

TABLE 3—HOLDING SCENARIO—MANEUVERS—Continued

Configuration	CG	Trim speed	Maneuver
Landing flaps, gear down	Optional (aft range) .....	VREF (Minimum AFM speed) .....	<ul style="list-style-type: none"> <li>• Level, 40° banked turn,</li> <li>• Bank-to-bank rapid roll, 30°–30°,</li> <li>• Speed-brake extension, retraction (if approved),</li> <li>• Deceleration to alpha-max (1 knot/second deceleration rate, wings level, power off).</li> </ul>

TABLE 4—APPROACH/LANDING SCENARIO—MANEUVERS

Test condition	Ice accretion thickness (*)	Configuration	CG	Trim speed	Maneuver
1 .....	First 13 mm (0.5 inch). Additional 6.3 mm (0.25 in) (19 mm (0.75 in) total).	Flaps up, gear up ..  First intermediate flaps, gear up.	Optional (aft range)  Optional (aft range)	Holding .....  Minimum AFM speed.	No specific test.  <ul style="list-style-type: none"> <li>• Level 40° banked turn,</li> <li>• Bank-to-bank rapid roll, 30°–30°,</li> <li>• Speed brake extension and retraction (if approved),</li> <li>• 1kt/s Level deceleration until the deceleration is stopped due to alpha-floor triggering.</li> </ul>
2 .....	Additional 6.3 mm (0.25 in) (25 mm (1.00 in) total).	First intermediate flaps, gear up (as applicable).	Optional (aft range)	Minimum AFM speed.	<ul style="list-style-type: none"> <li>• Bank-to-bank rapid roll, 30°–30°,</li> <li>• Speed brake extension and retraction (if approved),</li> <li>• 1kt/s Level deceleration until the deceleration is stopped due to alpha-floor triggering.</li> </ul>
3 .....	Additional 6.3 mm (0.25 in) (31 mm (1.25 in) total).	Landing flaps, gear down).	Optional (aft range)	V <sub>REF</sub> (Minimum AFM speed).	<ul style="list-style-type: none"> <li>• Bank-to-bank rapid roll, 30°–30°,</li> <li>• Speed brake extension and retraction (if approved),</li> <li>• Bank to 40°</li> <li>• Deceleration to alpha-max.</li> </ul>

(\*) The indicated thickness is that obtained on the parts of the unprotected airfoil with the highest collection efficiency.

8. In lieu of AC 25–25, 3. v., Failure conditions, § 25.1309, the following guidance is made for (2)(d):

(2) *Acceptable Test Program*

(d) In the configurations listed below, trim the airplane at the minimum AFM speed. Decrease speed to the minimum steady achievable speed, plus 1 second and demonstrate prompt recovery using the same recovery maneuver as for the non-contaminated airplane. It is acceptable for stall warning to be provided by a different means (for example, by the behavior of the airplane) for failure cases not considered probable.

1 High lift devices retracted configuration: Straight/Power Off.

2 Landing configuration: Straight/Power Off.

Issued in Renton, Washington.

**Michael Kaszycki,**

*Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.*

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## DEPARTMENT OF VETERANS AFFAIRS

### 38 CFR Part 17

#### RIN 2900–AP24

### Expanded Access to Non-VA Care Through the Veterans Choice Program

**AGENCY:** Department of Veterans Affairs.

**ACTION:** Interim final rule.

**SUMMARY:** The Department of Veterans Affairs (VA) amends its medical regulations concerning its authority for eligible veterans to receive care from non-VA entities and providers. The Veterans Access, Choice, and Accountability Act of 2014 directs VA to establish a program to furnish hospital care and medical services through non-VA health care providers to 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”). The law also requires VA to publish an interim final rule establishing this program. This interim final rule defines the parameters of the Veterans Choice

Program, and clarifies aspects affecting veterans and the non-VA providers who will furnish hospital care and medical services through the Veterans Choice Program.

**DATES:** *Effective Date:* This rule is effective on November 5, 2014.

*Comment date:* Comments must be received on or before March 5, 2015.

**ADDRESSES:** Written comments may be submitted by email through <http://www.regulations.gov>; by mail or hand-delivery to Director, Regulation Policy and Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420; or by fax to (202) 273–9026. (This is not a toll-free number.) Comments should indicate that they are submitted in response to “RIN 2900–AP24, Expanded Access to Non-VA Care through the Veterans Choice Program.” Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1068, between the hours of 8:00 a.m. and 4:30 p.m. Monday through Friday (except holidays). Please call (202) 461–4902 for an appointment. (This is not a toll-free number.) In addition, during the

comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at <http://www.regulations.gov>.

**FOR FURTHER INFORMATION CONTACT:**

Kristin Cunningham, Director, Business Policy, Chief Business Office (10NB), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 382-2508. (This is not a toll-free number.)

**SUPPLEMENTARY INFORMATION:**

*Executive Summary:* Purpose of This Regulatory Action: We are creating new regulations to define and authorize the Veterans Choice Program required by section 101 of the Veterans Access, Choice, and Accountability Act of 2014, as modified by the Department of Veterans Affairs Expiring Authorities Act of 2014. Specifically, under this Program, eligible veterans may elect to receive hospital care and medical services from eligible non-VA entities and providers. The Program does not modify VA's previously existing authorities to furnish care through non-VA providers, but instead enhances VA's options to furnish care that is timely and available in veterans' communities.

*Summary of the Major Provisions of this Regulatory Action:* This interim final rule—

- Modifies VA's existing copayment regulations to clarify that a copayment of \$0 is owed at the time of service for eligible veterans receiving care or services through the Program. VA will determine the copayment amount after the provider bills VA for the cost of furnished care, and veterans may be liable for some or all of the copayment amount at that time. Copayment rates will not exceed those currently established in regulation.
- Establishes the scope of the Program, including the types of care and services that are covered. By law, the Program is authorized to run until August 7, 2017, or until the Veterans Choice Fund established by the Act is exhausted.
- Defines key terms used throughout the regulation. These terms include episode of care, which is limited to 60 days but includes follow-up appointments and ancillary and specialty services; health-care plan, which includes any insurance plan or contract or agreement other than Medicare, Medicaid, or TRICARE; residence, which is a legal residence or personal domicile; VA medical facility, which includes VA hospitals, community-based outpatient clinics, and VA health care centers; and the

wait-time goals of the Veterans Health Administration, which are to furnish care within 30 days of either the date that an appointment is deemed clinically appropriate by a VA health care provider, or if no such clinical determination has been made, the date a veteran prefers to be seen.

- Defines eligibility criteria for veterans to participate in the Program. In general, veterans must have been enrolled in the VA health care system on or before August 1, 2014, or must be within 5 years of post-combat separation. Veterans must also either be unable to schedule an appointment within the wait-time goals of the Veterans Health Administration or qualify based on their place of residence. Veterans may qualify based on their place of residence if they live more than 40 miles from the closest VA medical facility; if they reside in a state without a VA medical facility that provides hospital care, emergency medical services, and surgical care rated by the Secretary as having a surgical complexity of standard, and they reside more than 20 miles from a medical facility that offers these services in another state; or, with certain exceptions, if they reside 40 miles or less from a VA medical facility and must travel by air, boat, or ferry, or face an unusual or excessive burden in traveling to a VA medical facility because of geographical challenges.
- Explains the process for authorizing non-VA care under the Program. Eligible veterans may elect to receive VA or non-VA care. If they elect to receive non-VA care, they may select the provider who will furnish their care, if that provider is eligible.
- Describes the effect of the Program on other benefits and services available to veterans. In general, the Program does not affect a veteran's eligibility for hospital care or medical services under the medical benefits package. VA will pay for and fill prescriptions written by non-VA providers under the Program to the extent such prescriptions are covered by the VA medical benefits package. VA will reimburse veterans' copayments or cost-shares required by their other health-care plan to the extent authorized by law, and VA will calculate veterans' VA copayments as described above. VA will also reimburse veterans for travel to receive care under the Program if the veteran is otherwise eligible to participate in VA's beneficiary travel program.
- Identifies the start date for eligible veterans under the Program. VA is phasing in implementation of the Program to ensure it has the necessary resources in place to furnish hospital

care and medical services to eligible veterans.

- Defines eligibility criteria for non-VA health care entities and providers to participate in the Program. Eligible non-VA entities and providers must enter into an agreement with VA to furnish care, and must be participating in the Medicare program, be a Federally-qualified health center, or be a part of the Department of Defense or the Indian Health Service. Non-VA entities or providers must be accessible to the veteran, meaning they must be able to provide timely care, must have the necessary qualifications to furnish the care, and must be within a reasonable distance of the veteran's residence. Eligible non-VA entities and providers must maintain at least the same or similar credentials and licenses as VA providers, and must submit information verifying compliance with this requirement annually.

- Establishes payment rates and methodologies for reimbursing participating non-VA health care entities and providers furnishing care and services through the Program. Except for in highly rural areas, VA may not pay an eligible entity or provider more than the applicable Medicare rate under Title XVIII of the Social Security Act for hospital care or medical services furnished under the Program. When there are no Medicare rates available, VA will follow its usual methodology for calculating payments to the extent such methodology is consistent with the Act. VA is a secondary payer for care furnished for a nonservice-connected disability if the veteran has another health-care plan. VA will only pay for authorized care where an actual encounter with a health care provider occurs. Veterans must seek authorization from VA before receiving care.

- Establishes a claims processing system to receive requests for payment and to provide accurate and timely payments for claims received under the Program. This system will be managed by the Veterans Health Administration's Chief Business Office.

*Costs and Benefits:* As further detailed in the *Regulatory Impact Analysis*, which can be found as a supporting document at <http://www.regulations.gov> and is available on VA's Web site at <http://www.va.gov/orpm/>, by following the link for "VA Regulations Published From FY 2004 Through Fiscal Year to Date," the interim final rule will affect eligible veterans and eligible non-VA health care entities and providers. Eligible veterans may elect to receive, at VA expense, care from a non-VA provider of their choice that is eligible

and accessible to them. These providers generally will either be able to provide care sooner than VA could or are located closer to the eligible veteran's residence than a VA medical facility. The Program is authorized to run for 3 years, or until resources appropriated in the Veterans Choice Fund are exhausted, and is intended as a short-term solution to expand access to care while VA enhances its capacity to furnish care in a timely and accessible manner. Participating eligible non-VA health care entities and providers will receive payment for furnishing authorized hospital care and medical services to eligible veterans under the Program.

