement as a similar payment.

Another commenter stated that VA did not provide any legal authority to broaden the statutory language in section 1725(c)(4)(D) to include deductibles and coinsurance. We disagree. First, Congress explicitly gave VA broad authority to implement section 1725 in regulations prescribed by the Secretary. Specifically, section 1725(c)(1)(B) provides that, "The Secretary, in accordance with regulations prescribed by the Secretary, shall…delineate the circumstances under which such payments may be made...." Moreover, as crafted, the language of section 1725(c)(4)(D) plainly allows for other payments to be included within its scope, provided they are similar to the one named. As noted throughout this discussion, the Federal Circuit in *Wolfe* and *Kimmel* acknowledged that inclusion of the phrase "similar payments" in the statute necessarily means that some payments that are not copayments are similar payments. The Federal Circuit interpreted section 1725(c)(4)(D) and its legislative history to determine that a

deductible is a similar payment to a copayment and thus excluded from payment or reimbursement. For these reasons, we believe that VA has authority to interpret the phrase “or similar payment” in paragraph (4)(D) of subsection (c).

The commenters also stated that the legislative history and the Veterans Court’s *Staab* decision provide that the purpose of the 2010 Act was to make VA responsible for the cost (of the emergency treatment) exceeding the amount payable or paid by the third-party insurer, noting that a deductible or coinsurance amount is not payable or paid by the third-party insurer. VA agrees that part of the legislative history related to the 2010 Act and the *Staab* decision each reflect an expectation or understanding that the 2010 Act amendments effectively enable VA to pay the entire remainder owed to the emergency provider after partial payment is made or payable under the veteran’s health-plan contract. However, even if this were intended, the 2010 Act did not accomplish this goal. The still relevant provisions of section 1725(c) explicitly require VA to limit the amount of reimbursement available under section 1725. Indeed, the header for subsection (c) is “Limitations on reimbursement.” To this end, section 1725(c)(1) directs VA to promulgate regulations that limit payment, to include establishing a maximum amount payable under section 1725. In addition, section 1725(c)(4)(D) expressly prohibits VA from reimbursing a veteran for any copayment or similar payment that the veteran owes the third party or for which the veteran is responsible under a health-plan contract. These, along with the other likewise intact provisions of subsection (c), reflect a continuing requirement to limit the budgetary impact of section 1725. If the drafters of the 2010 Act believed that VA’s secondary payment would cover all of the eligible veterans’ out-of-pocket costs, we conclude that they failed to execute all the amendments needed to accomplish this, and the Federal Circuit confirmed this by its interpretation of the statute.

Multiple commenters mentioned that the bar on reimbursement of deductibles and coinsurance acts as a disincentive to purchasing health insurance coverage. They suggest that the exclusion of veterans' out-of-pocket (cost sharing) costs could result in veterans foregoing the purchase of health insurance, leaving VA with increased costs as their sole payer. One of the commenters stated that veterans will always have personal liability if they have Medicare Part B and the proposed change will do nothing to resolve the veteran's personal liability. The commenter further stated that it will encourage veterans to discontinue their Medicare Part B and recommends that the rule require veterans to have Medicare Part B.

As discussed above, VA interprets "similar payments" to include deductibles; thus, VA does not have authority to reimburse these costs. As a matter of policy, VA interprets "similar payments" this way in order to avoid any conflict with the Federal Circuit. VA acknowledges that veterans who do not have health insurance would likely pay no out-of-pocket costs while veterans who do have health insurance may have out-of-pocket costs resulting from their cost share obligations. Nonetheless, VA does not believe that this potential disparity will deter veterans from purchasing health insurance. Most veterans enrolled in the VA health care system have an additional type of health insurance coverage. It seems unlikely that they would forego their health insurance protection for all other medical conditions, which are likewise subject to their plan's deductible requirements, merely to avoid having to pay copayments and similar payments owed in connection with the receipt of non-VA emergency treatment. Again, these are cost shares that they freely agreed to pay in exchange for health insurance coverage independent of their VA benefits. Ultimately, whether to keep or obtain health insurance is a personal financial decision for veterans enrolled in VA's health care system to make based on their own needs, financial capability, and preferences.

