DEPARTMENT OF VETERANS AFFAIRS 8320-01

38 CFR Part 17

RIN 2900-AP24

Expanded Access to Non-VA Care through the Veterans Choice Program

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Department of Veterans Affairs (VA) medical regulations implementing section 101 of the Veterans Access, Choice, and Accountability Act of 2014, which directed VA to establish a program to furnish hospital care and medical services through eligible non-VA health care providers to eligible veterans who either cannot be seen within the wait-time goals of the Veterans Health Administration or who qualify based on their place of residence (hereafter referred to as the “Veterans Choice Program”, or the “Program”). VA published an interim final rule implementing the Veterans Choice Program on November 5, 2014, and published a subsequent interim final rule making further amendments on April 24, 2015. This final rule responds to public comments received from both interim final rules and amends the regulations to modify payment rates under the Program.

DATES: Effective Date: This rule is effective on [insert date of publication in the FEDERAL REGISTER].

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SUPPLEMENTARY INFORMATION: On August 7, 2014, the President signed into law the Veterans Access, Choice, and Accountability Act of 2014 ("the Act," Public Law 113-146, 128 Stat. 1754). Further technical revisions to the Act were made on September 26, 2014, when the President signed into law the Department of Veterans Affairs Expiring Authorities Act of 2014 (Pub. L. 113-175, 128 Stat. 1901, 1906), on December 16, 2014, when the President signed into law the Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. 113-235, 128 Stat. 2130, 2568), on May 22, 2015, when the President signed into law the Construction Authorization and Choice Improvement Act (Pub. L. 114-19, 129 Stat. 215), and on July 31, 2015, when the President signed into law the Surface Transportation and Veterans Health Care Choice Improvement Act (Pub. L. 114-41, 129 Stat. 443). Section 101 of the Act creates the Veterans Choice Program and requires the Secretary to enter into agreements with identified eligible non-Department of Veterans Affairs (VA) entities or providers to furnish hospital care and medical services to eligible veterans who elect to receive care under the Program. Sec. 101(a)(1)(A), Public Law 113-146, 128 Stat. 1754. Congress directed VA to publish interim final regulations concerning this Program within 90 days of enactment. Sec. 101(n), Public Law 113-146, 128 Stat. 1754. On November 5, 2014, VA published an interim final rulemaking implementing the Program by creating new regulations at 38 CFR 17.1500-17.1540. 79 FR 65571 (hereinafter referred to as "the November interim final rule"). VA published another interim final rulemaking on

April 24, 2015, modifying § 17.1510(e) to revise the methodology for calculating distances under that section from geodesic (or "straight-line") distance to the actual driving distance. 80 FR 22906 (hereinafter referred to as "the April interim final rule").

In response to the November interim final rule, VA received 39 comments, and in response to the April interim final rule, VA received 12 comments. Several commenters expressed support for the Program, in whole or in part, and we appreciate their support. This final rule amends 38 CFR part 17 as discussed below.

VA Copayments

The November interim final rule modified 38 CFR 17.108, 17.110, and 17.111 to establish a VA copayment of $0 at the time of service for veterans receiving non-VA care under the Program who would have been required to make a copayment for the receipt of hospital care or medical services at a VA medical facility. We received several comments recommending that VA require veterans to make their VA copayment at the time services are rendered.

As we explained in detail in the November interim final rule, there are administrative difficulties in determining the proper copayment amount for a visit scheduled through the Program that make it inefficient to attempt to charge a copayment amount at the time of visit. In addition, not charging a copayment at the time of the visit was intended to ensure that veterans' experiences under the Program would be as similar as possible to their experiences when provided with non-VA care through other VA programs, where copayments are not due at the time of appointment. These reasons have not changed since November. Therefore, in the interests of

administrative efficiency and to avoid the appearance of inconsistency between non-VA care provided through the Program and under other authorities, we are not making a change as a result of these comments.

Duration and Scope of the Program

The Program is funded with $10 billion in appropriated resources in the Veterans Choice Fund through section 802 of the Act. The Program is authorized to continue until the date the Veterans Choice Fund is exhausted or August 7, 2017, whichever occurs first. Sec. 101(p), Pub. L. 113-146, 128 Stat. 1754. One commenter asked what happens when the Program ends. Section 101 of the Act only authorizes the Program to operate within the parameters described above, so when VA has exhausted the Veterans Choice Fund or on August 7, 2017 (whichever occurs first), the Program will end absent further appropriations, if funds are exhausted, or statutory authority. VA will still be able to refer veterans to community providers under other non-VA care authorities, but such referrals will be subject to the provisions of those statutes and contingent upon the availability of resources. VA is not making a change based on this comment.

VA received several comments suggesting that non-VA providers under the Program should be able to make referrals back to VA for specific care, services, or tests. The Act authorizes VA to furnish hospital care and medical services for eligible veterans through agreements with eligible entities, including any health care provider participating in the Medicare program, any Federally-qualified health center, the Department of Defense, and the Indian Health Service. Sec. 101(a)(1), Public Law 113-

146, 128 Stat. 1754. As we explained in the November interim final rule, the Act specifically envisions that care under the Program is provided by non-VA resources, as demonstrated by section 101(a)(3) of the Act, which requires VA to coordinate through the Non-VA Care Coordination Program the furnishing of care and services under this Program. For these reasons, we are not making any changes to the rule as a result of this comment. However, we note that veterans who receive non-VA care through the Program are still in the VA health care system, and can at any time return to VA for care. A veteran's election to participate in the Program does not foreclose returning to VA for care.

We received comments indicating that the Program should be used to provide unscheduled or emergency care, particularly under extraordinarily dangerous circumstances. We note that under the contract VA has signed with the vendors administering the Program, VA will cover the cost of emergency care in limited circumstances, namely when the vendor notifies VA within 72 hours of the veteran presenting to an emergency department for care. We believe this is consistent with the position taken in the November interim final rule, as VA can currently furnish emergency services under 38 CFR 17.54. This regulation permits VA to consider emergency care pre-authorized when VA is notified within 72 hours of admission to an emergency care facility. 38 CFR 17.54(a)(1). For veterans residing in Alaska, Hawaii, and the U.S. territories other than Puerto Rico, if there are no means of communicating with VA at the time of admission, the 72 hour period begins when such means of communication become available. 38 CFR 17.54(a)(2). We are not making a change based on these comments.