*General Discussion:* 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). Section 101 of the Act creates the Veterans Choice Program ("the Program"). Section 101 requires the Secretary to furnish hospital care and medical services to certain eligible veterans through agreements with identified eligible entities or providers. Sec. 101(a)(1)(A), Public Law 113–146, 128 Stat. 1754. Delivery of such care through non-VA health care providers will be at the election of eligible veterans. This interim final rulemaking primarily restates these mandates and prescriptions in a regulatory framework, and provides guidance where Congress' instructions were not clearly executable on the face of the law. 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. This rulemaking complies with that mandate.

Nothing in this rulemaking modifies VA's existing authority to furnish non-VA care, such as under 38 U.S.C. 1703, 1725, 1728, 8111, or 8153. The requirements of those statutes and their implementing regulations continue to apply, and VA will use those authorities when appropriate. Any veteran currently receiving non-VA care who is eligible for the Program will be provided the opportunity to elect to participate in the Program or to continue being provided care under VA's other authorities. As discussed below, there are some differences between the Program and other non-VA care.

VA is making changes to several other regulations as part of this rulemaking.

Specifically, VA is amending 38 CFR 17.108, 17.110, and 17.111 concerning copayment responsibilities for hospital care and medical services. Section 101(j) of the Act requires an eligible veteran to pay a copayment at the time of the appointment to the non-VA provider if such veteran would be required to pay a copayment for the receipt of hospital care or medical services at a VA medical facility. Under current practice, when veterans receive non-VA care, VA copayment obligations are not calculated until the end of the billing process. Consistent with this practice, VA is exercising its authority to establish copayment rates under 38 U.S.C. 1710(f) to revise its copayment regulations at §§ 17.108, 17.110, and 17.111 to state that veterans who receive hospital care and medical services under the Program are subject to a VA copayment of \$0 at the time of service, and that their copayment liability will be determined after the authorized care is furnished, but will be no greater than the amounts already specified in §§ 17.108, 17.110, or 17.111.

Currently, no veterans are charged a VA copayment at the time of their appointment. This is true whether such care is furnished by a VA or non-VA provider. Under current practice, if a veteran has other health insurance, any payment by the other health insurance is first applied against the veteran's VA copayment liability, and if the third party payment is equal to or greater than the veteran's copayment liability, the veteran owes no VA copayment. Even if a veteran does not have other health insurance, VA does not bill the veteran for the applicable copayment until after the appointment. This VA practice has been followed for years but has never been prescribed in regulation.

For many veterans with other health-care plans, the experience under the Program will be the same as they would experience receiving non-VA care under another authority. Payments made by the veteran's health-care plan are generally enough to extinguish the VA copayment liability in full, and to the extent this happens under the Program, these veterans would owe no VA copayment. If the other health-care plan does not pay enough to cover the amount of the VA copayment, the veteran will be liable for the balance.

VA is making changes to §§ 17.108, 17.110, and 17.111 to make the veteran's experience under the Program more like the veteran's experience in VA facilities and under other non-VA care authorities described above. Specifically, VA is establishing the copayment amount under these authorities at \$0 at the time of service and, consistent with

§§ 17.108, 17.110, and 17.111, as amended, VA will notify non-VA providers that the VA copayment amount required at the time of service is \$0. This ensures that VA's implementation of section 101(j), which states that non-VA entities and providers will collect at the time of furnishing care or services any copayment that would be required for the receipt of the care or services at a medical facility of the Department, is consistent with VA practice under existing non-VA care authorities and addresses a number of practical challenges, as described below.

While VA will authorize care in advance of an appointment, VA may not be able to determine the veteran's copayment liability until after VA receives a report of what specific services were furnished by the non-VA provider. For care provided by VA, there are specific copayment rates for different types of appointments. However, this coding practice is not necessarily consistent with the practices used by other health care providers. Thus, VA cannot accurately assess a veteran's potential copayment liability before care is actually furnished by the non-VA provider. When VA has received a report of what services were provided, it can then determine the proper copayment amounts for those services in accordance with §§ 17.108, 17.110, and 17.111. Establishing the copayment amount at \$0 at the time of services will ensure that VA is consistently determining the copayment responsibilities for eligible veterans. This is also consistent with section 101(j)(1) of the Act, which provides that the Secretary must require a copayment from eligible veterans "only if such eligible veteran would be required to pay a copayment for the receipt of such care or services at a medical facility of the Department." These changes to §§ 17.108, 17.110, and 17.111 will ensure that veterans are only liable for copayments they would have paid if the care or services had been provided in a VA facility or under the standard non-VA care program. We believe it is better to ensure that veterans are liable only for an appropriate copayment amount that is determined after the appointment than to institute a blanket requirement at the point of service that may result in either additional billing to the veteran or reimbursement to the veteran.

Billing the veteran at the end of the billing process is also consistent with VA's practice under existing non-VA care authorities. The difficulty in determining the appropriate copayment is present in the standard non-VA care program, but is not an issue because

when VA uses its existing authorities to pay for non-VA care, VA is the primary payer and can determine liabilities after the care is furnished. Thus, VA has resolved this issue through the standard non-VA care program administratively by calculating the copayment at the end of the billing process. This is a more efficient mechanism than assigning a copayment upfront that could be wrong and later determining that either reimbursement or further collections are needed.

VA is modifying § 17.108(b)(1) to note that copayments will be determined as set forth in paragraphs (b)(2), (b)(3), and a new (b)(4) of that section. The new paragraph (b)(4) provides that under the Program, the copayment amount is \$0 at the time of service, and that the copayment liability will be determined at the end of the billing process. VA is revising § 17.108(c)(1) to include an exception as set forth in a new (c)(4) of that section. VA is also making a minor technical adjustment to paragraphs (b)(1) and (c)(1) to include care pursuant to a contract, provider agreement, or sharing agreement consistent with the authorized forms of agreement under the Act. The new paragraph (c)(4) includes the same language as the new paragraph (b)(4). VA also is modifying §§ 17.110(b) and 17.111(b) in a similar way. The changes to § 17.110 provide that veterans will owe a copayment of \$0 at the time they fill a prescription, and the changes to § 17.111 read the same as those in § 17.108. VA notes that under the Program, only services that are considered hospital care and medical services may be furnished. Section 17.111 authorizes both institutional and non-institutional care, but only non-institutional care is considered part of hospital care or medical services under § 17.38(a)(1)(xi).

#### *Section 17.1500 Purpose and Scope*

Section 17.1500 states the purpose and scope of the Program authorized by section 101 of the Act. 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 until August 7, 2017, whichever occurs first. Sec. 101(p), Public Law 113–146, 128 Stat. 1754. Section 17.1500(a) cites to the Act but does not identify specifically the alternate termination events specified in the Act. When one of those events occurs, VA will no longer have authority to operate this Program. Absent further amendments to the Act, the Program will end upon the occurrence of one of these events, at

which time VA will issue a direct final rule to remove this regulation from the Code of Federal Regulations.

Section 17.1500(b) defines the scope of the Program as authorizing non-VA hospital care and medical services to eligible veterans through agreements with eligible entities or providers. This is consistent with section 101(a)(1)(A) of the Act. Eligible veterans are described in § 17.1510, and eligible entities or providers are described in § 17.1530.

The Act authorizes VA to provide hospital care and medical services to eligible veterans. VA has defined the terms hospital care and medical services through regulation at § 17.38, which establishes the medical benefits package. Any care that is covered by the medical benefits package, including prescriptions such as prescription medications or prosthetic devices, may be furnished through the Program, but any services for which there are specific eligibility criteria that must be met to receive these services (such as dental care) are still subject to those eligibility standards.

#### *Section 17.1505 Definitions*

Section 17.1505 defines key terms for the Program.

The term “appointment” is defined in these regulations as an authorized and scheduled encounter with a health care provider for the delivery of hospital care or medical services. The definition excludes unscheduled visits and emergency room visits because they are not scheduled encounters and cannot be authorized in advance. The purpose of the Program is to offer veterans the option to receive non-VA care if they cannot obtain a scheduled visit from a VA provider in a timely or geographically convenient manner. There is no indication in the law that it was intended to authorize unscheduled non-VA care. Emergency care would, however, continue to be reimbursed by VA consistent with 38 CFR 17.120–132 and 17.1000–1008. In short, if a veteran visits a non-VA health care provider without seeking authorization from VA to schedule such an appointment, VA cannot use Program funds to pay for the services delivered and cannot provide reimbursement after the fact.

“Attempt to schedule” is defined as contact with a VA scheduler or VA health care provider in which a stated request for an appointment is made. The contact must be with a VA employee who is responsible for scheduling appointments or with a VA health care provider. This limitation will ensure that an attempt to schedule only occurs when an individual contacts someone who has the capacity to actually

schedule an appointment or, in the case of a VA health care provider, ensure that a scheduler is made aware of the need for an appointment. There must also be a statement by the veteran that he or she is requesting an appointment. If a veteran does not request an appointment, he or she would not have attempted to schedule an appointment. While VA will apply this standard liberally, a veteran must indicate a desire to be seen by a VA health care provider. The requirement of an attempt to schedule an appointment is established under section 101(b)(2)(A) of the Act as a prerequisite for certain veteran eligibility under the Program; that section states that veterans are eligible under this Program if they attempt or have attempted to schedule an appointment with VA but were unable to do so within the wait-time goals of the Veterans Health Administration.

The term “episode of care” is defined 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. Section 101(h) of the Act states 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.” If an eligible veteran requires care beyond 60 days, and either the veteran continues to qualify for the Program based on residence or if VA cannot schedule an appointment with the veteran within the wait-time goals of the Veterans Health Administration, we will contact the veteran before the 60 days have expired to determine if the veteran would like to continue receiving care from the non-VA health care provider. If the veteran does, VA will issue a new authorization for up to another 60 days.

A “health-care plan” has the same definition as provided in section 101(e)(4) of the Act. The Act defines a health-care plan as an insurance policy or contract, medical or hospital service agreement not administered by VA, under which health services for individuals are provided, or the expenses of such services are paid, except that it does not include any such policy, contract, agreement, or similar arrangement under the Medicare or Medicaid programs or TRICARE.