As it concerns veterans who are eligible for reimbursement under section 1725 and who also have coverage for emergency treatment under Medicare Part A, VA has no authority to require that they be enrolled in Medicare Part B as a condition of payment or reimbursement under section 1725.

Based on these comments and the *Wolfe* decision and *Kimmel* order, we are removing coinsurance from the list of prohibited payments in § 17.1005(a)(5) but will not remove deductibles from that list. We are also retaining the "or similar payment" qualifier on the end of the list to maintain the flexibility originally envisioned by Congress's initial inclusion of the phrase in section 1725. Retaining "or similar payment" allows VA to be flexible in the future, should some new type of health care cost sharing arise.

Payment Limitations

Several commenters raised a concern that VA's payment limitation of 70 percent of the Medicare fee schedule rate was too low. The commenters requested that VA amend the rule to pay the fair market value for the services rendered. One commenter explained that payment below the fair market value could jeopardize the financial viability of the emergency care safety net.

To clarify, the scope of this rulemaking is to amend VA's regulations to comply with case law interpreting the scope of VA's reimbursement authority. Therefore, this rulemaking only affects reimbursement when the veteran has partial payment from a third party; it does not affect the amount VA will pay when the veteran has no other coverage, which is governed by a different provision of the payment regulation. When the veteran has partial payment for the emergency treatment expenses from a third party, VA is the secondary payer. Under the amended payment regulation, VA pays the lesser of: the amount for which the veteran is still personally liable after payment by a third party (including a health-plan contract); or 70 percent of the applicable Medicare fee schedule rate.

For example, a veteran has an initial liability of $100 dollars. 70 percent of the Medicare fee schedule is $70 and the veteran's health-plan contract paid the provider 80 percent of the Medicare fee schedule rate ($80). If the veteran has remaining liability to the provider (other than a copayment, deductible or similar payment), then VA would still be able to pay up to $20 towards the veteran's remaining liability even after the payment of $80 from the health plan contract. Although VA can pay up to 70 percent of the Medicare fee schedule, which is $70, the veteran's remaining liability in this instance would only be $20 after deducting the health-plan contract's payment of $80 from the $100 liability. As secondary payer, VA's maximum allowable amount is in addition to the amount already paid (or payable) by the health-plan contract. For this reason, VA believes that emergency treatment providers will ultimately receive at least fair market value for their services; consequently, this final rulemaking will not jeopardize the financial viability of emergency departments. VA does not make any changes to the rule based on these comments.

Other commenters stated that the low reimbursement rate would encourage health care professionals to deny treatment to veterans for fear of inadequate reimbursement. All veterans affected by this rulemaking already have coverage for emergency treatment expenses under their health-plan contracts, with rates presumably negotiated (by the carriers and providers) to ensure adequate reimbursement. Again, VA is secondary payer to these contracts. The combined payment by the primary payer (health-plan contract) and VA for the same emergency treatment episode should thus provide adequate reimbursement, as discussed above.

In addition, a Medicare-participating hospital with an emergency department that denies emergency care to an individual due to the individual's inability to pay would arguably violate the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. 1395dd, as amended. Under EMTALA, if any individual (regardless of Medicare-

eligibility) seeks examination or treatment for a medical condition at a covered hospital, then the hospital must provide a screening examination to determine whether an emergency medical condition exists. If so, the hospital is, in general, required to furnish needed emergency treatment until the individual is stabilized and able to be transferred irrespective of the patient's ability to pay. For these reasons, we do not make any changes to the rule based on these comments.