VA received comments that the Program was implemented too quickly, that staff were not adequately trained, and that there are operational issues that need to be resolved. The Act directed VA to begin the Program and publish implementing regulations within 90 days of enactment (August 7, 2014). Sec. 101(n), Pub. L. 113-146, 128 Stat. 1754. We continue to refine the Program and improve the quality of services we offer through the Program, but we are not making any changes to the rule as a result of this comment.

VA received a comment stating that we should not have sent Choice Cards to veterans who are not eligible to participate in the Program. While this comment is somewhat outside the scope of this rulemaking, which did not address the distribution of Choice Cards because it was not necessary to do so to establish the Program, VA was directed by law to send a Choice Card to every enrolled veteran and every separating servicemember. Sec. 101(f), Public Law 113-146, 128 Stat. 1754. Additionally, just because a veteran was not eligible at the time he or she received the Choice Card does not mean the veteran would never be eligible to participate in the Program. For example, if the veteran was unable to schedule an appointment within the wait-time goals of the Veterans Health Administration, he or she would be eligible under § 17.1510(b)(1), or if the veteran moved to a new residence that qualified him or her under § 17.1510(b)(2)-(4), the veteran could be eligible as well. VA is not making a change to the rule as a result of this comment.

Definition of Episode of Care

VA received several comments recommending we adopt different definitions for terms in the rule. Some commenters recommended that VA authorize an episode of care for a period beyond 60 days. As we explained in the November interim final rule, section 101(h) of the Act at that time stated that VA must ensure that an eligible veteran receives hospital care or medical services, including follow up care, "for a period not exceeding 60 days." Based on this provision of law, we defined the term "episode of care" to mean a necessary course of treatment, including follow-up appointments and ancillary and specialty services, that lasts no longer than 60 days from the date of the first appointment with a non-VA health care provider under the Program. Since the close of the comment periods for both the November 2014 and April 2015 interim final rules, section 4005(a) of Public Law 114-41 amended section 101(h) of the Choice Act by removing the 60-day limitation on an "episode of care." Sec. 4005(a), Pub. L. 114-41, 129 Stat. 443. As a result of this amendment to the Choice Act, VA will be publishing a separate rulemaking announcing the removal of the 60-day limitation.

Section 17.1510 Eligible Veterans

We received a number of comments regarding the eligibility criteria for the Program. At the time that the comment periods for both the November and April interim final rules closed, to be eligible to participate in the Program, the veteran must have enrolled in the VA health care system under 38 CFR 17.36 on or before August 1, 2014, or the veteran must have been eligible for hospital care and medical services under 38 U.S.C. 1710(e)(1)(D) and be a veteran described in 38 U.S.C. 1710(e)(3), and the veteran

must also have then met at least one of the criteria described in § 17.1510(b). These criteria can be summarized broadly as follows: wait-time eligibility; eligibility based on distance from a VA medical facility; and travel burden eligibility. Since the close of the comment periods for both the November and April interim final rules, section 4005(b) of Public Law 114-41 amended section 101(b)(1)(A) of the Choice Act to cover all enrolled veterans. Sec. 4005(b), Pub. L. 114-41, 129 Stat. 443. As a result of this amendment to the Choice Act, VA will be publishing a separate rulemaking announcing this expanded eligibility. We will now address the comments received on the other eligibility factors described in § 17.1510(b).

Wait-time Eligibility

Under § 17.1510(b)(1), a veteran is eligible if the veteran attempts, or has attempted, to schedule an appointment with a VA health care provider, but VA has been unable to schedule an appointment for the veteran within the wait-time goals of the Veterans Health Administration (VHA). VA received comments that the rule does not describe what is or is not a reasonable amount of time, or who decides whether such a period of time is reasonable; however, the wait-time determination is set forth clearly in § 17.1510(b)(1), which defines the wait-time eligibility criterion as meaning that VA is unable to schedule an appointment within 30 days after the date that the appointment was deemed clinically necessary by a VA health care provider, or, if no such clinical determination has been made, the date that a veteran prefers to be seen by a health care provider capable of furnishing the hospital care or medical services required by the

veteran. At the time that the November interim final rule published, this was consistent with the requirements in the Act at section 101(b)(2)(A). Since the close of the comment periods for both the November and April interim final rules, section 4005(d) of Public Law 114-41 amended section 101(b)(2)(A) of the Choice Act to create eligibility for veterans that are unable to be scheduled for an appointment within, "with respect to such care or services that are clinically necessary, the period determined necessary for such care or services if such period is shorter than" VHA's wait-time goals. Sec. 4005(d), Pub. L. 114-41, 129 Stat. 443. This new criterion creates eligibility when VA clinically determines that a veteran requires care within a period of time that is shorter than 30 days from the date an appointment is deemed clinically necessary by a VA health care provider, or shorter than 30 days from the date that a veteran prefers to be seen. As a result of this amendment to the Choice Act, VA will be publishing a separate rulemaking announcing this additional eligibility criterion. We continue to address other comments related to wait times below.

A commenter suggested that the term "wait-time goals of the Veterans Health Administration" should provide greater flexibility, as there are some times when a patient cannot wait 30 days for an appointment. VA agrees with this commenter that some care is urgent and should be furnished as soon as possible, or at least sooner than 30 days from the veteran's preferred date. We will make changes to the regulation to address the new wait-time criterion that is shorter than 30 days in the Choice Act as amended in a separate rulemaking. To address this comment more generally, the Program and its underlying authorities were established specifically to address situations in which veterans could not get scheduled appointments in a timely manner.