A “residence” is defined as a legal residence or personal domicile. A residence cannot be a post office box or non-residential point of delivery, because the address of the place a veteran resides is used to determine

eligibility under §§ 17.1510(b)(2)–(4). Sections 101(b)(2)(B)–(D) of the Act define eligibility based upon travel distance between a person's residence and a VA medical facility, and the regulatory definition recognizes that a post office box or other non-residential point of delivery could not be used to assess that eligibility criterion. However, we have added that a residence may be “seasonal,” and consequently, a veteran may maintain more than one residence, but only one residence at a time. Therefore, if a veteran lives in more than one location during a year, the veteran's residence is the residence or domicile where the person is staying at the time the veteran wants to receive hospital care or medical services through the Program. For example, if a veteran lived in New Hampshire during the summer months but in Florida during the winter months, and the veteran was seeking care in January, the veteran's residence in Florida would be used as the basis for determining his or her eligibility. Allowing for seasonal or multiple residences recognizes Congressional intent to reach, through the Program, those veterans who have geographical challenges in reaching a VA medical facility, without authorizing the use of Program funds for individuals who in fact are living near a VA medical facility at the time that they need an appointment. Homeless veterans currently provide an address to VA that is recorded in the Veterans Health Information Systems and Technology Architecture (VistA); this address is used for other VHA benefits and may be applied to veterans seeking to participate in the Program as well. For example, any homeless veteran who is residing in a place supported by a Department of Housing and Urban Development (HUD)-VA Supportive Housing (VASH) voucher can list that address, and any veteran using one of our community-based programs like the Homeless Grant and Per Diem or Health Care for Homeless Veterans programs can supply the address of the service provider.

The term “schedule” is defined to mean identifying and confirming a date, time, location, and entity or health care provider for an appointment, as the term appointment has been previously defined.

A “VA medical facility” is defined as a VA hospital, a VA community-based outpatient clinic (CBOC), or a VA health care center. We have included these types of VA facilities because they provide medical care or hospital services that may be provided as part of the Program. This is consistent with the

phrase “medical facility of the Department,” as used in the Act in section 101(b)(2)(B) and elsewhere. Vet Centers, or Readjustment Counseling Service Centers, are not considered a VA medical facility because they do not furnish hospital care or medical services.

The term “wait-time goals of the Veterans Health Administration” is defined to mean, unless changed by further notice in the **Federal Register**, a date that is not more than 30 days from either the date that an appointment is deemed clinically appropriate by a VA health care provider, or if no such clinical determination has been made, the date a veteran prefers to be seen by a health care provider capable of furnishing the hospital care or medical services required by the veteran. In the event a VA health care provider identifies a time range when care must be provided (e.g., within the next 2 months), VA will use the last clinically appropriate date for determining whether or not such care is timely. Section 101(s)(1) of the Act defines the wait-time goals of the Veterans Health Administration as being “not more than 30 days from the date on which a veteran requests an appointment for hospital care or medical services from [VA].” However, section 101(s)(2) authorizes VA to identify a different wait-time goal by submitting a report to Congress within 60 days of the enactment of the Act, and publishing that goal in the **Federal Register** and on a public Web site. On October 3, 2014, VA exercised this option and submitted a report to Congress; on October 17, 2014, VA published in the **Federal Register**, and posted notice on its Web site that it is adopting the definition contained in this regulation. 79 FR 65219. This definition ensures that clinical considerations and the preferences of the veteran are taken into account. In some cases, the date that a veteran prefers to be seen for an appointment may be the date on which the veteran contacts VA for an appointment. In other situations, though, the date the veteran prefers to receive hospital care or medical services may not be for some time, such as if the veteran is traveling, or if the veteran would prefer to delay care. Defining “wait-time goals of the Veterans Health Administration” to include a determination that an appointment is clinically appropriate acknowledges the primary reason for the appointment—to provide clinically appropriate care. For example, a VA health care provider may determine that a veteran needs to be seen, but that such a visit would not be

clinically useful until a certain time has passed (e.g., 2 months from the current appointment). This is a common scenario in the delivery of health care across the industry. In such a scenario, the wait-time goals of the Veterans Health Administration will be within 30 days of the date identified by a VA health care provider as clinically appropriate, even if the veteran requests to schedule the appointment immediately. In the event a VA health care provider identifies a time range when care must be provided (e.g., within the next 2 months), VA will use the last clinically appropriate date for determining whether or not such care is timely. For example, if a provider determines that a Veteran should be seen in October, VA will use October 31 as the clinically appropriate date. If no such clinical determination has been made, utilizing the preferred date of an appointment, rather than the date the veteran contacted VA, better reflects veterans' preferences for when they want to receive care. A veteran can specify any date, including the date the veteran contacts VA, as the preferred date for an appointment. The 30-day period established by this standard would begin on that preferred date.

VA believes that it may be necessary to make further revisions to its standards for the Program in the future. Specific metrics may evolve over time, and the prescribed methods of measurement today may not provide a full picture of veterans' experience in accessing health care in the future. VA has contracted with the Institute of Medicine to independently identify metrics that may be the basis for further changes to this standard. VA will carefully evaluate any recommendations from the Institute of Medicine or other sources and determine the most appropriate means of addressing or changing the standard, if warranted. Any such changes to the goals will be communicated through a report to Congress, an update to VA's Web site, and a publication in the **Federal Register**.

#### *Section 17.1510 Eligible Veterans*

VA will determine a veteran's eligibility to elect to receive non-VA care through the Program using a two-step process, consistent with the Act's structure and the requirements in section 101(b).

First, 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 be 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). These requirements are consistent with the standards established in sections 101(b)(1)(A)–(B) of the Act, and are included in §§ 17.1510(a)(1)–(2). If a veteran meets either of these requirements, the veteran then must also meet a criterion described in § 17.1510(b), and must provide the information required by § 17.1510(d).

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. As these terms are defined, this would mean that VA is unable to identify a particular date, time, location, and entity or health care provider within 30 days of 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. This is consistent with the requirements in the Act at section 101(b)(2)(A).

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. For example, if a veteran needs cardiac care and lives 10 miles from a VA community-based outpatient clinic (CBOC) that only offers primary care and mental health care, but 50 miles from a VA medical facility that offers cardiac care, the veteran would not be eligible based on his or her proximity to the CBOC. This interpretation is consistent with the plain language of the Act, which 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), Public Law 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.R. 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. Nothing in the Act modifies or precludes VA

from using its existing statutory authorities to furnish non-VA care, such as under 38 U.S.C. 1703, 1725, 1728, 8111, or 8153. Those statutes and their implementing regulations continue to apply, and VA will use those authorities as appropriate to ensure that veterans are able to access care.

Under § 17.1510(b)(3), a veteran is eligible if the veteran's residence is in a state without a full-service (meaning that it 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 medical facility and the veteran lives more than 20 miles from such a facility. This language is consistent with the requirements in section 101(b)(2)(C) of the Act. As of the publication of this rule, veterans in three states would qualify under this standard: Alaska, Hawaii, and New Hampshire. No veteran residing in Alaska or Hawaii lives within 20 miles of a full-service VA medical facility in another state, but some veterans residing in New Hampshire do live within 20 miles of a full-service VA medical facility that is located in a bordering state. We note that this specific, special eligibility for veterans in states without full-service VA medical facilities further supports our view that the Act requires VA to find veterans ineligible who live within 40 miles of a VA medical facility, even if such facility cannot provide the specific care required. When read as a whole, the Act specifically addresses the ability of a facility to provide care only in section 101(b)(2)(C). We believe that, in addition to the arguments presented earlier in this rulemaking, the legislative specificity in section 101(b)(2)(C) underscores the absence of reference to this issue in section 101(b)(2)(B) of the Act.

As noted previously when discussing the definition of residence, a veteran's residence may change throughout the year but the veteran's residence at the time he or she wants to schedule an appointment will determine his or her eligibility under this paragraph. In the prior example we presented, a veteran who resides in New Hampshire in the summer and in Florida in the winter may be eligible under this paragraph during the summer months, but not during the winter.

We also note that the term "surgical complexity of standard," used in § 17.1510(b)(3)(i) and section 101(b)(2)(C)(i)(III) of the Act, is a term of art coined by VA to describe the operative complexity of each VA medical facility with an inpatient surgical program. The designation of a

VA medical facility's surgical complexity as "standard" is used by VA to establish infrastructure requirements and compliance with VA quality standards. A "standard" designation refers to a VA facility that has the appropriate infrastructure to provide at least the most basic forms of surgical care. VA has published a list of VA medical facilities complying with at least a standard level of surgical care on the following Web site: [www.va.gov/health/surgery](http://www.va.gov/health/surgery). VA will post notice on this Web site of any changes to this list of facilities.

Finally, under paragraph (b)(4) of this section, a veteran who resides in a location other than one in Guam, American Samoa, or the Republic of the Philippines that is 40 miles or less from a VA medical facility can be eligible under two scenarios. First, if the veteran must travel by air, boat, or ferry to reach such a VA medical facility, the veteran is eligible for non-VA care under the Program. This is consistent with the text in sections 101(b)(2)(D)(i) and (ii)(I) of the Act. Second, veterans who reside 40 miles or less from a VA medical facility are eligible if they face an unusual or excessive burden in accessing such a facility due to geographical challenges. Sec. 101(b)(2)(D)(ii)(II), Public Law 113–146, 128 Stat. 1754. VA has interpreted this standard through regulation so that if the veteran's travel to the nearest VA medical facility is impeded by the presence of a body of water (including moving and still water) or a geologic formation that cannot be crossed by road, the veteran is eligible for non-VA care under the Program. VA believes that the emphasis on a geographical challenge as referring only to naturally occurring permanent or semi-permanent conditions is consistent with the plain meaning of the Act. While VA is able to take into account other factors, such as traffic or weather conditions or the veteran's health, when making determinations regarding beneficiary travel benefits provided under 38 CFR part 70, the Act does not provide us the authority to apply these or similar factors in operating the Program because it specifically limits eligibility to geographical challenges without allowing for environmental or circumstantial challenges.

Under paragraph (c) of this section, a veteran who changes his or her residence and is participating in the Choice Program must update VA about the change within 60 days. A veteran's residence may be the basis for his or her eligibility for the Program under paragraphs (b)(2)–(b)(4) of this section, so it is essential that VA have current and accurate information to make an

eligibility determination. Veterans who are eligible based on being unable to be seen within the wait-time goals of the Veterans Health Administration must also provide this information so VA can determine if they would become eligible based on residence. It is also important that VA have accurate information about a veteran's residence to ensure we can contact a veteran regarding any issues and for billing purposes. We believe that 60 days is an appropriate period of time, as it will allow veterans sufficient opportunity to submit this information while ensuring that VA has the ability to make accurate determinations about eligibility for the Program.