Another commenter stated that Congress did not intend for VA to set such a low rate and cited to a study that found that in-network emergency physician claims were paid at 297 percent of the Medicare rate and out-of-network emergency physicians charged an average of 798 percent of the Medicare rate. The legislative history from when 38 U.S.C. 1725 was originally enacted demonstrates that Congress intended for VA to set a rate that is lower than the Medicare fee schedule rate. The legislative history reads, "The Committee thus envisions that VA would establish rates that are significantly below those paid under the Medicare or Medicaid system (or under 38 United States Code, section 1728)." House Report 106-237 (July 16, 1999). Therefore, VA believes that the rate it set is precisely what Congress envisioned, and we do not make any changes to the rule based on this comment.

The commenter also noted that the interim final rule permits emergency providers to reject the payment amount, which would presumably leave the veteran fully responsible for the payment. Given the low rate, the commenter feared that these providers may reject the amount and seek full payment from the veteran. As noted above, VA has been paying 70 percent of the applicable Medicare fee schedule rate in instances when VA is the sole payer ever since the regulations were effective on May 29, 2000 (66 FR 36470) (unless, of course, the amount owed to the provider was less than 70 percent of the Medicare fee schedule rate, thereby requiring the lesser amount to be paid). Since that time, very few, if any, of VA's payments have been rejected,

presumably because these debts would have otherwise been written off by the providers. Because emergency providers may view the new cohort of veterans covered by the court's decision as having the ability to self-pay more than the VA allowable amount, we have devised a payment methodology to reduce the likelihood that the providers will reject VA payment. Emergency providers will be receiving greater than 70 percent of the Medicare fee schedule rate; again, they will receive a combined payment comprised of the third party's payment and VA's payment. At this time, and in the absence of compelling evidence requiring a changed approach, we decline to make any changes to the rule based on this comment.

One commenter sought clarification on liability for cost-sharing. In particular, the commenter asked whether a veteran's cost sharing responsibilities are also extinguished if a health care provider accepts payment from VA for the emergency treatment. We clarify that some of the veteran's cost sharing obligations, such as a copayment or deductible, are not extinguished by VA payment. Those are contractual payment obligations, non-reimbursable by VA, that are owed by the veteran to the provider, consistent with the terms of the veteran's health-plan contract. We do note however, under this amended rule, VA will pay or reimburse for a veteran's coinsurance as part of its underlying payment for medical treatment. Therefore, acceptance of payment from VA will extinguish any coinsurance responsibility on the part of the veteran. See 38 CFR 17.1005(a)(4). We do not make any changes to the rule based on this comment.

Miscellaneous

One commenter requested that VA provide clarity on two provisions in the regulations. The first provision is the prudent layperson standard in 38 CFR 17.1002(b). The regulation provides that, in order to receive reimbursement, the veteran must have sought care for which a prudent layperson would have reasonably expected that delay

in seeking immediate medical attention would have been hazardous to life or health. The commenter recommended that VA provide a list of services that would meet this standard to ensure that emergency treatment claims filed by veterans are not improperly rejected. The commenter suggested that VA adopt the list from the American College of Emergency Physicians. VA appreciates the commenter's suggestion, but the scope of the rulemaking is narrowly limited to amending VA's regulations to comply with the *Staab* and *Wolfe* decisions and the *Kimmel* order by permitting reimbursement when the veteran has partial payment from a health-plan contract. Therefore, this comment is beyond the scope of this rulemaking, and we do not make any edits based on the comment. However, VA will continue to monitor the program and consider whether additional rulemaking may be necessary in the future.

The commenter also requested that VA amend the rule to affirmatively state that VA cannot deny a claim after a veteran passes away if the emergency medical treatment is furnished prior to the veteran's death. The commenter noted that the interim final rule states that reimbursement is not available if death occurs before emergency treatment is provided. We want to clarify that the interim final rule does not state that reimbursement is not available if death occurs before emergency treatment is provided. Instead, the interim final rule provides that VA can provide reimbursement for emergency transportation even if the veteran passes away before emergency treatment is rendered at the community hospital. While VA appreciates the suggestion, VA believes that the interim final rule, in conjunction with the explanation provided here, is sufficiently clear that reimbursement can be provided even if the veteran passes away. Therefore, we do not make any changes to the rule based on this comment.