As noted above, the Program is not designed to take the place of VA's existing authority to provide emergent care through non-VA providers—such care, and other non-VA care, is available under other authorities than the Act. In short, our goal is to furnish timely care to all veterans, whether within a VA medical facility or through a non-VA provider, and Choice is not the only mechanism available to furnish this care. If a veteran requires care sooner and VA is unable to furnish this care, while the veteran would not be eligible for the Program, VA may and does use another statutory authority to furnish non-VA care.

We also received a comment recommending that VA streamline the eligibility process for veterans who qualify under the wait-time criterion. The commenter stated that there can be up to a 72-hour delay before a veteran is added to the Veterans Choice List, the record system VA uses to identify veterans who are eligible for the Program. The commenter further stated that there can be a 2-3 day delay between placement on the Veterans Choice List and when the vendors administering the program are able to verify the veteran's eligibility. The commenter expressed concern that these administrative steps are delaying care for veterans. While this comment is outside the scope of the rulemaking, which only needs to define the eligibility criteria and not the specific procedures VA follows to execute the Program, we are working to streamline eligibility determinations and have learned a great deal about how to operate the Program more effectively during the first several months of operation. For example, VA is now sending the updated Veterans Choice List to the vendors administering the Program on a daily basis. The list includes all veterans who are eligible based on the wait time criterion as well as those veterans who elect to be placed on an electronic

waiting list to receive services from VA. We are not making a change as a result of this comment.

Eligibility Based on Distance from a VA Medical Facility

Under § 17.1510(b)(2), a veteran is eligible if the veteran resides more than 40 miles from the VA medical facility that is closest to the veteran's residence. This standard considers the distance between a veteran's residence, as defined in § 17.1505, and any VA medical facility, even if that facility cannot provide the care that the veteran requires. We received several comments suggesting that the 40 mile criterion in general should be removed or eased so that more veterans can participate in the Program. In April, VA published an interim final rule modifying this standard in accordance with the comments we received, to change the methodology for calculating distances from geodesic (or "straight-line") distance to driving distance. 80 FR 22906. In response to the interim final rule published in April changing this methodology, VA received 12 comments. Many of these comments supported this change. Several commenters raised issues beyond the scope of that rulemaking but in response to the larger Program. For example, some comments noted that traffic conditions or the veteran's health make even a 40 mile driving distance too much for some veterans to bear. We understand this concern and believe that the discussion later in this final rule related to the "excessive or unusual burden on travel" standard under § 17.1510(b)(4) may help address these concerns. VA is not making a change to the driving distance provision as a result of these comments.

The April interim final rule greatly expanded veteran eligibility based on this criterion, representing liberalization similar to what had been suggested by many commenters. However, to the extent that commenters believe that 40-miles driving distance is still an unreasonable calculation, we do not believe that the Act gives us authority to depart from that standard.

VA received a large number of comments recommending that VA measure distance from the closest VA medical facility that can provide the care a veteran needs. As we explained in detail in the November interim final rule, the plain language of the Act refers only to "the medical facility of the Department that is closest to the residence of the veteran," without allowing VA to consider whether the facility can actually provide the care needed by the veteran. Sec. 101(b)(2)(B), Pub. L. 113-146, 128 Stat. 1754. Additionally, the Conference Report accompanying the legislation states that veterans are eligible if they live "within 40 miles of a medical facility," again without regard to such facility's ability to provide the required care. H. Rpt. 113-564, p. 55. The use of the general article "a" demonstrates that Congress intended for this to refer to any facility, rather than to a specific facility. The Act also specifically included community-based outpatient clinics (CBOC) among VA medical facilities, and Congress was aware that CBOCs offer a more limited set of services than VA medical centers and hospitals. We do not believe we have authority under the Act to modify this standard, and as a result, we are not making a change in response to these comments.

VA also received a comment recommending that we modify the definition of "VA medical facility" to exclude health care centers. We defined the term "VA medical facility" to mean a VA hospital, a VA community-based outpatient clinic (CBOC), or a VA

health care center. "VA health care center" is a term we use to describe a facility that offers services between what is available at a CBOC and a VA hospital. The phrase "medical facility of the Department," as used in the Act in section 101(b)(2)(B) and elsewhere, specifically includes CBOCs, so we conclude that any facility that offers more services than those available at a CBOC should be included within the definition of a VA medical facility. As a result, we are not making a change based on this comment.

Under § 17.1510(b)(3), a veteran is eligible if the veteran's residence is in a state without a full-service VA medical facility and the veteran lives more than 20 miles from such a facility. A full-service VA medical facility is one that provides--on its own and not through a joint venture--hospital care, emergency medical services, and surgical care having a surgical complexity of standard. VA received one comment about the applicability of this provision to veterans residing in New Hampshire. The commenter stated that veterans living in New Hampshire near the Manchester VA Medical Center were not eligible to participate in the Program based on their proximity to this facility. That reading of the law and regulations is incorrect and does not reflect VA's practice in implementing the Program. Section 101(b)(2)(C) of the Act, and § 17.1510(b)(3) of the regulations, state that a veteran may be eligible if he or she resides in a State without a full-service VA medical facility and lives more than 20 miles from such a facility. The Manchester VA Medical Center is not a full-service VA medical facility because it does not have a surgical complexity of standard, and because no other facility in New Hampshire has such a designation, veterans in New Hampshire may be eligible if they reside more than 20 miles from a full-service VA medical facility. The only full-service

VA medical facility within 20 miles of New Hampshire's borders is the White River Junction VA Medical Center in Vermont. Veterans residing in New Hampshire and within 20 miles of this facility are not eligible to participate in the Program under the § 17.1510(b)(3) criterion, but all other veterans in New Hampshire are eligible to participate based on this criterion. The Manchester, NH area is more than 20 miles from White River Junction, VT. Therefore, as long as a veteran residing in Manchester meets the initial eligibility criteria in § 17.1510(a), he or she will be eligible to participate in the Program. VA is not making any changes to the rule as a result of this comment

One commenter asked what system VA will use, and how VA will ensure that it is properly measuring distances from newly constructed housing. VA uses the Esri Geographic Information System to identify locations for purposes of determining mileage under the Program. In the vast majority of situations, VA is able to locate a new address. In those cases where VA is unable to locate the new address, our staff work with the veteran to correct the issue.