In addition to meeting the eligibility criteria under paragraphs (a) and (b) of this section, a veteran must also provide to VA information about any health-care plan under which the veteran is covered. Section 17.1510(d) requires that a veteran provide this information to be able to receive authorized non-VA care through the Program. This is consistent with the requirement in the Act in section 101(e)(1), which states that before a veteran can receive hospital care or medical services under the Program, the veteran must provide information about other health insurance. Section 17.1510(d) requires a veteran to submit information and updated information to VA within 60 days if the veteran changes health-care plans. We believe that 60 days is an appropriate period of time, as it will allow veterans sufficient time to submit this information while ensuring that VA has the ability to provide accurate information to eligible entities and providers under the Program.

Under § 17.1510(e), VA will calculate distance between a veteran's residence and the nearest VA medical facility using a straight-line distance, rather than the driving distance. The Conference Report accompanying the final bill provides strong support for this interpretation, as it states, "In calculating the distance from a nearest VA medical facility, it is the Conferees' expectation that VA will use geodesic distance, or the shortest distance between two points." H.R. Rpt. 113–564, p. 55. The shortest distance between two points is a straight line, so a veteran who is outside of a 40 mile radius of a VA medical facility would be eligible under this provision. VA understands that actual travel distances may be longer than 40 miles for some veterans who reside within the 40 mile radius based on the layout of roads or other factors, and to the extent that such travel is due to geographic challenges, these veterans may be eligible for the Program under § 17.1510(b)(4). These

veterans may also be eligible to receive non-VA care under another authority.

#### *Section 17.1515 Authorizing Non-VA Care*

Section 17.1515 describes the process and requirements for authorizing non-VA care under this Program.

Paragraph (a) states that eligible veterans may choose between scheduling an appointment with a VA health care provider, being placed on an electronic waiting list for a VA appointment, or receiving authorized non-VA hospital care or medical services from an eligible entity or provider. Section 101(c) of the Act provides that eligible veterans can make an election to have the Secretary schedule an appointment for the veteran with a VA health care provider, place him or her on an electronic waiting list, or authorize non-VA care. If a veteran elects to receive VA care and VA is able to schedule an appointment for the veteran, even if such an appointment is outside of the wait-time goals of the Veterans Health Administration or is at a facility more than 40 miles from the veteran's residence, we will do so. Otherwise, we will place a veteran who elects to receive VA care on an electronic waiting list. We will continue to track and report the average length of time an individual must wait for an appointment, disaggregated by medical facility and type of care or services needed. We will provide this facility-level information at the time the veteran makes his or her choice so the veteran can make an informed election about whether to receive hospital care or medical services from a VA or non-VA health care provider. Sections 101(c)(1)(A) and (c)(2) require VA to schedule an appointment for a veteran or place the veteran on an electronic waiting list, which must be available to determine the place of an eligible veteran on the waiting list and to determine the average length of time an individual spends on a waiting list, disaggregated by medical facility and type of care or services needed. The Act clearly specifies that this information must be provided "for purposes of allowing such eligible veteran to make an informed election." Sec. 101(c)(2)(B), Public Law 113–146, 128 Stat. 1754. Additionally, if the veteran elects to receive care from a non-VA health care provider, VA will notify the veteran by the most effective means available, as identified by the veteran, of the scope of the authorization for care, thereby complying with the requirements of section 101(c)(1)(B)(ii).

Section 17.1515(b) states that eligible veterans may specify a particular non-

VA entity or health care provider from whom they wish to receive care, if the entity or health care provider is eligible under § 17.1530. Section 101(a)(2) of the Act establishes that veterans who are eligible for the Program based upon the wait-time standard have the right to select the specific health care provider they wish to see, so long as the provider is eligible under the Act and under § 17.1530. The Act does not address whether or not veterans who are eligible based upon residence may select a particular non-VA provider. VA is filling this gap in the law by providing these veterans the same opportunity to select a particular provider as veterans eligible based upon the wait-time standard. Eligible veterans may nevertheless choose not to make such a selection, and in such a situation, those veterans will be referred to an eligible entity or provider identified by VA.

#### *Section 17.1520 Effect on Other Provisions*

Section 17.1520 addresses the effect of the Program on other provisions and programs administered by VA. Paragraph (a) of this section provides that, generally, eligibility under the Program does not affect a veteran's eligibility for hospital care or medical services under the medical benefits package or other benefits addressed in part 17. If particular services, such as health care for newborns of veterans under 38 CFR 17.38(a)(xiv) and dental benefits under §§ 17.160–17.169, have unique eligibility standards, only veterans who are eligible under § 17.1510 and meet the eligibility standards for those services can elect to receive non-VA care for them. Nothing in the Act or these regulations waives the eligibility requirements established in other statutes or regulations.

The regulation also provides that notwithstanding any other provision of this part, VA will cover prescription medications and other prescriptions made while furnishing hospital care or medical services through the Program. This is consistent with section 101(a)(1)(A) of the Act, which requires VA to furnish medical services to eligible veterans under the Program, and with 38 U.S.C. 1710. VA fills emergency prescriptions written by non-VA health care providers, but does not normally fill prescriptions written by non-VA providers when veterans receive authorized non-VA care. However, we interpret the requirement in section 101 to furnish hospital care and medical services to include these benefits. The terms "hospital care" and "medical services" are defined through the medical benefits package at 38 CFR



17.38, which specifically includes prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system. 38 CFR 17.38(a)(1)(iii). Veterans receiving care under the Program are eligible because they either could not be seen within the wait-time goals of the Veterans Health Administration or because of their place of residence. Typically, VA requires veterans to visit a VA medical facility so one of our providers can establish that the prescription is medically needed and appropriate for the patient. Imposing such a requirement on veterans eligible under the Program would not make sense because their eligibility is predicated on either being unable to be seen within a timely manner or because of difficulties they face in traveling to a VA medical facility. We believe this decision is consistent with section 101(r) of the Act, which states that nothing in section 101 shall be construed to alter the process for filling and paying for prescription medications. This regulation does not alter how prescriptions are filled or purchased. VA will pay for prescriptions, including prescription drugs, over-the-counter drugs, and medical and surgical supplies prescribed by eligible entities and providers under the Program. However, VA will only pay for those items that are on the VA National Formulary, in accordance with § 17.38(a)(1)(iii), and eligible veterans will be charged a VA copayment, if applicable, as with all other care and services offered under the Program. If prosthetics are prescribed as part of the care that is provided under the Program, VA will pay for these items as well.

Section 17.1520(b) states that VA will be liable for any deductibles, cost-shares, or copayments required by the health-care plan of an eligible veteran participating in the Program and owed to the non-VA provider, to the extent that such reimbursement does not result in expenditures by VA for the furnished care or services that exceed the rates determined under § 17.1535. Currently, non-VA providers who accept VA payments for hospital care or medical services must accept VA payment as payment in full and cannot assess any additional charges. 38 CFR 17.55 and 17.56. By contrast, VA is a secondary payer under the Program for care and services related to a nonservice-connected disability. Under section 101(e)(3)(B)(ii) of the Act, VA is authorized to pay the cost of care or services that is not covered by a veteran's health-care plan, except that

VA's payment may not exceed the rate established under § 17.1535. We interpret section 101(e)(3)(B)(ii) to authorize VA to cover the balance due the non-VA provider after any payment by the veteran's health-care plan and any payment made by the veteran, and to be liable for any copayments, cost-shares, or deductibles required of the veteran by the other health-care plan, up to the amount established under § 17.1535.

Under the Program, the non-VA provider is responsible for first billing the veteran's other health-care plan, if the care provided under the Program is related to a nonservice-connected disability. Any payment made by a health-care plan to the non-VA provider reduces the amount owed by VA as the secondary payer. If the balance due to the non-VA provider, after any payment by the veteran's health-care plan and any payment by the veteran, is less than the rate established under § 17.1535, VA will, consistent with its authority in section 101(e)(3)(B)(ii), cover the veteran's copayments, cost-shares, or deductibles required by the health-care plan. If the veteran paid any such costs to the non-VA provider, VA will reimburse the veteran for the paid costs.

To the extent the amount contributed by the health-care plan would cover the veteran's VA copayment obligation, VA will apply that amount to reduce the veteran's VA copayment obligation as determined under §§ 17.108, 17.110, and 17.111. In some instances, though, veterans will still owe a VA copayment. As is currently the case, to the extent the veteran qualifies for a hardship exemption or a waiver of that debt under §§ 17.104 or 17.105, the veteran may seek such relief. VA is establishing a hotline, 1-866-606-8198, that veterans and health care providers can call with questions about payments and liabilities.

Paragraph (c) of this section addresses the beneficiary travel program administered under 38 CFR part 70. This paragraph provides that veterans who are eligible for beneficiary travel under part 70 will be reimbursed for travel to and from the location of the eligible entity or provider who furnishes hospital care or medical services for an authorized appointment under the Program, even if there is another non-VA health care provider that is closer. Current regulations governing the beneficiary travel program at 38 CFR 70.30(b)(2) provide that VA will pay mileage reimbursement for travel between a beneficiary's residence and the closest non-VA health care provider that could furnish such care. For veterans who have the right to select a

provider of their own choice under § 17.1515(b), they may select a provider who is slightly farther away from their residence than another non-VA provider who could furnish the same care. For veterans who elect non-VA care, VA may schedule an appointment with an eligible non-VA entity or provider that is farther away because that non-VA provider can see the veteran sooner. We believe that it is fair and consistent to provide mileage reimbursement in these instances. VA has authority under 38 U.S.C. 111(b)(2) to define the parameters under which it will reimburse eligible veterans for travel expenses, and VA is exercising that authority here to help veterans who obtain non-VA care through the Program access non-VA health care entities and providers. Hence, § 17.1520(c) waives the requirements of 38 CFR 70.30(b)(2) for purposes of the Program.

#### *Section 17.1525 Start Date for Eligible Veterans*

Section 17.1525 defines when eligible veterans may begin receiving hospital care and medical services through the Program. VA is phasing in implementation of the Program for different categories of eligible veterans to ensure that VA has the resources in place to support care for these veterans. Paragraph (a) of this section identifies the start date for eligible veterans based on which criterion in § 17.1510(b) they meet. In paragraph (a)(1) of this section, veterans who are eligible based on their place of residence under 17.1510(b)(2) through (b)(4) will be able to start receiving hospital care and medical services on the date of publication of this rule. We are starting with this population because it is more easily identified and less subject to change over time than those who are eligible based on being unable to be seen within the wait-time goals of the Veterans Health Administration. Veterans eligible under 17.1510(b)(1) will be able to start receiving hospital care and medical services no later than December 5, 2014. Paragraph (b) of this section states that notwithstanding the dates identified in paragraph (a), VA may publish a Notice in the **Federal Register** informing the public that veterans may receive care sooner. This will ensure VA has flexibility so that if we determine we have the necessary resources in place to furnish care, we can begin doing so without further delay.