One commenter expressed a concern about whether and how VA informs a veteran when the veteran has an outstanding debt with a medical facility and the veteran's first notification comes in the form of a debt collection letter. The commenter

explained that a veteran received a letter from a local hospital and it took four months to determine that there was no outstanding balance on the veteran's account and the letter was sent as a result of a bookkeeping error on the part of the hospital. Although VA is sympathetic to the veteran we note that this is scenario is not representative of most instances of reimbursement for emergency treatment. However, this rulemaking expands eligibility criteria for reimbursement for the costs of emergency treatment rendered by community emergency providers to veterans for their non-service-connected conditions. Because the comment is beyond the scope of this rulemaking, we do not make any changes to the rule based on this comment.

One commenter inquired as to why they were taken to a community hospital when a VA medical center was less than eight minutes away. The commenter received a bill for the transportation to the community hospital. The commenter also discussed the poor treatment rendered by the community hospital, as perceived by the commenter. To the extent that the commenter seeks reimbursement for the costs of transport to the community hospital, we invite the commenter to file an emergency transportation claim under section 1725 as implemented by 38 CFR 17.1003 and 17.1004. But again, because this rulemaking only expands eligibility requirements for reimbursement of the costs of emergency treatment rendered by community hospitals for veterans' non-service-connected conditions, this comment is beyond the scope of the rulemaking. No changes are made to the rule based on these comments.

We also received one comment regarding Executive Order 13771. This rulemaking was not affected by Executive Order 13771. Therefore, this comment is beyond the scope of the rulemaking, and we do not make any changes to the rule based on the comment.

Changes to § 17.1003

While we did not receive any public comments on this issue we are amending § 17.1003(a)(1) as a logical outgrowth of the interim final rule to add VA as a clarifying example of payor of emergency treatment which would not forestall eligibility for emergency transportation.

In the interim final rule, we amended § 17.1003 to add paragraph (a)(1) which provides that payment or reimbursement for ambulance services may be made if payment or reimbursement would have been authorized under 38 U.S.C. 1725 for emergency treatment had the veteran's personal liability for the emergency treatment not been fully extinguished by payment by a third party, including under a health-plan contract. VA amended § 17.1003 in the interim final rule to address a long-standing tension in § 17.1003 with VA's interpretation that emergency transportation is part of emergency treatment. VA has historically interpreted the phrase "emergency treatment" in section 1725(f)(1) to include emergency transportation if the transportation is provided as part of the emergency medical treatment administered at the non-VA facility. However, § 17.1003 did not allow VA to pay for the transportation if the liability for the emergency treatment had already been extinguished by a third party. The interim final rule explained that if VA's sole basis to deny a transportation claim is satisfaction by a third party of the related emergency treatment claim, even if that transportation claim meets all of the other requirements for reimbursement under 38 U.S.C. 1725, VA would be, in effect, treating the emergency transportation claim differently than the related emergency treatment claim. Therefore, in order to make § 17.1003 consistent with VA's interpretation that the emergency transportation is part of the claim for emergency treatment, VA amended § 17.1003 to ensure that payment or reimbursement for emergency transportation would not be prohibited on the sole basis that the emergency treatment claim was fully extinguished. While in the interim final rule VA only referenced liability being extinguished by a third party, VA believes that the

public was sufficiently put on notice that the intended effect of the change was to ensure emergency transportation under § 17.1003 would not be prohibited on the sole basis that the emergency treatment was fully extinguished by another source.