On May 22, 2015, the Construction Authorization and Choice Improvement Act was signed into law (Pub. L. 114-19); section 3(a)(1) of this law amended section 101(b)(2)(B) of the Act to clarify that the 40 miles is to be "calculated based on distance traveled". VA is interpreting this revision as support for the use of driving distance, which reflects the distance traveled, rather than the straight-line or geodesic distance standard VA previously adopted. VA is not making a further change to § 17.1510(e) as a result of the statutory revision enacted in Public Law 114-19.

Eligibility Based on Burden in Traveling

Under the November interim final rule, § 17.1510(b)(4), a veteran may be eligible if she or he lives 40 miles or less from a VA medical facility but faces an unusual or excessive burden in traveling to such medical facility based on the presence of a body of water or a geologic formation that cannot be crossed by road. We received several comments recommending that this standard be loosened to provide greater flexibility to allow veterans to participate in the Program. The commenters did not recommend a specific alternative interpretation, but on May 22, 2015, the Construction Authorization and Choice Improvement Act was signed into law modifying this standard. Pub. L. 114-19. Specifically, section 3(a)(2) of Public Law 114-19 revised section 101(b)(2)(D)(ii) of the Act by changing the standards that could be the basis for an unusual or excessive burden. Specifically, the Act now allows VA to determine that there is an unusual or excessive burden in traveling to a VA medical facility based on geographical challenges; environmental factors, such as roads that are not accessible to the general public, traffic, or hazardous weather; a medical condition that impacts the ability to travel; or other factors, as determined by the Secretary. We appreciate Congress' assistance with modifying this provision of law and allowing VA to consider other factors that may create a burden on veterans traveling to a VA medical facility. As a result of the change in law, VA will be publishing a separate rulemaking announcing the criteria VA will use to determine veteran eligibility based on this new law.

Section 17.1515 Authorizing Non-VA Care

Section 17.1515 describes the process and requirements for authorizing non-VA care under the Program. We received several comments on different aspects of the authorization process. Although some of these comments addressed issues beyond

the immediate scope of the November interim final rule, VA is responding to the comments here nonetheless.

First, we received a comment asking why a patient would be required to travel to a different VA facility farther from home, when seeking advanced authorization would not have been reasonable, sound, wise, or practicable. The commenter cited to VA's regulations at 38 CFR 17.120(c), which uses some of this terminology. That regulation, however, deals with reimbursing veterans for emergency treatment when Federal facilities are unavailable. As explained in the interim final rule published in November, the Program generally does not cover emergency care, which is covered instead by other statutes and regulations. Any veteran requiring emergency care should not contact VA to use the Program but should seek such emergency services as are necessary. Furthermore, under the Program, VA would not require a veteran to travel to another VA facility; a veteran's eligibility is determined based upon the veteran's residence or whether the veteran can be seen by VA within the wait-time goals of the Veterans Health Administration. VA is not making a change to its regulations based on this comment.

Another comment stated that requiring advanced authorization may prevent veterans from receiving timely care. VA also received several comments that non-VA providers should be able to be reimbursed for care furnished for conditions present that were not identified during the initial authorization. The Act requires VA to furnish hospital care and medical services through the completion of the episode of care deemed necessary as part of the recommended treatment. Sec. 101(h), Public Law 113-146, 128 Stat. 1754. If a non-VA health care provider believes that a veteran

needs additional care outside the scope of the authorized course of treatment, the health care provider must contact VA prior to administering such care to ensure that this care is authorized. There is no indication in the law that it was intended to authorize unscheduled or unauthorized non-VA care. Indeed, the preauthorization requirement is important to ensure that VA is not subject to an open ended commitment, and so that veterans are not subjected to unnecessary procedures and tests but only receive care that is necessary. VA is not making a change based on these comments.

Several commenters recommended that VA simplify and standardize the authorization and claims processes in order to reduce the administrative burdens on participating eligible providers. VA also received a comment stating that VA should reduce or eliminate the preauthorization requirement for treatment from approved non-VA providers who have an established record of effective and efficient care within the Program. The Program's regulations do not identify any requirement for providers beyond what is included in the Act, and the authorization of care is also required for the reasons stated above. We believe that continued experience with the Program will help VA and eligible, participating providers streamline this process to facilitate faster access to care. We are not making a change to the rule as a result of these comments.

VA also received comments offering recommendations for a simpler method for authorizing care. For example, some comments stated that there should be a unique call-in number for providers, and that VA and the vendors administering the Program should have a better records system so that a veteran does not have to provide the same information multiple times. Most of these comments are beyond the scope of the rulemaking because they deal with purely administrative or operational issues, like the

use of a dedicated phone line for providers or recordkeeping, which are not mandated by regulation. We appreciate this feedback and will consider it as part of our ongoing effort to more efficiently execute the Program. One goal of VA and the vendors administering the Program is to record information accurately so that others can have access to the same information, and as we have more experience with the Program, we are improving the customer service experience as well. We are not making a change to the rule as a result of these comments because these matters are not covered by regulation, nor is it necessary to address them through regulation.

Commenters also suggested that authorizations or contracts should be retroactive to the date of an eligible request because this would result in fewer non-health-center providers refusing to care for unauthorized veterans, and fewer uncompensated care costs for health centers. It is unclear how this change would produce that result. Moreover, VA is concerned that imposing a retroactive date could create confusion as to when the 60 day authorization period begins, and in such a case, a retroactive date would limit a veteran's ability to receive care. Consequently, VA is not making a change to the rule.