#### *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. Paragraph (a) of this section provides that an entity or provider must be accessible to the veteran and be one of the four entities specified in section 101(a)(1)(B) of the Act. These include 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. 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 would be eligible providers under section 101(a)(1)(B).

Additionally, the entity or provider must not be a part of, or an employee of, VA, or if the provider is an employee of VA, he or she cannot be acting within the scope of such employment while providing hospital care or medical services through the Program. Many of VA's health care providers are also appointed to other institutions, so if these health care providers are furnishing care under this Program, they must be doing so on non-Department time and using non-VA resources. 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. Furthermore, non-VA care is a general term applied throughout VA to refer to any care furnished by a non-VA entity or health care provider under any authority or agreement. 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.

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. This requirement is consistent with section 101(a)(1)(A) of the Act.

This section of the Act also authorizes VA to use agreements reached before the enactment of the Act, so long as such agreement is with an eligible entity or provider as defined in section 101(a)(1)(B) of the Act. Agreements may be formed by contract, intergovernmental agreement, or a provider agreement, consistent with section 101(d)(1)(B) of the Act. Each form of agreement must be executed by a duly authorized Department official to ensure that Federal resources are being committed by a person with the authority to do so. As an operational matter, VA will, to the maximum extent practicable and consistent with the requirements of section 101, use existing sharing agreements, existing contracts, and other processes available at VA medical facilities prior to using provider agreements under this section. This is consistent with the requirements of section 101(d)(1)(A), as modified by section 409 of Public Law 113–175.

Paragraph (c) of § 17.1530 defines whether an entity or provider is accessible to a veteran. Under section 101(a)(2) of the Act, a veteran who is eligible for the Program based on being unable to schedule an appointment within the wait-time goals of the Veterans Health Administration can only select an entity or provider that is accessible to the veteran. The broad intent of the Act is to ensure that veterans are able to be seen quickly and close to their home. The Act did not contemplate, for example, that a veteran living in New York would have his or her care in California and travel paid for by VA. Under the Act, this accessibility requirement technically only applies to veterans who are eligible based on being unable to be seen within the wait-time goals of the Veterans Health Administration. However, we believe the same standard should apply when any eligible veteran elects to receive non-VA care under the Program because it would be unfair to impose an accessibility requirement to limit the non-VA entities and providers available to some veterans but not others. Also, in those situations when a veteran does not select a provider, it would be inconsistent with the purpose of the Act if VA were able to select a non-VA provider who was inaccessible to veterans whose basis for eligibility is their residence. The factors identified in § 17.1530(c)(1)–(3) are intended to ensure that, as often as possible, veterans are able to access the care they need from an entity or provider that can see them quickly and that is at least as close as the nearest VA medical facility.

VA will consider several factors when determining whether an entity or

provider is accessible. Under § 17.1530(c)(1), VA will consider the length of time an eligible veteran would have to wait to receive hospital care or medical services. One of the principal issues the Act was intended to address was extended wait times for hospital care and medical services in VA facilities. Senate Veterans' Affairs Committee Chairman Sanders explained the purpose of the Program shortly before the Senate passed an early version of this bill by saying, "this legislation says to veterans that if there are long wait times, if they cannot get into a facility in a reasonable time, they can go out outside of . . . VA." See 160 Cong. Rec. S3591 (June 11, 2014). By considering the length of time a veteran would have to wait to receive hospital care or medical services from a non-VA entity or provider, VA can ensure that veterans receive care as quickly as possible. If a veteran selects a provider who cannot see the veteran for several months, VA would probably determine that provider was inaccessible. Alternatively, under this standard, there may be several eligible entities or providers who could provide care more quickly than VA could, and in such a situation, in those instances when an eligible veteran does not specify a particular eligible entity or provider, VA could select the eligible entity or provider that is able to schedule the earliest appointment for the eligible veteran.

Under § 17.1530(c)(2), VA will consider the qualifications of the entity or provider to furnish the hospital care or medical services the veteran requires. If an entity or provider does not have the expertise or equipment necessary to provide the required care or services, the needed care is not accessible from that provider, and VA will not authorize a patient to receive hospital care or medical services from that entity or provider. This will ensure that veterans have access to, and can receive, the care they need and that appropriated resources are spent only for services that actually can be delivered.

Under § 17.1530(c)(3), VA will consider the distance between the eligible veteran's residence and the entity or provider. Three of the four bases for eligibility under the Program focus on the residence of the veteran, and therefore we believe that travel distance was a clear concern and focus of the Act. If a veteran has to travel long distances to receive care, then these non-VA providers may be no more accessible than a VA medical facility that is more than 40 miles away from the veteran's residence.

VA will consider these factors together. Sometimes, there may be several eligible entities or providers that could deliver care close to the veteran's residence, and in such a scenario, distance likely will not matter. In other situations, there may only be one provider near the veteran's residence, but this provider either has extended wait times or lacks the expertise or equipment to provide the necessary care. VA will need to balance these competing interests and the preference of the veteran to determine whether or not an entity or provider is accessible. We will also make accessibility determinations on a case-by-case basis, considering each veteran's specific needs and ability to travel, as well as changes in the status of a non-VA entity or provider. For example, VA might find a health care provider inaccessible to a veteran in one month because the provider cannot see new patients in a timely manner or because the provider lacks the qualifications to treat a particular condition. But the following month, VA might find that same health care provider accessible to the same veteran because the provider's wait time has decreased or the provider has gained expertise through a newly hired health care provider.

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. This requirement is codified in section 101(i)(1) of the Act, which also provides further support for the qualification standard in paragraph (c)(2) of this section. The agreement VA reaches with the non-VA entity or provider will clarify the requirement referenced in § 17.1530(d). These requirements will be the same or similar to the requirements included in VA policy and are also available through Veterans Health Administration (VHA) Handbook 1100.19 and VHA Directive 2012-030, available online at: <http://www.va.gov/vhapublications/>. Non-VA health care entities or providers must submit verification of this information to VA at least once per 12-month period to continue to remain eligible under this Program. This requirement is consistent with section 101(i)(2) of the Act.

For purposes of the Program, qualifications of non-VA providers will be set forth in the terms of the agreement with VA, but, in accordance with the Act, those terms must specify requirements that are "at least the same or similar credentials and licenses" as those required of VA providers. Sec. 101(i)(1), Public Law 113-146, 128 Stat. 1754. We also note that to the extent there may be concerns about the

qualifications of a particular provider, section 101(a)(1)(B) of the Act requires that eligible entities and providers of non-VA care must either be Federal providers themselves (the Department of Defense or the Indian Health Service), a Federally-qualified health center, or be a participating provider in the Medicare program. Accordingly, these non-VA entities and providers have already met quality standards established in Federal law.

Entities are not required by the Act to maintain the same or similar credentials and licenses as VA providers because entities are not direct health care providers. Any entities that are eligible to provide care through the Program must ensure that any of their providers furnishing care and services through the Program meet these standards. If an eligible entity has more than one provider furnishing hospital care or medical services under this Program, the entity may submit the information required by paragraph (d) of this section on behalf of its providers. This will reduce the administrative responsibilities of each provider and VA by allowing for a consolidated submission of information.

Although not addressed in the regulation, 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. This will ensure that the veteran's medical record is as complete as possible to provide quality care in a timely manner. The agreements VA reaches with eligible entities and providers will clarify this requirement.

#### *Section 17.1535 Payment Rates and Methodologies*

Section 17.1535 addresses payment rates and payment methodologies.

Section 17.1535(a) addresses payment rates. This paragraph states that rates will be negotiated and set forth in an agreement between VA and an eligible entity or provider. This is consistent with sections 101(d)(1)(A) and (d)(2)(A) of the Act.

Section 17.1535(a)(1) establishes the default payment rule that reimbursement rates under the Program will not exceed the applicable Medicare rate under Title XVIII of the Social Security Act. This limitation is established in section 101(d)(2)(B)(i) of the Act.

Section 17.1535(a)(2) states that VA may pay a rate higher than the default Medicare rate 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. A highly rural area is an area located in a county that has fewer than seven individuals residing in that county per square mile. This limited exception to the default Medicare rate is specifically contemplated, and narrowly circumscribed, by section 101(d)(2)(B)(ii) of the Act. The limitation that such rate be determined by VA to be fair and reasonable is necessary to ensure that VA is committing and using budgetary resources appropriately.

Section 17.1535(a)(3) addresses situations where there is no Medicare rate. As cited above, section 101(d)(2)(B) of the Act establishes that, except in highly rural areas, VA must pay the Medicare rate. However, there are certain types of care, such as obstetrics/gynecological and dental care, that are authorized by the VA medical benefits package in 38 CFR 17.38 but for which Medicare does not have established rates. The Act does not address the appropriate rate in such a situation. Because Congress did not address what rate can be paid when Medicare rates do not exist, we must fill the gap left by the law. See *Chevron U.S.A., Inc. v NRDC*, 467 U.S. 837, 842-843 (1984).

Under § 17.1535(a)(3), VA follows the process and methodology outlined in specified paragraphs of 38 CFR 17.55 and 17.56, to the extent these paragraphs are consistent with the requirements of section 101 of the Act, when there are no available rates as described in § 17.1535(a)(1). Sections 17.55 and 17.56 establish rates for payment for care provided to veterans by non-VA providers under different authorities than the Act. Paragraphs (g) and (k) of § 17.55 conflict with the Act and therefore are not applicable to payments made under the Program and would not be followed. Section 17.55(g), for example, states that payment by VA is payment in full, and the health care provider or agent may not impose any additional charge on a veteran or his or her health care insurer for any inpatient services for which payment is made by VA. This is inconsistent with sections 101(e) and 101(j) of the Act, which, as discussed above, specifically require billing to a health-care plan and copayments by a veteran for services rendered. Section 17.55(k) states that VA will not pay more than the amount determined under paragraphs (a)-(j) of § 17.55 or the negotiated amount, but § 17.1535(a) already establishes a rate ceiling for payments made under the Program. Sections 17.55(j) and 17.56(b) address payment for care furnished in Alaska, but section 101 of the Act does not permit us to follow these rates. If the

Act is further modified by Congress to provide flexibility to pay different rates, VA will comply with the new statutory requirements and will follow any methodologies in §§ 17.55 and 17.56 that are consistent with those requirements.