In this rulemaking we revise § 17.1003(a)(1) by adding the phrase “or by VA” after health plan contract. This addition is necessary to ensure that, consistent with the interpretation discussed above, VA can pay or reimburse for emergency transportation under section 1725 even if VA extinguishes the liability for the underlying emergency treatment using a different authority, such as under VA’s Community Care Program at 38 CFR 17.4020(c).

Thus, we are revising § 17.1003(a)(1) to make clear that a veteran may be reimbursed for ambulance services made for transporting a veteran to a facility if payment or reimbursement would have been authorized under section 1725 for emergency treatment had the veteran’s personal liability for the emergency treatment not been fully extinguished by a third party, to include under a health plan contract, or by VA. Based on the rationale set forth in the Supplementary Information sections of the interim final rule and this final rule, VA is adopting as final the interim final rule with the changes stated in this final rule.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is a significant regulatory action under

Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at www.regulations.gov.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601-612). This rule would not cause a significant economic impact on small entities since this exemption is limited to individual veterans who VA determines to be affected by the Stabb or Wolfe cases. Only individual veterans are effects by the virture of being able to submit claims for coinsurance reimbursement. Individuals are not the small entities, they cannot be broken out by appropriate size standard, number affected, and business revenue. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply. Although some eligible entities or providers that furnished emergency care and services to veterans under this authority may be considered small entities, there will be no significant adverse economic impact because this rule does not create a new payment obligation on such entities; it merely creates a new payment methodology for services already rendered.

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 final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

This final rule involves a collection of information that is controlled by the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521). While there are no provisions associated with this rulemaking constituting a new collection of information, the changes to reimbursement may constitute substantive revisions to the existing collection of information. The Office of Management and Budget (OMB) previously approved a Paperwork Reduction Act (PRA) clearance for information collected pursuant to 38 U.S.C. 1725 under OMB control number 2900-0620, which expired on July 31, 2018. The collection of information is being processed for a reinstatement of the PRA clearance from OMB through a separate Federal Register notice (FRN) published in the Federal Register. The FRN will provide the public with an opportunity to comment on the information collection and any revisions for Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-Department Facilities. A final FRN also will be published in the Federal Register when the collection of information is submitted to OMB for approval of the PRA clearance renewal.

Congressional Review Act

Under the Congressional Review Act, this regulatory action may result in an annual effect on the economy of $100 million or more, 5 U.S.C. 804(2), and so is subject to the 60-day delay in effective date under 5 U.S.C. 801(a)(3). In accordance with 5 U.S.C. 801(a)(1), VA will submit to the Comptroller General and to Congress a copy of this Regulation and the Regulatory Impact Analysis (RIA) associated with the Regulation.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Claims, Health care, Health facilities, Health professions, Health records, Reporting and recordkeeping requirements, Travel and transportation expenses, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on December 30, 2022, 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.

Consuela Benjamin*,*

Regulations Development Coordinator,
Office of Regulation Policy & Management,
Office of General Counsel,
Department of Veterans Affairs.

For the reasons stated in the preamble, the interim final rule amending 38 CFR part 17, which was published at 83 FR 974 on January 9, 2018, is adopted as final with the following changes:

PART 17--MEDICAL

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

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

* * * * *

2. Amend § 17.1003 by revising paragraph (a)(1) to read as follows:

§ 17.1003 Emergency transportation.

(a) * * *

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

* * * * *

3. Amend § 17.1004 by revising paragraph (f) to read as follows:

§ 17.1004 Filing claims.

* * * * *

(f) Notwithstanding paragraph (d) of this section, VA will provide retroactive payment or reimbursement for emergency treatment received by the veteran, on or after February 1, 2010 but more than 90 days before [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER], if the claimant was eligible for partial payment from a health-plan contract for the emergency treatment and the claimant files a claim for reimbursement no later than 1 year after [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER].

* * * * *

4. Amend § 17.1005 by revising paragraph (a)(5) to read as follows:

§ 17.1005 Payment limitations.

(a) * * *

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

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