Several comments stated that veterans and providers should be notified if care will not be continued past 60 days and that authorizations for care for patients with chronic conditions should cover emergency primary care needs. As we stated in the November interim final rule, we will be working with providers and veterans to notify them in advance if the 60 day authorization period is coming to an end, particularly if such care will not be re-authorized because the veteran or provider is no longer eligible to participate in the Program. For patients with chronic conditions, VA may authorize

care to address related issues that could develop, such as respiratory infections or other complications, if VA has a basis to determine that this care is necessary. For veterans who have never been seen by a VA health care provider, such a determination would be more difficult because we would not know the type of treatment a veteran has previously received, what other conditions the veteran may have, or the medications the veteran is taking. Another comment suggested that veterans should be able to make their own appointments once care has been authorized. In our experience, many veterans prefer to have VA schedule their appointments, but a veteran may opt to schedule his or her own appointment once care has been authorized. We do require through the contract with the vendors administering the program, though, that such vendors request that the veteran provide information about the appointment and the vendors then report this information to VA so we can ensure that appointments are timely. VA is not making a change based on these comments.

Some commenters asserted that requiring authorization for each and every treatment is time consuming and does not produce any benefits, and that VA should find ways to facilitate quicker appointments. As we explained in the November interim final rule, VA has an obligation to ensure that care furnished under the Program is necessary, and we will continue to abide by this requirement. However, VA can issue a broad authorization in some circumstances for care that is determined at the outset to likely be necessary. For example, if we know that a patient is being treated for a condition that has several common comorbidities, or if we know that a treatment approach that will be administered has common side effects or complications, we could

authorize treatment for these services in advance to include ancillary or specialty services. We are not making a change to the rule based on these comments.

We received several comments raising additional issues concerning authorizations for care. The comments stated that it was sometimes unclear which services were being authorized and who is making the determination, and asked VA to explain what criteria VA is using to determine what care is necessary. The authorization the eligible provider receives from VA should clearly identify what services are covered—if the provider is unsure, he or she should contact VA to ensure that only those services covered by the authorization are performed. The commenter also suggested VA provide more details on the authorization process, including timeframes for authorizations. These timelines and other operational details are case-specific, and as such, VA does not believe they can or should be placed in regulation. If providers have any questions about the process or a specific authorization, they should feel free to contact VA for clarification. We are not making changes to the regulations based on these comments because they concern administrative matters beyond the scope of the regulations.

Finally, one commenter suggested that veterans should not have to contact the vendors administering the Program to verify their eligibility prior to care being authorized. This is not an express requirement in the regulation, and as such is outside the scope of this rulemaking. As a result, we are not making a change based on this comment. However, as a practical matter, VA believes the step of the veteran contacting the vendors administering the Program is important to ensure that necessary care is authorized for the right veteran with the right provider.

Section 17.1530 Eligible Entities and Providers

Section 17.1530 defines requirements for non-VA entities and health care providers to be eligible to be reimbursed for furnishing hospital care and medical services to eligible veterans under the Program. VA received a number of comments on this section.

VA received several comments recommending that other entities, such as rural health clinics, community health centers, women's health centers, essential community providers, and Medicaid providers, be included among eligible entities. At the time that the comment periods for both the November and April interim final rules closed, section 101(a)(1)(B) of the Act identified only four categories of eligible entities or providers: any health care provider that is participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including any physician furnishing services under such program; any Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)); the Department of Defense; or the Indian Health Service. Since the close of the comment periods for both the November and April interim final rules, section 4005(c) of Public Law 114-41 amended sections 101(a)(1)(B) and 101(d) of the Act to permit VA to expand provider eligibility beyond those providers expressly listed in section 101(a)(1)(B) of the Act, in accordance with eligibility criteria as established by VA. Sec. 4005(c), Pub. L. 114-41, 129 Stat. 443. As a result of this amendment to the Act, VA will be publishing a separate rulemaking announcing the additional eligible providers. We will now address other comments related to eligible entities and providers.

One commenter recommended that VA publish a list of eligible providers under the Program on a Web site to help veterans elect to receive care closer to home. This is an administrative recommendation outside the scope of the rulemaking, but we do note that VA maintains a list of all eligible providers that can be found on the Choice Program Web site at www.va.gov/opa/choiceact/. VA updates this list regularly to ensure accuracy of information. Veterans also can request a specific provider that is not on the list but meets the eligibility criteria under this section and who is willing to enter into an agreement with VA. VA is not making a change to the rule as a result of this comment.

Under § 17.1530(b), an entity or provider must enter into an agreement with VA to provide non-VA hospital care or medical services under the Program. VA received several comments on the process for entering into agreements. Several comments suggested that local facilities should be able to enter into contracts to provide services through the Program. The rulemaking is silent on this point, and we do not believe the regulation needs to be specific on this issue. Nothing in the regulations governing the program would prevent a local VA facility from entering into a contract with a local provider, although the Program is presently administered only under national contracts. If VA determines that the national contracts cannot provide all of the care needed and available in the Program, VA can use the provider agreement authority established by the Act to obtain the needed care. We note that VA has not yet implemented this provider agreement authority, but is developing a provider agreement template that can be used by local facilities. VA therefore is not making a change as a result of these comments.

Several comments also stated that existing agreements, including agreements with Tribal and urban health programs among others, should be used to furnish care. Existing contracts and agreements with eligible providers can be used to furnish care, and VA is promoting their use, particularly prior to the implementation of the provider agreement authority established by the Act. VA is not making a change as a result of these comments.

Under § 17.1530(d), a non-VA provider must maintain at least the same or similar credentials and licenses as required by VA of its own providers. We received several comments on this provision. We received comments that the process for submitting and reviewing credentials and privileging information should not be overly burdensome. Administratively, we have tried to make this process as simple as possible, while still adhering to the requirements of the Act in section 101(i), by making the credentialing and privileging process part of the provider's approval process with the vendors administering the program. The regulations do not address the system for this specifically, and we do not think such detail is needed in case we need to modify the system at a later time. We are not making a change to the rule as a result of these comments.

We also received a recommendation to broaden the language about credentialing and licensing to ensure qualified non-physician practitioners qualify to participate in the Program. Another commenter suggested that VA include osteopathic and allopathic credentials for physicians. VA is limited by section 101(i) of the Act to accepting non-VA providers who meet the same or similar standards as VA providers; to the extent non-physician practitioners or physicians with osteopathic or allopathic

credentials in VA could perform functions or procedures, those in the community could do so as well under the Program if they have the same qualifications. VA is not making a change to the rule based on these comments.