Section 17.1535(b) details payment responsibilities. Section 17.1535(b)(1) concerns payments for care related to a nonservice-connected disability. VA defines a nonservice-connected disability consistent with 38 CFR 3.1(l). This longstanding VA definition is consistent with section 101(e)(3)(C) of the Act, as well as the use of that term in other VA programs. We believe that using this definition will result in the same outcomes as the definition presented in the Act and is more familiar to the VA staff who will be administering the Program. VA has defined the term “nonservice-connected” at 38 CFR 3.1(l) to refer to a disability that was not incurred or aggravated in line of duty in the active military, naval, or air service. The Veterans Benefits Administration (VBA) is responsible for making determinations about whether a specific disability is service connected or not, and any disability that VBA has not identified as service connected is considered nonservice connected.

When a veteran is seeking care for a nonservice-connected disability through the Program, the health-care plan of the eligible veteran, if one exists, is primarily responsible for paying the eligible entity or provider for authorized hospital care or medical services that are furnished to an eligible veteran. This is consistent with the requirements of section 101(e)(3)(A) of the Act. The health-care plan is only responsible to the extent the care or services are covered by the health-care plan; this is again consistent with the language of section 101(e)(3)(A) of the Act. VA will be responsible for promptly paying only the amount that is not covered by the health-care plan, except VA cannot pay more than the rate determined under § 17.1535(a).

Section 101(e)(3)(B) of the Act defines when VA is secondarily responsible for care. The Act states that the eligible entity or provider is responsible for seeking reimbursement for the cost of furnishing hospital care or medical services from the health-care plan of the veteran, if applicable, and VA is responsible for only paying for the VA-authorized service to the extent not covered by such health-care plan. Under section 101(d)(2)(C) of the Act, an eligible entity or provider cannot collect more than the negotiated rate for the furnishing of care or services. If a

veteran is required to make a VA copayment under section 101(j) of the Act and § 17.1520(b) of this regulation, the copayment will be applied to the rate established by § 17.1535(a). This will, in turn, reduce VA’s ultimate liability.

Paragraph (b)(2) of this section provides that if hospital care or medical services are being furnished for a service-connected disability or pursuant to 38 U.S.C. 1710(e), 1720D, or 1720E, VA is solely responsible for paying the eligible entity or provider for such hospital care or medical services. VA has defined the term “service-connected” at 38 CFR 3.1(k) to mean, with respect to a disability, that such disability was incurred or aggravated in line of duty in the active military, naval, or air service. VA only has authority to recover or collect reasonable charges from a health-care plan when the care is being furnished for a nonservice-connected disability, so VA cannot collect such charges when service-connected care is involved. 38 U.S.C. 1729. The Act is silent in terms of collecting payment for service-connected care, so VA believes its existing authorities should apply here. The three additional authorities cited, 38 U.S.C. 1710(e), 1720D, and 1720E, are what VA refers to as special authorities, which require VA to furnish care based on certain conditions or exposures associated with military service. Excluding hospital care and medical services furnished under these authorities from liability by health-care plans is consistent with VA’s past practice and with the intent and language of section 101(e)(3) of the Act. VA is developing a separate rulemaking that would specifically restrict the ability of VA to collect charges from health-care plans for care provided under these special authorities. Both that proposed rulemaking and this rulemaking are consistent with current practice.

Paragraph (c) of this section states that VA will only pay for hospital care or medical services authorized by VA. Accordingly, if in the course of providing authorized care or services under the Program, the eligible entity or provider determines that additional hospital care or medical services are necessary beyond what VA has authorized, the eligible entity or provider must contact VA for authorization prior to furnishing such care or services, in order for such care and services to be paid for by VA under the Program. Section 101(h) of the Act requires that, at the election of the veteran, VA must ensure that a veteran receives such hospital care or medical

services through the completion of the episode of care, including all specialty and ancillary services deemed necessary as part of the recommended treatment. We believe that the language “deemed necessary” authorizes VA to make such determinations. This belief is supported by the Conference Report of the final bill, which stated, “When coordinating care for eligible veterans through the Non-VA Care Coordination program, the Department should attempt to ensure when an appointment is authorized, the eligible veteran receives care within an appropriate time period, as defined by medical necessity as determined by the referring physician, or a mandatory time period established by the Secretary when the request for care is not initiated by a physician.” H.R. Rpt. 113–564, p. 55, (emphasis added). In this context, the referring physician would be a VA health care provider. Furthermore, for non-VA care authorized under other statutes, VA must periodically review the necessity for continuing such care. 38 U.S.C. 1703(b). We interpret the language in section 101(h) of the Act to impose a similar obligation to ensure that VA has not entered into an open-ended commitment. VA will craft authorizations for non-VA care to ensure that veterans can receive the episode of care they need, including specialty and ancillary service, from eligible entities and providers. While some episodes of care may only involve a single visit, such as a specific procedure or test, others may involve multiple visits. VA will authorize only the care that it deems necessary as part of the treatment plan; if a non-VA health care provider believes that additional services are needed beyond 60 days or outside the scope of the initial course of treatment that was authorized, the health care provider must contact VA prior to administering such care to ensure that this care is authorized and therefore will be paid for by VA. These provisions are included so that veterans are not subjected to unapproved procedures and tests, and so that appropriated resources are not used for unapproved care or services.

Also, there must be an actual encounter with a health care provider, who is either an employee of an entity in an agreement with VA or who is furnishing care through an agreement the health care provider has entered into with VA, and such encounter must occur after an election is made by an eligible veteran. The encounter may be virtual through use of telehealth or other technologies, but the health care provider must furnish hospital care or medical services during the

appointment. This will ensure that VA only pays for hospital care or medical services that were actually furnished, and is consistent with the Act's requirement in section 101(m) that the Department does not pay for care or services that were not furnished to an eligible veteran.

#### *Section 17.1540 Claims Processing System*

Section 17.1540 provides general requirements for a VA claims processing system. This is required by section 101(k) of the Act. Paragraph (a) of this section establishes the claims processing system within the Chief Business Office of the Veterans Health Administration. This is required by section 101(k)(3) of the Act. The system will process and pay bills or claims for authorized hospital care and medical services furnished to veterans through the Program, as required by section 101(k)(1).

Paragraph (b) of this section establishes responsibility for overseeing the system with the Chief Business Office of the Veterans Health Administration. Section 101(k)(3) requires this assignment of authority.

Paragraph (c) of this section states that the system will receive requests for payment from eligible entities and providers for hospital care or medical services furnished to eligible veteran, and that the system will provide accurate and timely payments for claims received under the Program. This is required by section 101(k) and section 105 of the Act.

#### *Administrative Procedure Act*

The Secretary of Veterans Affairs finds that there is good cause under 5 U.S.C. 553(b)(B) and (d)(3) to dispense with the opportunity for advance notice and opportunity for public comment and good cause to publish this rule with an immediate effective date. Section 101(n) of the Act requires publication of an interim final rule no later than November 5, 2014, the date that is 90 days after the date of the enactment of the law. We interpret this mandate to mean that, as a matter of law, 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.

VA is making the rule effective for certain veterans prior to the usual 30 day delay for an interim final rule to allow VA to begin furnishing hospital care and medical services immediately to certain eligible veterans. Delaying implementation could result in delayed health care for these veterans, which

could have unpredictable negative health effects.

For the above reasons, the Secretary issues this rule as an interim final rule. However, VA will consider and address comments that are received within 120 days of the date this interim final rule is published in the **Federal Register**.

#### *Effect of Rulemaking*

Title 38 of the Code of Federal Regulations, as revised by this interim final rulemaking, 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*

This interim final rule includes a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521) that requires approval by the Office of Management and Budget (OMB). Accordingly, under 44 U.S.C. 3507(d), VA has submitted a copy of this rulemaking to OMB for review.

OMB assigns a control number for each collection of information it approves. VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Sections 17.1510(d), 17.1515, and 17.1530 contain a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521). If OMB does not approve the collection of information as requested, VA will immediately remove the provisions containing a collection of information or take such other action as is directed by OMB.

Comments on the collection of information contained in this interim final rule should be submitted to the Office of Management and Budget, Attention: Desk Officer for the Department of Veterans Affairs, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies sent by mail or hand delivery to the Director, Regulation Policy and Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420; fax to (202) 273–9026; or through [www.Regulations.gov](http://www.Regulations.gov). Comments should indicate that they are submitted in response to “RIN 2900–AP24—Expanded Access to Non-VA Care through the Veterans Choice Program.”

A comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment on the rule.

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

- Evaluating whether the proposed collections of information are necessary for the proper performance of the functions of VA, including whether the information will have practical utility;

- Evaluating the accuracy of VA's estimate of the burden of the proposed collections of information, including the validity of the methodology and assumptions used;

- Enhancing the quality, usefulness, and clarity of the information to be collected; and

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

The amendments to title 38 CFR part 17 contain collections of information under the Paperwork Reduction Act of 1995 for which we are requesting approval by OMB. These collections of information are described immediately following this paragraph, under their respective titles.

*Title:* Election to Receive Authorized Non-VA Care and Selection of Provider for the Veterans Choice Program.

*Summary of collection of information:* 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.

*Description of the need for information and proposed use of information:* The information is required by the Act. Section 101(c) of Public Law 113–146 requires an eligible veteran to make an election 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 101(a)(2) authorizes certain eligible veterans to select a non-VA health care provider, and through regulation at § 17.1515(b), all eligible veterans may

select a non-VA health care provider that is eligible under § 17.1530. This information is necessary because VA must know what the veteran's choice is and whom the veteran would like to see for an appointment.

*Description of likely respondents:* Eligible veterans seeking authorization to receive non-VA care through the Veterans Choice Program.

*Estimated number of respondents per year:* 440,794 eligible persons.

*Estimated frequency of responses per year:* 12.64 times per year.

*Estimated average burden per response:* 2 minutes.

*Estimated total annual reporting and recordkeeping burden:* 185,721 hours.

*Title:* Health-Care Plan Information for the Veterans Choice Program.

*Summary of collection of information:* Section 17.1510(d) requires eligible veterans to submit to VA information about their health-care plan to participate in the Veterans Choice Program.

*Description of the need for information and proposed use of information:* The information is required by the Act. Section 101(e)(1) of Public Law 113–146 requires an eligible veteran to provide to the Secretary information on any health-care plan under which the eligible veteran is covered. This information is necessary because the veteran's other health-care plan is primarily responsible for paying for hospital care or medical services furnished through the Veterans Choice Program for a nonservice-connected disability.