Although not addressed in the regulation, VA stated in the November interim final rule notice that eligible entities and providers furnishing hospital care and medical services to eligible veterans through the Program, to the extent possible, should submit medical records back to VA in an electronic format. The agreements VA reaches with eligible entities and providers clarify this requirement. We received several comments on the exchange of information under the Program, which are outside the scope of the rulemaking but will be addressed here nonetheless. Several commenters suggested that VA should ensure that participating providers have timely access to the necessary patient information to help them make informed clinical decisions regarding treatment. VA's Non-VA Care Coordination (NVCC) program is intended to help facilitate care by sharing information, to the extent authorized by law and regulation, with non-VA providers prior to a patient's appointment. However, some veterans who have never received health care from VA are eligible to participate in the Program, and for these veterans, VA cannot furnish information in advance of an appointment. We are working to standardize the transmission of information, both to and from VA, to improve the delivery of health care for veterans receiving treatment in VA and the community. Other comments suggested that electronic submission of medical records back to VA should be streamlined and simple so that providers do not have to struggle to comply with this requirement. VA has set up a secure Web site where providers can submit this

information, and we believe it is simple and easy to use. VA is not making a change to the rule as a result of these comments.

Section 17.1535 Payment Rates and Methodologies

Section 17.1535 addresses payment rates and payment methodologies. VA received a number of comments on this section.

Several commenters stated that VA should be paying Medicare rates under the Program. Section 17.1535(a)(1) establishes the payment rule that most reimbursement rates under the Program will not exceed the Medicare rate, consistent with section 101(d)(2)(B)(i) of the Act. There are only two exceptions to this rule in the Act. First, § 17.1535(a)(2) authorizes VA to pay a rate higher to an eligible entity or provider in a highly rural area, so long as such rate is still determined by VA to be fair and reasonable. Second, § 17.1535(a)(3) authorizes VA to pay a higher rate when no Medicare rate is available. We explain in the discussion below that we are adding two additional exceptions to § 17.1530.

The vendors administering the Program also operate the Patient-Centered Community Care (PC3) contract, which can pay rates lower than the Medicare rate, and it is possible that there is some confusion among providers regarding whether they are providing care under the Program or the PC3 contract. Indeed, we received some comments stating that providers did not always know under which authority they were furnishing care. We shared these comments with the vendors administering the Program and are working to improve communication so that providers understand what care is furnished under the Program and what is performed pursuant to PC3. Providers

who signed contracts to furnish care under PC3 at a set rate may also be subject to receiving that negotiated rate when furnishing care under the Program as well, but VA is not a party to those agreements between vendors and providers and cannot interfere with the terms of those agreements. We are not making any changes based on these comments.

However, we are adding two additional exceptions to § 17.1535(a). First, we are adding a new paragraph (a)(3) authorizing VA to pay eligible providers or entities in the State of Alaska using rates set forth in 38 CFR 17.55(j) and 17.56(b). The rates in §§ 17.55(j) and 17.56(b) are currently used to establish special rates to pay for non-VA care in Alaska under authorities other than the Program, and the new paragraph would simply make the Program comparable. We are also adding a new § 17.1535(a)(4) authorizing VA to use the rate set forth in a State with an All-Payer Model Agreement under the Social Security Act that became effective on January 1, 2014. These two new exceptions were authorized by section 242 of Division I of Public Law 113-235. 128 Stat. 2568. We are redesignating current § 17.1535(a)(3) as § 17.1535(a)(5).

One commenter suggested that VA should ensure Federally Qualified Health Centers (FQHC) are reimbursed for their reasonable costs under Medicare and refer to Medicare Part B for pharmaceutical rates. VA is permitted to pay up to the Medicare rate under section 101(d)(2)(B) of the Act, and this includes special rates available for FQHCs under 42 U.S.C. 1395 et seq. Another commenter urged VA to allow medication prescriptions from non-VA providers to be filled at VA pharmacies. We clarify that VA is not making payments to providers for medications under the Program; as explained in the November interim final rule, VA will fill prescriptions, including

prescription drugs, over-the-counter drugs, and medical and surgical supplies prescribed by eligible non-VA entities and providers. VA has been filling these prescriptions through its own Pharmacy Benefits Management program or at VA expense and will continue to do so to ensure participating veterans have access to the medications they need. We are not making a change as a result of these comments.

Section 17.1535(b) details payment responsibilities. One comment stated that VA should explicitly reference in its regulations section 101(e)(2) of the Act to clearly communicate that VA is responsible for care, the responsibilities of any other parties (e.g., insurance companies), and whether such care is for a non-service connected disability. This comment also suggested that VA supply to non-VA providers the necessary documentation so those providers may pursue payment from any other parties. We do not believe it is necessary to be this specific in our regulations, but VA will certainly comply with any statutory requirement in the Act, including the requirements of section 101(e)(2). The agreements entered into under the Program contain greater specificity on some of these issues, and the authorizations for care provide additional information. VA is not making a change as a result of this comment.

Section 17.1540 Claims processing system

Section 17.1540 provides general requirements for a VA claims processing system. We received a number of comments on this system. Most of the comments urged VA to pay promptly, and to pay interest on claims that are overdue. Some comments recommended specific timelines for reviewing claims, and others urged VA to reference the Prompt Payment Act, 31 U.S.C. 3901 et seq., in § 17.1540. VA is

working to pay claims under the Program as quickly as possible, and is bound to adhere to the Prompt Payment Act under section 105 of the Act. The Prompt Payment Act, and its implementing regulations at 5 CFR part 1315, define the parameters within which Federal agency payments are considered timely, requirements for reviewing claims, and the penalties for late payments. We do not believe modifications to the Program's regulations are necessary.

We received comments stating the processing system should be simple, and that it should be easy for providers and entities to submit information. We also received comments suggesting that VA provide further information on the new claims processing system, in particular how it will be restructured to facilitate the appropriate reimbursement of claims and how it will ensure prompt payments. Some of these comments indicated that the new system has not improved the efficiency of the payment system. We are working to ensure all aspects of the Program are as simple as possible, and welcome recommendations for how to improve our administrative operations. However, it is not appropriate to include such operational details in our regulations, as such specificity could serve to restrict our ability to innovate and adapt the system to become more efficient and easy to use. We are not making any changes to the regulation as a result of these comments.

Miscellaneous Comments

In addition to the areas above, VA also received comments on other matters. For example, several comments requested case management assistance with their own particular health care situations and/or claims under the Program, and we reached out

to these veterans to help them; however, we are not making any changes to the regulation based on these comments.

Several comments asked about other non-VA care programs. Some stated that eligible veterans were unsure whether to use the Program or another non-VA authority. Other comments stated that the staff at their facilities were not sufficiently trained to explain the differences between the Program and other non-VA care programs. We recognize that the number and different types of non-VA care programs and authorities can be confusing to veterans, our stakeholders, and our employees, and we are currently reexamining these various programs as part of a greater effort to streamline VA's use of non-VA care. As we stated in the November interim final rule and above, we have attempted to administer the Program similarly to other non-VA health care programs in an effort to reduce confusion. For some veterans, particularly those with their own health insurance, there may be some differences under the Program, because while VA will attempt to cover the veteran's financial obligations under his or her insurance plan, VA cannot pay more than the Medicare rate (with limited exceptions) for the services provided, meaning the veteran may owe some copayment, cost share, or deductible amount from their other health insurance to the provider. VA is unable to completely eliminate any potential copayment liability because under the Program, VA is a secondary payer, while under other non-VA care, we are the primary payer, and our payment to the non-VA health care provider is payment in full. Consequently, there may be some differences in a veteran's experience between the Program and other non-VA care, and we are available to assist eligible veterans with any questions they may have. We are not making any changes to the rule as a result of these comments.

Other comments were that VA should use its existing legal authority to furnish non-VA care for veterans who do not qualify for the Program. Specifically, some comments stated that VA should permit veterans to access non-VA health care providers if they need services that no VA medical facility that is accessible (by geography or timeliness) can provide. We are unsure whether these specific comments referenced care under the Choice Program or care under other non-VA care programs. We reiterate that the 40-mile distance criterion in the Choice Program considers the distance between a veteran's residence and any VA medical facility, even if that facility cannot provide the care that the veteran requires. However, we note that over the past 12 to 18 months VA has been using non-VA authorities other than the Act with much greater frequency than in prior years; in fiscal year 2014, VA completed 16.2 million appointments in the community, an average of more than 1.3 million appointments per month. We will continue to use these authorities when available and appropriate. We are not making a change to the rule based on these comments.

VA received comments that it should address late payment claims for care authorized under other authorities so that community providers would be more likely to participate in the Program. This is outside the scope of the rulemaking, but we are working to pay promptly claims under any authority, including the Program, and if there are specific claims that are late, we encourage the providers to contact us so we can rectify the situation. We are not making any changes as a result of these comments.

We also received a number of comments about other issues. One comment stated that VA should not be using funds appropriated by the Act to expand the number of residency positions in VA. This is outside the scope of the rulemaking, which only

implements section 101 of the Act, while provisions regarding residency programs were addressed in section 302 of the Act. However, VA is complying with the requirements of that section as directed by Congress, and we believe that increasing our own capacity to furnish care will allow us to better meet the needs of all enrolled veterans. VA is not making a change to the rule based on this comment.

Another comment stated that VA should not be authorized to define the Program or eligibility criteria for it. VA was expressly required to do this through section 101(n) of the Act, which directed VA to publish interpretive regulations for the Program within 90 days of enactment. Therefore, VA is not making a change to the rule based on this comment.

Several comments recommended better communication with the public about the Program. For example, some suggested outreach to medical societies and physician associations to increase awareness, some suggested better education materials for eligible veterans and providers, and some recommended better coordination and consistency with the vendors administering the Program to clarify the requirements of the Program. Although these comments are outside the scope of the rulemaking, we appreciate this feedback and are working with all of these populations to increase awareness of the Program. For example, when we initially launched the Program, we mailed explanatory letters to over eight million veterans, and we completed an outbound call campaign to those veterans who were initially eligible under the wait-time criterion. We have prepared and updated fact sheets for veterans that can be accessed online or at a facility, and we have worked with provider groups and Veterans Service Organizations to support further outreach. Earlier this year, VA launched a public

service announcement for eligible veterans, and we began hosting town halls related to the Program at VA medical facilities. We have also increased staff education and training and appointed more than 900 “Choice Champions” to assist veterans and the public with questions about the Program. One comment suggested the vendors administering the Program should inform providers if they are signing up for the Program or another non-VA health care program, and that VA should clarify which vendor is responsible for patients who live in states served by both vendors. We are also in close and constant communication with the vendors to ensure we are sharing a clear and consistent message with the public and our stakeholders. We forwarded applicable comments like these to the vendors to ensure they were aware of some of the feedback we were receiving, and we will continue to work together so that patients and providers understand the Program better. We are not making a change to the rule based on these comments.

One comment recommended that non-VA providers that participate in the Program be permitted to provide primary care services to Veterans. We clarify that VA does permit non-VA providers to furnish primary care services, as primary care services are part of the hospital care and medical services that may be provided under section 101(a)(1)(a) of the Choice Act, as well as under § 17.1500(b). We therefore do not make any changes to the rule based on this comment.

One comment recommended that VA should permit non-VA providers that participate in the Program to be covered by the Federal Tort Claims Act (FTCA). The FTCA only covers Federal agencies and agency employees acting within the scope of their employment. See 28 U.S.C. 2671 et al. However, non-VA providers that

participate in the Program cannot be VA employees, or, if they are VA employees, such providers must not be acting within the scope of their VA employment when they provide services under the Program. See 38 CFR 17.1530(a)(1)-(2). We reiterate from the November interim final rule that § 17.1530(a)(1)-(2) was promulgated because the Act specifically envisions that care under the Program is provided by non-VA resources, as demonstrated by section 101(a)(3) of the Act, which requires VA to coordinate through the Non-VA Care Coordination Program the furnishing of care and services under this Program. The title of section 101 of the Act, "Expanded availability of hospital care and medical services for veterans through use of agreements with non-Department of Veterans Affairs entities," also clearly demonstrates Congress's intent that any entity or provider that is a VA resource should not be eligible to participate in the Program. We therefore do not make any changes to the rule based on this comment.