*Description of likely respondents:* Eligible veterans seeking authorization to receive non-VA care through the Veterans Choice Program.

*Estimated number of respondents per year:* 440,794 eligible persons.

*Estimated frequency of responses per year:* 1.2 times per year.

*Estimated average burden per response:* 10 minutes.

*Estimated total annual reporting and recordkeeping burden:* 88,159 hours.

*Title:* Submission of Medical Record Information under the Veterans Choice Program.

*Summary of collection of information:* 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.

*Description of the need for information and proposed use of information:* The information is required by the Act. Section 101(l) of Public Law 113–146, as amended by section 409 of Public Law 113–175,

requires VA to ensure that any health care provider that furnishes care or services under the Program to an eligible veteran submits to VA a copy of any medical record related to the care or services that were provided. This is necessary to ensure continuity of care for the health and well-being of the veteran.

*Description of likely respondents:*

Eligible entities and health care providers furnishing hospital care or medical services to eligible veterans through the Veterans Choice Program.

*Estimated number of respondents per year:* 187,000 eligible persons.

*Estimated frequency of responses per year:* 29.80 times per year.

*Estimated average burden per response:* 5 minutes.

*Estimated total annual reporting and recordkeeping burden:* 464,428 hours.

*Title:* Submission of Information on Credentials and Licenses by Eligible Entities or Providers.

*Summary of collection of information:* 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.

*Description of the need for information and proposed use of information:* The information is required by the Act. Section 101(i) of Public Law 113–146 requires non-VA entities or providers to maintain the same or similar credentials and licenses as those required of health care providers of the Department, as determined by the Secretary, and to submit not less than once per year verification of such licenses and credentials maintained by the health care provider. Under the interim final rule, an eligible entity may submit this information on behalf of its providers. This information is necessary to ensure that non-VA entities and providers who are furnishing hospital care and medical services to eligible veterans are meeting the same quality standards as VA health care providers.

*Description of likely respondents:*

Eligible entities or providers furnishing hospital care and medical services through the Veterans Choice Program.

*Estimated number of respondents per year:* 187,000 eligible persons.

*Estimated frequency of responses per year:* 1 time per year.

*Estimated average burden per response:* 5 minutes.

*Estimated total annual reporting and recordkeeping burden:* 15,583 hours.

VA is also developing a survey to understand veteran satisfaction with

receipt of care under the Veterans Choice Program. The information is required by the Act. Section 101(q)(2)(D) of Public Law 113–146 requires VA to report to Congress the results of a survey of eligible veterans who have received care or services under this Program on the satisfaction of such eligible veterans with the care or services they received. This information is necessary because VA must report this information to Congress, and this feedback will help VA better understand whether veterans like the Program. A separate notice will be published in the **Federal Register** providing more information about the planned veteran satisfaction survey.

#### *Executive Orders 12866 and 13563*

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

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined 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](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 interim final rule. Congress directed VA to publish an interim final rule within 90 days of the date of enactment of the law, and further delay in expanding access to non-VA care for eligible veterans could result in the deterioration of their health. Accordingly, the Secretary finds that additional advance notice and public procedure thereon are impractical, unnecessary, and contrary to the public interest. 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 interim 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 interim 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 interim 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. Jose D. Riojas, Chief of Staff, Department of Veterans Affairs, approved this document on October 30, 2014, 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 31, 2014.

**William F. Russo,**

*Acting Director, Office of Regulation Policy & Management, Office of the General Counsel, U.S. Department of Veterans Affairs.*

For the reasons set out 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. Amend § 17.108 by:

■ a. Revising paragraph (b)(1).

■ b. Adding paragraph (b)(4).

■ c. Revising paragraph (c)(1).

■ d. Adding paragraph (c)(4).

■ e. Revising the authority citation at the end of the section.

The revisions and additions read as follows:

#### **§ 17.108 Copayments for inpatient hospital care and outpatient medical care.**

\* \* \* \* \*

(b) *Copayments for inpatient hospital care.* (1) Except as provided in paragraphs (d) or (e) of this section, a veteran, as a condition of receiving inpatient hospital care provided by VA (provided either directly by VA or obtained by VA by contract, provider agreement, or sharing agreement), must agree to pay VA (and is obligated to pay VA) the applicable copayment, as set forth in paragraph (b)(2), (b)(3), or (b)(4) of this section.

\* \* \* \* \*

(4) For inpatient hospital care furnished through the Veterans Choice Program under § 17.1500 through 17.1540, the copayment amount at the time of furnishing such care or services by a non-VA entity or provider is \$0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraphs (b)(2) or (b)(3) of this section.

\* \* \* \* \*

(c) *Copayments for outpatient medical care.* (1) Except as provided in paragraphs (d), (e), or (f) of this section, a veteran, as a condition for receiving outpatient medical care provided by VA (provided either directly by VA or obtained by VA by contract, provider agreement, or sharing agreement), must agree to pay VA (and is obligated to pay VA) a copayment as set forth in paragraph (c)(2) or (c)(4) of this section.

\* \* \* \* \*

(4) For outpatient medical care furnished through the Veterans Choice

Program under § 17.1500 through 17.1540, the copayment amount at the time of furnishing such care or services by a non-VA entity or provider is \$0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraph (c)(2) of this section.

\* \* \* \* \*

(Authority: 38 U.S.C. 501, 1710, 1730A, Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

■ 3. Amend § 17.110 by:

■ a. Adding paragraph (b)(4).

■ b. Revising the authority citation at the end of the section.

The revisions read as follows:

**§ 17.110 Copayments for medications.**

\* \* \* \* \*

(b) \* \* \*

(4) For medications furnished through the Veterans Choice Program under § 17.1500 through 17.1540, the copayment amount at the time the veteran fills the prescription is \$0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraphs (b)(1)(i) through (b)(1)(iii) of this section.

\* \* \* \* \*

(Authority: 38 U.S.C. 501, 1710, 1720D, 1722A, 1730A, Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

■ 4. Amend § 17.111 by:

■ a. Adding paragraph (b)(3).

■ b. Revising the authority citation at the end of the section.

The addition and revision read as follows:

**§ 17.111 Copayments for extended care services.**

\* \* \* \* \*

(b) \* \* \*

(3) For hospital care and medical services considered non-institutional care furnished through the Veterans Choice Program under § 17.1500 through 17.1540, the copayment amount at the time of furnishing such care or services by a non-VA entity or provider is \$0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraphs (b)(1) or (b)(2) of this section.

\* \* \* \* \*

(Authority: 38 U.S.C. 101(28), 501, 1701(7), 1710, 1710B, 1720B, 1720D, 1722A, Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

■ 5. Add an undesignated center heading and §§ 17.1500 through 17.1540 to read as follows:

**Expanded Access to Non-VA Care Through the Veterans Choice Program**

Sec.

17.1500 Purpose and scope.

17.1505 Definitions.

17.1510 Eligible veterans.

17.1515 Authorizing non-VA care.

17.1520 Effect on other provisions.

17.1525 Start date for eligible veterans.

17.1530 Eligible entities and providers.

17.1535 Payment rates and methodologies.

17.1540 Claims processing system.

**Expanded Access to Non-VA Care Through the Veterans Choice Program**

**§ 17.1500 Purpose and scope.**

(a) *Purpose.* Sections 17.1500 through 17.1540 implement the Veterans Choice Program, authorized by section 101 of the Veterans Access, Choice, and Accountability Act of 2014.

(b) *Scope.* The Veterans Choice Program authorizes VA to furnish hospital care and medical services to eligible veterans, as defined in § 17.1510, through agreements with eligible entities or providers, as defined in § 17.1530.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

**§ 17.1505 Definitions.**

For purposes of the Veterans Choice Program under §§ 17.1500 through 17.1540:

*Appointment* means an authorized and scheduled encounter with a health care provider for the delivery of hospital care or medical services. A visit to an emergency room or an unscheduled visit to a clinic is not an appointment.

*Attempt to schedule* means contact with a VA scheduler or VA health care provider in which a stated request by the veteran for an appointment is made.

*Episode of care* means a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than 60 days from the date of the first appointment with a non-VA health care provider.

*Health-care plan* means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement not administered by the Secretary of Veterans Affairs, under which health services for individuals are provided or the expenses of such services are paid; and does not include any such policy, contract, agreement, or similar arrangement pursuant to title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.) or chapter 55 of title 10, United States Code.

*Residence* means a legal residence or personal domicile, even if such residence is seasonal. A person may

maintain more than one residence but may only have one residence at a time. If a veteran lives in more than one location during a year, the veteran's residence is the residence or domicile where the person is staying at the time the veteran wants to receive hospital care or medical services through the Program. A post office box or other non-residential point of delivery does not constitute a residence.

*Schedule* means identifying and confirming a date, time, location, and entity or health care provider for an appointment.

*VA medical facility* means a VA hospital, a VA community-based outpatient clinic, or a VA health care center. A Vet Center, or Readjustment Counseling Service Center, is not a VA medical facility.

*Wait-time goals of the Veterans Health Administration* means, unless changed by further notice in the **Federal Register**, a date not more than 30 days from either:

(1) The date that an appointment is deemed clinically appropriate by a VA health care provider. In the event a VA health care provider identifies a time range when care must be provided (e.g., within the next 2 months), VA will use the last clinically appropriate date for determining whether or not such care is timely.

(2) Or, if no such clinical determination has been made, the date that a veteran prefers to be seen for hospital care or medical services.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

**§ 17.1510 Eligible veterans.**

A veteran must meet the eligibility criteria under both paragraphs (a) and (b) of this section to be eligible for care through the Veterans Choice Program. A veteran must also provide the information required by paragraphs (c) and (d) of this section.

(a) A veteran must:

(1) Be enrolled in the VA health care system under § 17.36 on or before August 1, 2014; or

(2) Be 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).

(b) A veteran must also meet at least one of the following criteria:

(1) The veteran attempts, or has attempted, to schedule an appointment with a VA health care provider, but VA is unable to schedule an appointment for the veteran within the wait-time goals of the Veterans Health Administration.

(2) The veteran's residence is more than 40 miles from the VA medical



facility that is closest to the veteran's residence.

(3) The veteran's residence is both:

(i) In a state without a VA medical facility that provides hospital care, emergency medical services, and surgical care having a surgical complexity of standard (VA maintains a Web site with a list of the facilities that have been designated with at least a surgical complexity of standard. That Web site can be accessed here:

[www.va.gov/health/surgery](http://www.va.gov/health/surgery)); and

(ii) More than 20 miles from a medical facility described in paragraph (b)(3)(i) of this section.

(4) The veteran's residence is in a location, other than one in Guam, American Samoa, or the Republic of the Philippines, which is 40 miles or less from a VA medical facility and the veteran:

(i) Must travel by air, boat, or ferry to reach such a VA medical facility; or

(ii) Faces an unusual or excessive burden in traveling to such a VA medical facility based on the presence of a body of water (including moving water and still water) or a geologic formation that cannot be crossed by road.

(c) If the veteran changes his or her residence, the veteran must update VA about the change within 60 days.

(d) A veteran must provide to VA information on any health-care plan under which the veteran is covered prior to obtaining authorization for care under the Veterans Choice Program. If the veteran changes health-care plans, the veteran must update VA about the change within 60 days.

(e) For purposes of calculating the distance between a veteran's residence and the nearest VA medical facility under this section (except for purposes of calculating a driving route under paragraph (b)(4)(ii) of this section), VA will use the straight-line distance between the nearest VA medical facility and a veteran's residence.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

(The information collection requirements have been submitted to the Office of Management and Budget and are pending OMB approval.)

#### **§ 17.1515 Authorizing non-VA care.**

(a) *Electing non-VA care.* A veteran eligible for the Veterans Choice Program under § 17.1510 may choose to schedule an appointment with a VA health care provider, be placed on an electronic waiting list for VA care, or have VA authorize the veteran to receive an episode of care for hospital care or medical services under 38 CFR 17.38 from an eligible entity or provider.

(b) *Selecting a non-VA provider.* An eligible veteran may specify a particular non-VA entity or health care provider, if that entity or health care provider meets the requirements of § 17.1530. If an eligible veteran does not specify a particular eligible entity or provider, VA will refer the veteran to a specific eligible entity or provider.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

(The information collection requirements have been submitted to the Office of Management and Budget and are pending OMB approval.)

#### **§ 17.1520 Effect on other provisions.**

(a) *General.* In general, eligibility under the Veterans Choice Program does not affect a veteran's eligibility for hospital care or medical services under the medical benefits package, as defined in § 17.38, or other benefits addressed in this part. Notwithstanding any other provision of this part, VA will pay for and fill prescriptions written by eligible providers under § 17.1530 for eligible veterans under § 17.1510, including prescriptions for drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.

(b) *Copayments.* VA will be liable for any deductibles, cost-shares, or copayments required by an eligible veteran's health-care plan for hospital care and medical services furnished under this Program, to the extent that such reimbursement does not result in expenditures by VA for the furnished care or services in excess of the rate established under § 17.1535. Veterans are also liable for a VA copayment for care furnished under this Program, as required by §§ 17.108(b)(4), 17.108(c)(4), 17.110(b)(4), and 17.111(b)(3).

(c) *Beneficiary travel.* For veterans who are eligible for beneficiary travel benefits under part 70 of this chapter, VA will provide beneficiary travel benefits for travel to and from the location of the eligible entity or provider who furnishes hospital care or medical services for an authorized appointment under the Veterans Choice Program without regard to the limitations in § 70.30(b)(2) of this chapter.

(Authority: 38 U.S.C. 111; Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

#### **§ 17.1525 Start date for eligible veterans.**

(a) VA will begin furnishing hospital care and medical services under the Program authorized by 38 CFR 17.1500 through 17.1540 as follows:

(1) Beginning November 5, 2014, to Veterans eligible under § 17.1510(b)(2), (b)(3), or (b)(4).

(2) Beginning no later than December 5, 2014, to Veterans eligible under § 17.1510(b)(1).

(b) If the start date will be earlier than the date identified in paragraph (a)(2) of this section, the Secretary will notify the public of the start date by publishing a Notice in the **Federal Register**.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

#### **§ 17.1530 Eligible entities and providers.**

(a) *General.* An entity or provider is eligible to deliver care under the Veterans Choice Program if, in accordance with paragraph (c) of this section, it is accessible to the veteran and is an entity or provider identified in section 101(a)(1)(B) of the Veterans Access, Choice, and Accountability Act of 2014 and is either:

(1) Not a part of, or an employee of, VA; or

(2) If the provider is an employee of VA, is not acting within the scope of such employment while providing hospital care or medical services through the Veterans Choice Program.

(b) *Agreement.* An entity or provider must enter into an agreement with VA to provide non-VA hospital care or medical services to eligible veterans through one of the following types of agreements: contracts, intergovernmental agreements, or provider agreements. Each form of agreement must be executed by a duly authorized Department official.

(c) *Accessibility.* An entity or provider may only furnish hospital care or medical services to an eligible veteran if the entity or provider is accessible to the eligible veteran. VA will determine accessibility by considering the following factors:

(1) The length of time the eligible veteran would have to wait to receive hospital care or medical services from the entity or provider;

(2) The qualifications of the entity or provider to furnish the hospital care or medical services to the eligible veteran; and

(3) The distance between the eligible veteran's residence and the entity or provider.

(d) *Requirements for health care providers.* To be eligible to furnish care or services under the Veterans Choice Program, a health care provider must maintain at least the same or similar credentials and licenses as those required of VA's health care providers, as determined by the Secretary. The agreement reached under paragraph (b) of this section will clarify these requirements. Eligible health care providers must submit verification of such licenses and credentials

maintained by the provider to VA at least once per 12-month period. Any entities that are eligible to provide care through the Program must ensure that any of their providers furnishing care and services through the Program meet these standards. An eligible entity may submit this information on behalf of its providers.

(Authority: Secs. 101, Pub. L. 113–146, 128 Stat. 1754)

(The information collection requirements have been submitted to the Office of Management and Budget and are pending OMB approval.)

#### **§ 17.1535 Payment rates and methodologies.**

(a) *Payment rates.* Payment rates will be negotiated and set forth in an agreement between the Secretary and an eligible entity or provider.

(1) Except as otherwise provided in this section, payment rates may not exceed the rates paid by the United States to a provider of services (as defined in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)) or a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d)) under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for the same care or services. These rates are known as the “Medicare Fee Schedule” for VA purposes.

(2) For eligible entities or providers in highly rural areas, the Secretary may enter into an agreement that includes a rate greater than the rate defined paragraph (a)(1) of this section for hospital care or medical services, so long as such rate is still determined by VA to be fair and reasonable. The term “highly rural area” means an area located in a county that has fewer than seven individuals residing in that county per square mile.

(3) When there are no available rates as described in paragraph (a)(1) of this section, the Secretary shall, to the extent consistent with the Veterans Access, Choice, and Accountability Act of 2014, follow the process and methodology outlined in §§ 17.55 and 17.56 and pay the resulting rate.

(b) *Payment responsibilities.* Responsibility for payments will be as follows.

(1) For a nonservice-connected disability, as that term is defined at § 3.1(l) of this chapter, a health-care plan of an eligible veteran is primarily responsible, to the extent such care or services is covered by the health-care plan, for paying the eligible entity or provider for such hospital care or medical services as are authorized under §§ 17.1500 through 17.1540 and

furnished to an eligible veteran. VA shall be responsible for promptly paying only for costs of the VA-authorized service not covered by such health-care plan, including a payment made by the veteran, except that such payment may not exceed the rate determined for such care or services pursuant to paragraph (a) of this section.

(2) For hospital care or medical services furnished for a service-connected disability, as that term is defined at § 3.1(k) of this chapter, or pursuant to 38 U.S.C. 1710(e), 1720D, or 1720E, VA is solely responsible for paying the eligible entity or provider for such hospital care or medical services as are authorized under §§ 17.1500 through 17.1540 and furnished to an eligible veteran.

(c) *Authorized care.* VA will only pay for an episode of care for hospital care or medical services authorized by VA. The eligible entity or provider must contact VA to receive authorization prior to providing any hospital care or medical services the eligible non-VA entity or provider believes are necessary that are not identified in the authorization VA submits to the eligible entity or provider. VA will only pay for the hospital care or medical services that are furnished by an eligible entity or provider. There must be an actual encounter with a health care provider, who is either an employee of an entity in an agreement with VA or who is furnishing care through an agreement the health care provider has entered into with VA, and such encounter must occur after an election is made by an eligible veteran.

(Authority: Secs. 101, 105, Pub. L. 113–146, 128 Stat. 1754)

#### **§ 17.1540 Claims processing system.**

(a) There is established within the Chief Business Office of the Veterans Health Administration a nationwide claims processing system for processing and paying bills or claims for authorized hospital care and medical services furnished to eligible veterans under §§ 17.1500 through 17.1540.

(b) The Chief Business Office is responsible for overseeing the implementation and maintenance of such system.

(c) The claims processing system will receive requests for payment from eligible entities and providers for hospital care or medical services furnished to eligible veterans. The claims processing system will provide accurate, timely payments for claims received in accordance with §§ 17.1500 through 17.1540.

(Authority: Secs. 101, 105, Pub. L. 113–146, 128 Stat. 1754)

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## **ENVIRONMENTAL PROTECTION AGENCY**

### **40 CFR Part 52**

**[EPA–R01–OAR–2014–0243; A–1–FRL–9918–00–Region 1]**

### **Approval and Promulgation of Air Quality Implementation Plans; Maine; Volatile Organic Compound Regulations**

**AGENCY:** Environmental Protection Agency.

**ACTION:** Final rule.

**SUMMARY:** The Environmental Protection Agency (EPA) is approving four State Implementation Plan (SIP) revisions submitted by the State of Maine. These revisions establish Reasonably Available Control Technology (RACT) for two categories of volatile organic compound (VOC) sources and revise two existing VOC RACT regulations previously approved into Maine’s SIP. The intended effect of this action is to approve these requirements into the Maine SIP. This action is being taken under the Clean Air Act (CAA).

**DATES:** This rule is effective on December 5, 2014.

**ADDRESSES:** EPA has established a docket for this action under Docket Identification No. EPA–R01–OAR–2014–0243. All documents in the docket are listed on the [www.regulations.gov](http://www.regulations.gov) Web site. Although listed in the index, some information is not publicly available, i.e., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through [www.regulations.gov](http://www.regulations.gov) or in hard copy at the U.S. Environmental Protection Agency, EPA New England Regional Office, Office of Ecosystem Protection, Air Quality Planning Unit, 5 Post Office Square—Suite 100, Boston, MA. EPA requests that if at all possible, you contact the contact listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office’s official hours of business are Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding legal holidays.

Copies of the documents relevant to this action are also available for public