We also received several comments that Tribes and Tribal organizations can contribute to the Program. As we stated in the November interim final rule, outpatient health programs or facilities operated by a Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act are defined as Federally-qualified health centers in section 1905(l)(2)(B) of the Social Security Act and can be eligible providers under section 101(a)(1)(B) of the Act. The comments urged VA to establish direct communication with these programs and include them at the table with the Indian Health Service when considering new model language or agreements and when identifying and developing performance metrics, and recommended that VA

use and expand where possible current agreements to furnish care. These comments touch on issues beyond the scope of the rulemaking, principally how VA works with the Indian Health Service, Tribes, and Tribal organizations generally, but we are committed to using existing agreements and partnerships where possible. We are not making a change to the rule based on these comments.

Administrative Procedure Act

In accordance with 5 U.S.C. 553(b)(B) and (d)(3), the Secretary of Veterans Affairs concluded that there was good cause to publish this rule without prior opportunity for public comment and to publish this rule with an immediate effective date. The Secretary found that it was impracticable and contrary to law and the public interest to delay this rule for the purpose of soliciting advance public comment or to have a delayed effective date, and therefore issued two interim final rules published at 79 FR 65571 (November 5, 2014) and 80 FR 22906 (April 24, 2015). This rulemaking amends § 17.1535(a) to establish two alternative rates of payments. These provisions were mandated by Congress in a public law that was enacted subsequent to the November interim final rule. See Pub. L. 113-235 (discussed above). These regulatory changes reflect these new provisions, and notice and public comment could not therefore result in any change to these provisions. Further, since the public laws became effective on their respective dates of enactment, VA believes it is impracticable and contrary to law and the public interest to delay this rule for the purpose of soliciting advance public comment or to have a delayed effective date.

Effect of Rulemaking

Title 38 of the Code of Federal Regulations, as revised by this final rule, represents VA's implementation of its legal authority on this subject. Other than future amendments to this regulation or governing statutes, no contrary guidance or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this rulemaking if possible or, if not possible, such guidance is 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)(3)(vi).

This final rule will impose the following new information collection requirements. Section 17.1515 requires eligible veterans to notify VA whether the veteran elects to receive authorized non-VA care through the Veterans Choice Program, be placed on an electronic waiting list, or be scheduled for an appointment with a VA health care provider. Section 17.1515(b)(1) also allows eligible veterans to specify a particular non-VA entity or health care provider, if that entity or provider meets certain requirements. Section 17.1510(d) requires eligible veterans to submit to VA information about their health-care plan to participate in the Veterans Choice Program. Participating eligible entities and providers are required to submit a copy of any medical record related to

hospital care or medical services furnished under this Program to an eligible veteran. Section 17.1530 requires eligible entities and providers to submit verification that the entity or provider maintains at least the same or similar credentials and licenses as those required of VA's health care providers, as determined by the Secretary.

As required by the Paperwork Reduction Act of 1995 (at 44 U.S.C. 3507(d)), VA has submitted these information collections to OMB for its review. OMB approved these new information collection requirements associated with the final rule and assigned OMB control number 2900-0823. We have added the approved OMB control number to the relevant parentheticals.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a "significant regulatory action," requiring review by OMB, unless OMB waives such review, as "any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity,

competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order."

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined that this is 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 regulatory impact analysis are available on VA's Web site at http://www.va.gov/orpm/, by following the link for "VA Regulations Published From FY 2004 Through Fiscal Year to Date."

Congressional Review Act

This regulatory action is a major rule under the Congressional Review Act, 5 U.S.C. 801–08, because it may result in an annual effect on the economy of $100 million or more. Although this regulatory action constitutes a major rule within the meaning of the Congressional Review Act, 5 U.S.C. 804(2), it is not subject to the 60-day delay in effective date applicable to major rules under 5 U.S.C. 801(a)(3) because the Secretary finds that good cause exists under 5 U.S.C. 808(2) to make this regulatory action effective on the date of publication, consistent with the reasons given

for the publication of this final rule. Delay in expanding access to non-VA care for eligible veterans could result in the deterioration of their health. In accordance with 5 U.S.C. 801(a)(1), VA will submit to the Comptroller General and to Congress a copy of this regulatory action and VA's Regulatory Impact Analysis.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any 1 year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. This final rule will not have a significant economic impact on participating eligible entities and providers who enter into agreements with VA. To the extent there is any such impact, it will result in increased business and revenue for them. We also do not believe there will be a significant economic impact on insurance companies, as claims will only be submitted for care that will 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.

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.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Robert L. Nabors II, Chief of Staff, Department of Veterans Affairs, approved this document on October 6, 2015, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, Travel and transportation expenses, Veterans.

Dated: October 22, 2015.

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Michael Shores,
Chief Impact Analyst,
Office of Regulation Policy & Management,
Office of the General Counsel,
Department of Veterans Affairs.

For the reasons stated in the preamble, VA amends 38 CFR part 17 as follows:

PART 17 – MEDICAL

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

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

2. In § 17.1535, redesignate paragraph (a)(3) as paragraph (a)(5) and add paragraphs (a)(3) and (4) to read as follows:

§ 17.1535 Payment rates and methodologies.

(a) * * *

(3) For eligible entities or providers in Alaska, the Secretary may enter into agreements at rates established under §§ 17.55(j) and 17.56(b).

(4) For eligible entities or providers in a State with an All-Payer Model Agreement under the Social Security Act that became effective on January 1, 2014, payment rates will be calculated based on the payment rates under such agreement.

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[FR Doc. 2015-27481 Filed: 10/28/2015 8:45 am; Publication Date: 10/29/2015]